NOVEMBER 2021

BENEFITS
NATIONAL EMPLOYEE SERVICES CENTER

EMPLOYEE BENEFITS

LEGACY

SKILLED TRADES

“NEW” SKILLED TRADES

NEW TRADITIONAL

UAW-REPRESENTED HOURLY EMPLOYEES

We are pleased to provide this revised edition of the UAW-Ford Employee Benefits handbook. It includes changes resulting from the 2019 UAW-Ford Motor Company negotiations. The benefit programs negotiated between the UAW and the Company are excellent — offering comprehensive and valuable benefits for you and your family.

We hope this handbook helps to answer questions you may have regarding your benefits. However, should you have additional questions, please contact the National Employee Services Center (NESC) or your local Union Benefits Representative (UBR). Information on how to contact the NESC or a benefit provider can be found in the Introduction section of this handbook.

This handbook and any updates are also available online at **myfordbenefits.com**.

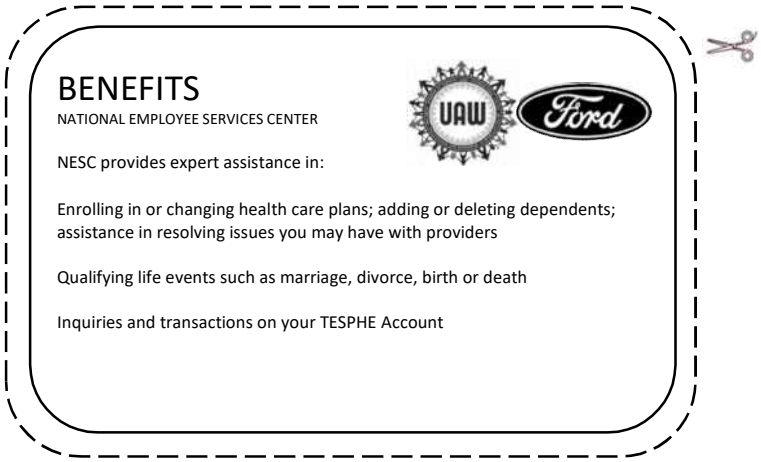
Sincerely,

Charles Browning
Vice President and Director
UAW - National Ford Department

Kevin Legel
Vice President, Labor Affairs
Ford Motor Company

Your NESC Wallet Card

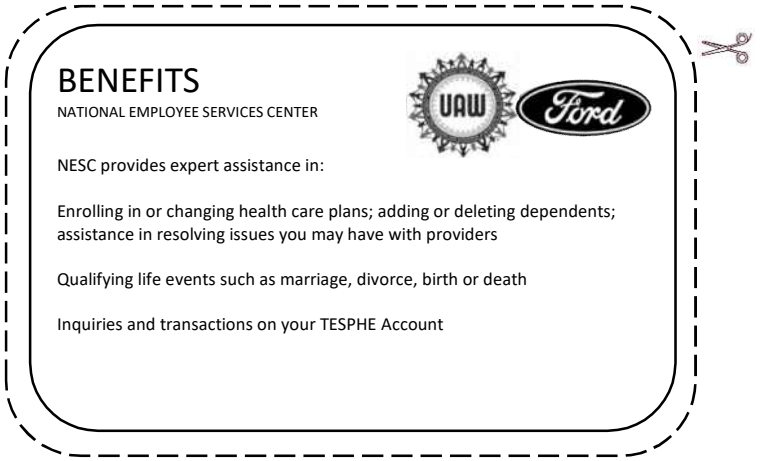
Here is your National Employee Services Center (NESC) Wallet Card. Cut it out and keep it handy.



To change your address or other personal information with Ford:

For active employees:
Contact your Hourly Personnel Office

For employees who have terminated with the Company:
Contact the NESC at 1-800-248-4444



BENEFITS

NATIONAL EMPLOYEE SERVICES CENTER

myfordbenefits.com provides 24-hour access to benefit information and plan documents, and allows you to perform most transactions.

To reach a NESC benefits representative, call:

- 1-800-248-4444 (TDD: 711)
- From overseas, call 1-312-479-9571

NESC Hours of Operation:
9 a. m. to 9 p. m. (ET), Monday through Friday, except on New York Stock Exchange (NYSE) holidays

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UAW-Ford Benefits, November 2021

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- **Legacy Employees**: Hired or rehired prior to November 19, 2007
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- **New Traditional Employees**: Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

**Available only to eligible Skilled Trades, "New" Skilled Trades and New Traditional employees*

***Available only to eligible Legacy and Skilled Trades employees*

Introduction

UAW-Ford Benefits, November 2021

For UAW-Ford Represented:

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Benefits Overview

Your handbook is divided into sections — one for each benefit program and one section to describe administrative and ERISA information, (also included in some of the separate sections). Once you turn to the section in which you're interested, look for information using:

- The table of contents with page numbers for that section
- The overview page with the major points of that plan
- An in-depth explanation with a summary of each plan
- Examples and tables with an easy-to-understand summary of certain plan features

If you cannot find the answers to your benefits questions in this handbook, call the National Employee Services Center (NESC) or contact your local Union Benefits Representative (UBR).

Covered Employees

This handbook describes your benefits based on the November 18, 2019, Collective Bargaining Agreement between Ford Motor Company and the UAW.

Unless specifically noted, the materials in this handbook describe benefit programs for UAW-represented hourly employees of Ford Motor Company who are:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees:** Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Benefits

Your employee benefits are important for you and your family. They are described in this handbook.

Benefits are a valuable part of your compensation as a Ford employee represented by the UAW.

You and your dependents may be eligible for the benefit programs negotiated by Ford Motor Company and the UAW (see Volumes II, III and IV-B of the UAW-Ford Collective Bargaining Agreement). The chart on the next page outlines each of the benefit programs, as well as the requirements you must meet to be eligible for those benefits. Refer to the sections within your handbook for complete information.

This handbook contains an explanation of your employee benefits based on the documents, policies and negotiated Agreements by which these benefits are provided. If there is any difference between the Plan texts, negotiated Agreements and this handbook, the Plan texts and negotiated Agreements always will govern.

The Company reserves the right to end, suspend or amend these plans, subject to the applicable Collective Bargaining Agreement. Amendments also will be made to comply with applicable statutes and regulations. If changes are made, you will be notified.

In certain cases, employees may be eligible for some — but not all — benefits in this handbook. If someone receives this handbook in error, it does not make them eligible for benefits.

Benefit Program	Description	Eligibility
Health Care Plans	Provides hospital, surgical, medical, prescription drug, dental, vision care and hearing aid coverages	On the 90th day following date of hire
Life Insurance	Provides financial protection in case of death	Date of hire or rehire
Optional Life & Accident Insurance Program • Optional Group Life Insurance Benefits • Dependent Group Life Insurance Benefits • Optional Accident Insurance Benefits	Additional employee paid optional life and accidental death and dismemberment insurance	First day of the month following the month you are hired or rehired (enroll within 60 days or during Annual Open Enrollment)
Disability Insurance Plan	Provides financial protection in case of disability	First day of the sixth month following date of hire
Optional Long-Term Disability (OLTD) Insurance	Additional employee paid disability insurance for certain eligible employees	To learn if and when you are eligible, review "Eligibility" in the OLTD section
Retirement Plan	Pays a monthly benefit when you retire, based on type of retirement, date of retirement and years of credited service	Participation is automatic for eligible Legacy and Skilled Trades employees
Tax-Efficient Savings Plan for Hourly Employees (TESPHE)	Offers you an opportunity to save and invest on a pre-tax, Roth or after-tax basis. New hires (not rehires) are automatically enrolled at 3%, which increases by 1% per year up to 6%	Date of hire or rehire
Supplemental Unemployment Benefit (SUB) Plan	Provides income benefits if you are laid off	One year of seniority as of your last day of work prior to a qualifying layoff
Profit Sharing Plan	Provides additional income based on Company profits (in the form of direct deposit or check, TESPHE or Ford Interest Advantage contributions)	Full-time employees who have eligible compensated hours prior to the end of the plan year (December 31)
UAW-FCA-Ford-General Motors Legal Services Plan	Provides certain legal services for covered matters arising within the U.S. and Canada, such as preparation of wills, powers of attorney, deeds, uncontested family matters, real estate purchases or sales, and credit reporting matters	On the 90th day following date of hire
Dependent Care Assistance Plan (DCAP)	Allows you to make pre-tax contributions into an account that reimburses you for eligible dependent care expenses	On the 90th day following date of hire
Ford Interest Advantage (FIA)	Provides you another opportunity to invest	Date of hire or rehire

When you have a benefits question, you may be able to find the answer in this handbook. If you cannot find the answer to your question, visit myfordbenefits.com, call the National Employee Services Center (NESC) at 1-800-248-4444 (TDD: 711) or contact your local Union Benefits Representative (UBR).

Online Account Access

The myfordbenefits.com website provides 24-hour access to your benefits, including a summary of your health care benefits and TESPHE account information and permits a variety of transactions to be initiated online. Some of the things you can do on the myfordbenefits.com website:

- Confirm and update dependent information online
- Enroll in or change your health plan benefit coverage
- Access the Health Plan Evaluator tool
- Ask benefit questions via the real-time Chat feature
- View documents, forms and helpful links while researching your health plan benefits
- Electronically transfer documents directly to the NESC via Document Upload
- Link to websites to search for healthcare providers, hospitals and labs that participate in your plan
- For the TESPHE you can:
    - Select, change or review contribution rates, beneficiaries, investment options, and investment performance
    - Request fund transfers, loans and withdrawals
    - View your statements online

National Employee Services Center (NESC)

The NESC was opened in 1993 to provide improved benefit service for you and your family. The Personal Benefits Representatives receive specialized training that enables them to assist you with your needs. Some of the services the NESC provides include:

- Toll-free phone access
- Experts to handle complex cases
- Simplified processing
- Fewer forms and faster service
- Personal service and benefits counseling

Comments and suggestions for improving service should be sent to:

Quality Coordinator
National Employee Services Center
P.O. Box 1590
Lincolnshire, IL 60069-1590

The NESC cannot assist you with your leave of absence, except to answer questions related to your health care eligibility. Your work location can assist you with questions related to a leave of absence and address any employment termination associated with an expired leave of absence. In the case of a medical leave of absence, please see the *Disability Insurance Plan* section for additional information about the process.

Contact the NESC

To reach the NESC system, call 1-800-248-4444 (TDD: 711).

Personal Benefits Representatives are available Monday through Friday from 9 a.m. to 9 p.m., ET, except on New York Stock Exchange holidays.

USERRA (Uniformed Services Employment and Reemployment Rights Act)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Benefits Service Directory

Here is a quick directory for assistance with your benefits questions:

For This Information:	Call/Contact:
Health Care Plan • Health care claims or benefit coverage • To add or delete dependents or for problems that cannot be resolved with your health care plan	The number on your health care plan ID card **NESC:** 1-800-248-4444 (TDD: 711) Website: **myfordbenefits.com**
Life Insurance Program and Optional Life & Accident Insurance Program • Company-provided coverages (basic life and accidental death and dismemberment (AD&D)) • Enroll in optional insurance coverages (optional life insurance, dependent life insurance, or optional accident insurance) • File a death claim • Add or change beneficiaries	**MetLife** (on or after January 1, 2021)**:** 1-833-552-FORD (3673) Website: **mybenefits.metlife.com** **UniCare** (on or before December 31, 2020)**:** 1-800-843-8184 Website: **unicare.com/ford**
Disability Insurance Plan • Disability claims (Accident & Sickness Benefits or Extended Disability Benefits) • To file a disability claim or report a medical leave of absence	**UniCare:** 1-800-572-1581 1-877-HRLY-MLA (1-877-475-9652)
Optional Long-Term Disability (OLTD) Insurance (for eligible employees)	**UniCare:** 1-800-232-0113
Retirement Plan (for eligible Legacy and Skilled Trades employees)	**NESC:** 1-800-248-4444 (TDD: 711) Website: **myfordbenefits.com**
Tax-Efficient Savings Plan for Hourly Employees (TESPHE)	**NESC:** 1-800-248-4444 (TDD: 711) Website: **myfordbenefits.com**
Supplemental Unemployment Benefit (SUB) Plan	Your local hourly personnel office
Profit Sharing Plan • Eligible compensated hours issues	Your local hourly personnel office
UAW-FCA-Ford-General Motors Legal Services Plan	**UAW-FCA-Ford-General Motors Legal Services Plan** at: 1-800-482-7700, 9 a.m. to 5 p.m. ET, Monday through Friday

For This Information:	Call/Contact:
Dependent Care Assistance Plan	**NESC:** 1-800-248-4444 (TDD: 711) Website: **myfordbenefits.com**
Ford Interest Advantage (FIA) • Enrollment packages • Investment status/interest • FIA Payroll Deduction information only	Contact **Investor Services** at: 1-800-462-2614 (for new and existing requests) Website: **ford.com/finance/investor-center/ford-interest-advantage**
Other Personnel Matters Address changes, Anniversary Awards, United Way, vehicles, FERA, suggestions, education programs, vacation, direct deposit of paycheck, tax withholding of wages, and leaves of absence	Your local hourly personnel office
Sterling Auto and Homeowners Insurance Program	**Sterling:** 1-888-525-7575

Health Care Benefits

UAW-Ford Health Care Plan Summary Plan Description, November 2021

For UAW-Ford Represented:

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Health Care Plan Overview

Your Health Care Plan, which includes Hospital-Surgical-Medical-Prescription Drug-Dental-Vision Care-Hearing Aid coverages, provides important protection for you, your spouse and your eligible dependents.

Your health care benefits cover most health-related expenses. As an hourly Ford employee represented by the UAW, you may be eligible for the following categories of health care coverage:

- Hospital-Surgical-Medical
- Prescription Drug
- Dental
- Vision Care
- Hearing Aid

The Company, in conjunction with the UAW, provides you with access to quality health care services. The Company is not a health care provider and it will not be responsible for any liability stemming from the care you or your dependents receive from a specific health care provider.

Nothing in this Summary Plan Description (or any other explanation of benefits provided to you by or on behalf of the Company) should be considered a representation as to the quality of specific health care services you or your dependents will receive from a particular provider.

Plans

The Blue Cross Blue Shield National Preferred Provider Organization Plan (BCBS National PPO Plan) is available to you, regardless of where you live or work. The National PPO Plan is administered by Blue Cross Blue Shield of Michigan (BCBSM). BCBSM partners with local Blue Cross Blue Shield (BCBS) plans, leveraging their local networks and discounts (allowed amounts), to provide a plan that covers you wherever you go.

The national dental plan is provided through Delta Dental Plan of Michigan. Similar to the BCBS National PPO Plan, it is available to you regardless of where you live or work.

In most areas of the country, alternative health care (hospital, surgical, medical, prescription) plans are also available. In some areas, dental coverage is available under alternative dental care plans.

Depending upon where you live or work, alternatives to the BCBS National PPO Plan and the Delta Dental PPO Plan may be available to you. Alternative plans include:

- Health Maintenance Organizations (HMOs)
- Blue Preferred Plus PPO (Michigan only)
- Dental Health Maintenance Organizations (DHMO)

For more information on alternative plans, you may visit **myfordbenefits.com**, contact the NESC (1-800-248-4444) or contact your local Union Benefits Representative.

Brief descriptions of the BCBS National PPO Plan and alternative plan options available are presented below.

BCBS National PPO Plan

The BCBS National PPO Plan is a Preferred Provider Plan that pays for a greater part of covered expenses if a preferred (network) provider is used. You must use BCBS in-network hospitals, physicians, and pharmacies to receive the maximum benefits payable under the plan. If you use out-of-network providers, your office visit may not be covered and you will be required to pay an additional 10% coinsurance for other covered services.

Refer to *National PPO Plan Overview* and *Hospital-Surgical-Medical Benefits* sections of this handbook for additional information regarding National PPO Plan provisions.

HMO (Health Maintenance Organization)

When you join an HMO, generally most of your health care is covered, when services are provided by the physicians affiliated with the HMO Plan you choose. The HMO usually is associated with specific hospitals. The doctor you choose will coordinate all your health care needs. You usually can choose a different physician for each member of your family. HMOs put a great deal of emphasis on preventive care such as immunizations, allergy testing, well-baby care, and physical exams. Services received outside the HMO network of providers are not covered unless preauthorized by the Plan or in an emergency.

PPO (Preferred Provider Organization)

When you join a PPO, you may receive care from any physician affiliated with the Plan. A PPO also gives you the option of receiving medical services from a doctor or hospital not affiliated with the Plan, but you will be responsible for paying more of the costs yourself.

Health Care Plan Pilot Programs

From time to time, Ford and the UAW may agree to implement “pilot programs” with the goal of providing high quality, cost-effective care. In some areas of the country, part of your Health Care coverage may be provided through a pilot program.

Traditional Dental Plan

You may select any licensed dentist, and he or she is reimbursed by the Plan for covered services. The Traditional Dental Plan, administered by Delta Dental Preferred Provider Organization (PPO), generally pays a percentage of the approved amount for covered procedures, up to an annual dollar maximum (or a lifetime maximum for orthodontics). In addition, when you receive services from a Delta Dental PPO provider, the cost you pay is often less.

DHMO (Dental Health Maintenance Organization)

If there is a DHMO available in your area, you may choose coverage under the DHMO regardless of which Medical Plan you choose. If you choose a DHMO, you must receive your dental care from a dentist who is affiliated with that Dental Plan. A DHMO generally pays all or most of the cost for covered procedures from affiliated dentists with more favorable (or even no) dollar maximums than under the Traditional Dental Plan.

Health Care Benefit Eligibility

UAW-Ford Health Care Plan Summary Plan Description, November 2021

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Health Care Plan Eligibility Overview

Health care plan coverage is available to you, your spouse and your dependent children.

Eligibility

The Company, in conjunction with the UAW, provides you with the BCBS National PPO Plan, regardless of where you live or work. You also may be eligible to enroll in alternative health care plans. The plan in which you are eligible to enroll depends on where you live or work.

Note: The Blue Preferred Plus (BPP) Plan is an alternative health care plan available to employees in Michigan. Members of the BPP Plan have the same eligibility criteria as defined for the National PPO Plan members. For more information on the BPP plan, refer to the *Hospital-Surgical-Medical Coverage* section of this handbook.

Enrollment

Coverage is effective the first day of the month following election.

Your medical election automatically determines your prescription drug, vision and hearing aid coverages. You do not need to enroll separately.

Your Identification Card

Once you and your spouse (and any other dependents) are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans in which you enroll. These cards should be presented to health care providers as confirmation of coverage.

Coverage

Review the eligibility requirements in the *Dependent Eligibility* section to ensure that your dependents are eligible. To elect coverage for yourself and eligible dependents, please call the NESC at 1-800-248-4444 (TDD: 711) or visit **myfordbenefits.com** to make your election.

You will need to provide the following information:

- Full name
- Social Security Number
- Birth date

Transfer from Salaried to Hourly Employment or Vice-Versa

If you transfer from salaried to hourly employment or vice-versa, call the NESC at 1-800-248-4444 and a Personal Benefits Representative will assist you regarding your enrollment options and the enrollment process.

Note:

- Under certain circumstances, you may choose to continue your group (Ford) health care coverage
- Refer to the *Other Non-Ford Group Health Care Plan Information* section for detailed information on when you can pay to continue coverage or convert your coverage to an individual policy.

Plan Election Changes

You may change your plan elections during any month of the year.

Under the Hourly Rolling Enrollment system, you may change your medical and/or dental plan elections during any month of the year (provided 12 months have elapsed since your last change) and you are eligible for coverage.

To make a change, visit **myfordbenefits.com** or call the NESC at 1-800-248-4444.

Hourly Rolling Enrollment	
If you elect a change during the month of:	**Your election takes effect on:**
January	February 1
February	March 1
March	April 1
April	May 1
May	June 1
June	July 1
July	August 1
August	September 1
September	October 1
October	November 1
November	December 1
December	January 1

Once you make a change to your medical and/or dental plan, you must wait 12 months to make another change. Certain limited changes are allowed during the 12-month period. Visit **myfordbenefits.com,** call the NESC (1-800-248-4444) or contact your Union Benefits Representative to determine if a change is allowable.

If you are on an approved medical leave of absence, health care coverage for you, your spouse and your eligible dependents continues while you are away from work for up to the greater of:

- A period of time equal to the number of years of seniority you had when you left
- The period of time during which you receive Extended Disability Benefits

If you are on an FMLA leave of absence, health care coverage for you, your spouse and your eligible dependents continues while you are away from work for the duration of the FMLA leave. For additional information on FMLA, please refer to “What are my rights under the Family and Medical Leave Act (FMLA) of 1993?” in the *Administrative, ERISA and Family and Medical Leave Act of 1993 Information* section of this handbook.

Health care coverage will continue as legally required to comply with individual state family leave laws.

If you are on a qualifying layoff under the Ford-UAW Supplemental Unemployment Benefit (SUB) Plan, health care coverage for you, your spouse and your eligible dependents continues for the time period in the schedule below:

Your years of seniority on the last day you worked prior to layoff	Number of months coverage will be provided without cost to you
Less than 1	0
1 but less than 2	2
2 but less than 3	4
3 but less than 4	6
4 but less than 5	8
5 but less than 6	10
6 but less than 10	12
10 and over	24

When your months of continued coverage are up, you may continue coverage for up to 12 consecutive months by making payments for coverage.

When Coverage Ends

Your coverage will end:

- If your employment is terminated by quitting, being discharged, failing to report or overstaying a leave, all your health care coverages terminate as of the employment termination date.
- If you have a grievance pending to protest your loss of seniority resulting from your termination for discharge, failing to report or overstaying a leave, all your health care coverages end the last day of the month after the month in which your employment is terminated. You may, however, continue coverage after Company-paid coverage terminates by paying the cost while the grievance is pending.
- If you go on leave of absence (other than an approved medical leave, FMLA leave or other state mandated family leave), all your health care coverages (except dental coverage) end the last day of the month following the month in which you leave. If you wish, you may continue health care coverage (except dental coverage) during the leave for up to twelve consecutive months by making payments for coverage. Dental coverage ends the last day of the month in which you leave.

Note: While on local union leave of absence, health care, including dental, may be continued for the duration of the leave by paying the cost.

USERRA (Uniformed Services Employment and Reemployment Rights Act)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service.

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Dependent Removal

You are responsible for notifying the NESC to remove a dependent from your Company-paid coverage as soon as they no longer meet the eligibility requirements. Please refer to the applicable dependent type in the *Dependent Eligibility* section below for more information.

If and when your circumstances change causing a dependent to lose eligibility, call the NESC at 1-800-248-4444 and remove your ineligible dependent.

For example, if your child, spouse or disabled dependent no longer qualifies as a dependent, then you have an obligation to remove them from coverage. Removing dependents when they lose eligibility will eliminate any action by the Company to recover any health care claims or premiums incurred by an ineligible dependent.

You can also get information about self-pay continuation of coverage options. Refer to the *COBRA* section of this handbook for information about self-pay continuation of coverage options.

Benefit Overpayment Recovery

If the Plan determines that your act (such as adding a person not eligible under the Plan) or omission (for example, failing to remove a person no longer eligible under the Plan) results in or contributes to an overpayment under this Program, you will be sent written notice from the Company and you must repay the amount of overpayment.

Note: If repayment is not made within 60 days following the date of the written notice, the Company has the right, in accordance with and subject to any limitations under applicable federal laws, to make, or arrange to have made, deductions for recovering such overpayments from any present or future compensation (excluding the Ford-UAW Retirement Plan) or benefits payable under the Ford Hospital-Surgical-Medical-Drug-Dental-Vision (HSMDDV) Program that are or become payable to you.

Deductions for such overpayments will not exceed $100 per paycheck except in cases of fraud or willful misrepresentation.

Dependent Eligibility

The following pages list the dependent types and explain the eligibility guidelines for each dependent type. Please be sure to read each category to find plan requirements for:

- Eligibility for health care
- Enrollment and effective dates
- Termination of your dependent's health care

You will need to provide the following information for each dependent:

- Full name
- Social Security Number — when enrolling eligible dependents to your health care coverage, you must provide the Company with the dependent's Social Security Number. If the eligible dependent has not been assigned a Social Security Number at the time they are enrolled, one must be obtained and reported to the Company within six months of the date coverage becomes effective.
- Birth date

Dependent Types: (explained in more detail on the following pages)

- Spouse
- Common-Law Spouse
- Children Up to 26 Years of Age
- Children Covered by a Qualified Medical Child Support Order
- Principally Supported Dependents (e.g., a grandchild, niece or nephew)
- Children by Legal Guardianship
- Totally and Permanently Disabled Dependents
- Optional Sponsored Dependents

Spouse

Your spouse is eligible for coverage, if you are eligible for and enrolled in a health care plan offered by the Company.

Enrollment and Effective Dates

Your spouse is eligible for coverage effective the later of the date your coverage began or your date of marriage.

Visit **myfordbenefits.com**, or call the NESC at 1-800-248-4444 to initiate the enrollment of a spouse. The NESC will inform you of any required documentation for proving eligibility for a spouse you enroll for coverage. If you need assistance submitting your documentation, please contact your Union Benefits Representative.

Note: Failure to furnish any required documentation will result in denial of coverage.

If Your Spouse also has Ford Medical or Dental Coverage

You may have your own coverage or be under your spouse's plan. Neither you nor your spouse may have your own Ford-sponsored coverage and be a dependent on another Ford-sponsored plan.

Termination

Your spouse's eligibility for coverage ends on the earliest to occur of:

- The date your coverage ends
- The date of a final decree of divorce
- The date your marriage is annulled
- The last day of the month following the month in which you die unless:
  - You were retired or eligible to retire at the time of your death and your spouse is eligible for a surviving spouse benefit under the Ford-UAW Retirement Plan
  - Your surviving spouse is eligible to receive Bridge Survivor Income Benefits from the Group Life and Disability Insurance Program (or would be eligible except that your surviving spouse was age 60 or older at the time of your death), Company-paid coverage (other than dental and vision) continues for the following continuation period:
    - 24 months following the month in which you die if you have less than 10 years of credited service under Company retirement plans at the time of your death
    - 30 months following the month in which you die if you have 10 or more years of credited service under Company retirement plans at the time of your death
- The date your surviving spouse remarries if your death is the result of an occupational injury caused solely by employment with the Company
- The date your surviving spouse is not enrolled in Medicare Part B coverage
- The date of your spouse's or surviving spouse's death
- The date your spouse or surviving spouse no longer meets any other eligibility requirements of the Plan

If and when any of the aforementioned circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible spouse.

Refer to *COBRA* found in the *Other Non-Ford Group Health Care Plan Information* section of this handbook for information about self-pay continuation of coverage options.

Common-Law Spouse

Your common-law spouse is eligible for coverage, if the relationship is recognized by the laws of the state in which you reside, provided you meet the requirements for documentation of the status as may be necessary by law and required by the Company.

In the event you relocate to another state, your common-law marriage would continue to be recognized by the Company.

Enrollment and Effective Dates

Coverage for a common-law spouse is effective on the latest to occur of the effective date of your coverage, or the date of a valid enrollment and receipt by the Company of any necessary supporting documentation.

Call the NESC at 1-800-248-4444 to initiate the enrollment of your common-law spouse. The NESC will inform you of any required documentation for proving eligibility for a common-law spouse you enroll for coverage.

Note: Failure to furnish any required documentation will result in denial of coverage.

Termination

Your common-law spouse's eligibility for coverage ends on the earliest to occur of:

- The date your coverage ends
- The date of a final decree of divorce
- The date your marriage is annulled
- The last day of the month following the month in which you die unless:
  - You were retired or eligible to retire at the time of your death and your spouse is eligible for a surviving spouse benefit under the Ford-UAW Retirement Plan
  - Your surviving spouse is eligible to receive Bridge Survivor Income Benefits from the Life and Disability Insurance Program (or would be eligible except that your surviving spouse was age 60 or older at the time of your death), Company-paid coverage (other than dental and vision) continues for the following continuation period:
    - 24 months following the month in which you die if you have less than 10 years of credited service under Company retirement plans at the time of your death
    - 30 months following the month in which you die if you have 10 or more years of credited service under Company retirement plans at the time of your death
- The date your surviving spouse remarries if your death is the result of an occupational injury caused solely by employment with the Company
- The date your surviving spouse is not enrolled in Medicare Part B coverage
- The date of your spouse's or surviving spouse's death
- The date your spouse or surviving spouse no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to *COBRA* in the *Other Non-Ford Group Health Care Plan Information* section of this handbook for information about self-pay continuation of coverage options.

Children Under the Age of 26

Your children are eligible for coverage if you are eligible and enrolled for coverage, and they meet all the following requirements:

Relationship

A "child" (as defined by Health Care Reform) includes:

- Your natural child
- Your stepchild
- You or your spouse's legally adopted child
- A child under the age of 18 placed for legal adoption
- A foster child (under court or agency order)

Age

The child must be newborn up to 26 years of age.

Enrollment and Effective Dates

Coverage for a child under the age of 26 is effective on the later of the effective date of your coverage, the date they first meet the eligibility criteria, or in the case of:

- Birth – the date of birth
- Legal Adoption – the date of placement in your household or petition for adoption, whichever occurs earlier, or the date the assumption and retention of a legal obligation for total or partial support
- Stepchild – the date the child becomes a member of your household
- Court Order, Divorce, or other Qualified Medical Child Support Order (QMCSO) – the date of the court order, divorce decree, or other QMCSO

Visit **myfordbenefits.com**, or call the NESC at 1-800-248-4444 to initiate the enrollment of your child under age 26. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage.

Note:

- Failure to furnish any required documentation will result in denial of coverage.
- A child may not be covered by more than one Ford employee.

Termination

Your child will lose eligibility for coverage on the earliest to occur of:

- The date your coverage ends
- The last day of the month following the month in which you die (unless the child is eligible for coverage as a dependent child of your eligible and enrolled surviving spouse)
- The last day in the month the child becomes age 26, except in the case of a totally and permanently disabled child
- The date your surviving spouse's coverage ends
- The date you or your spouse, 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 the Omnibus Budget Reconciliation Act of 1998 (OBRA 93)
- The date your relationship to a stepchild ends due to the termination of the marriage
- The date the foster child relationship ends
- The date of the child's death
- The date the child no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to *COBRA* in the *Other Non-Ford Group Health Care Plan Information* section of this handbook for information about self-pay continuation of coverage options.

Children Covered by a Qualified Medical Child Support Order (QMCSO)

The Ford Health Plan must follow the provisions of a Qualified Medical Child Support Order (called a "QMCSO"). A QMCSO is a judgment, decree or order from a court or administrative agency (that the Ford health plan determines meets all QMCSO requirements) requiring a Ford health plan participant to provide coverage to a child under a state domestic relations law (such as a divorce judgment) or a law relating to child support (such as a National Medical Support Notice issued by a state child support agency).

As Plan Administrator, Ford determines whether a court or agency order meets the requirements for a QMCSO. For a copy of the Ford Health Plan QMCSO procedures, write to:

Ford Motor Company
National Employee Services Center
Qualified Order Center
P.O. Box 1590
Lincolnshire, IL 60069-1590

A court or agency order will not be a QMCSO unless the child that is subject to the order meets the following requirements:

Relationship

"Children" include the employee's:

- Natural Child
- Legally Adopted Child

Enrollment and Effective Dates

The effective date of coverage for a Court Order, Divorce Decree or other QMCSO dependent will be the 1st of the month following the receipt of the court documents.

Call the NESC at 1-800-248-4444 to initiate the enrollment of your QMCSO child. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage.

Note:

- Failure to furnish any required documentation will result in denial of coverage.
- A dependent may not be covered by more than one Ford employee.

Termination

Your QMCSO child will lose eligibility for coverage the date:

- Your coverage ends
- The child no longer meets any other eligibility requirements of the Plan

Note: Prior to the expiration of the QMCSO order (or the child's 18th birthday if no expiration date appears on the order), the NESC will mail a notice to your address of record advising that once your legal obligation to provide health care coverage ceases, you may remove the child from your coverage. If you do not contact the NESC to request removal, the child will remain on your coverage in accordance with the Federal Patient Protection & Affordable Health Care Act rules, which currently allow you to continue health care coverage for your eligible child through the end of the month in which they turn 26.

Principally Supported Dependents

If a principally supported dependent is on your coverage **prior to 11/19/2007**, that child will be deemed to be grandfathered as long as they continue to meet all other Company eligibility requirements. If that child loses eligibility or is terminated from your coverage during an audit, you will be unable to reinstate the child to coverage unless you obtain "legal guardianship" of the child. These dependents are not eligible for coverage if your spouse claims them.

Relationship

The child must be related to you by blood or marriage:

- Grandchildren
- Nieces
- Nephews
- Siblings

Age

Dependent children will be removed from coverage at age 19 unless the employee responds to a written notification to continue coverage.

A child is eligible between the ages of 19 and the end of the calendar year in which they turn age 24, if they qualify as a full-time student as defined by the school and they meet the Company's eligibility requirements, or has been determined to be totally and permanently disabled by the Plan Administrator (Company).

Residency

The child **must** reside with you as a member of your household.

Tax Dependent

You **must** claim an exemption for the child on your Federal Income Tax return.

Marital Status

Children must be unmarried.

Full-Time Student Status

Dependents between the ages of 19 and the end of the year they reach 24 must qualify as a full-time student as defined by the school and meet all other Company dependent eligible requirements. This does not apply if your dependent has been determined by the Company to be totally and permanently disabled.

Termination

Your principally supported dependent will lose eligibility for coverage on the earliest to occur of:

- The date the Company terminated the child's coverage because you did not comply with an audit and prove the child's eligibility for coverage
- The date of marriage of the child
- The date the child ceases to be dependent upon you for Federal Income Tax purposes
- The date the child no longer meets the residency requirement
- The date the child is no longer a full-time student (for dependents age 19 to 24), except in the case of a totally and permanently disabled child
- The last day of the calendar year in which the child, who is a full-time student, becomes age 24
- The date your coverage ends, except that in the case of your death, coverage for the dependent child will end on the last day of the month following the month in which you die (unless the child is eligible for coverage as a dependent child of an eligible surviving spouse in which case the child's coverage ends when the surviving spouse is no longer eligible for coverage)
- The date you or your spouse, 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
- The date of the child's death
- The date the child no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Children by Legal Guardianship Under the Age of 18

A child by legal guardianship is eligible for coverage if you are eligible and enrolled for coverage, **have obtained legal guardianship and the child meets all the following requirements:**

Relationship

A child by legal guardianship will be limited to children who are related by blood (up to and including second degree relatives) to the primary enrollee or the primary enrollee's current spouse. A child by legal guardianship is eligible until 18 years of age, not graduated from high school. The dependent children that are eligible as “legal guardianship dependents” are:

- Brother, Sister, Half-brother and Half-sister
- Grandson and Granddaughter
- Niece and Nephew

Age

The child must be newborn to 18 years of age.

Residency

The child **must** reside with you, the employee, as a member of your household.

Tax Dependent

You, the employee, **must** claim an exemption for the child on your Federal Income Tax return.

Marital Status

Children must be unmarried.

Enrollment and Effective Dates

Coverage for a child by legal guardianship is effective on the later of the effective date of your coverage or the date of petition for guardianship and residence.

Call the NESC at 1-800-248-4444 to initiate the enrollment of your child by legal guardianship. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage.

Note:

- Failure to furnish any required documentation will result in denial of coverage.
- A dependent may not be covered by more than one Ford employee.

Termination

Your child by legal guardianship shall lose eligibility for coverage on the earliest to occur of:

- The date your coverage ends
- The date the child no longer resides with you
- The date the child ceases to be dependent upon you for Federal Income Tax purposes
- The date of marriage of the child
- The last day of the month in which the child becomes age 18, except in the case of a totally and permanently disabled child
- The last day of the month the enrollee's legal guardianship of the child is terminated
- The date of the child's death
- The date the child no longer meets any other eligibility requirements of the Plan

Important: If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to *COBRA* in the *Other Non-Ford Group Health Care Plan Information* section of this handbook for information about self-pay continuation of coverage options.

Totally and Permanently Disabled Children

Totally and permanently disabled is defined by having any medically determinable physical or mental condition that prevents the child from engaging in substantial gainful activity, which can be expected to result in death or be of long-continued or indefinite duration.

Coverage will not be reinstated for a child who first becomes totally and permanently disabled after the end of the month in which age 26 is attained **or** who was eligible and enrolled for coverage as a totally and permanently disabled child, recovers, and after coverage has ended, again has a total and permanent disability.

Your child shall be eligible for coverage if you are eligible and enrolled for coverage and he or she is deemed to be totally and permanently disabled by the Plan (Company) before attaining age 26, when coverage would have ended.

Relationship

"Children" include:

- Your natural child
- Your stepchild
- A legally adopted child

To continue to cover a dependent as totally and permanently disabled after the end of the month in which the dependent turns age 26, you must remain eligible and enrolled for coverage and the dependent must also continue to meet all the following requirements:

Residency

The child **must** reside with you, the employee, as a member of your household.

Tax Dependent

- The totally and permanently disabled child must qualify for a dependency exemption under the Internal Revenue Code for income tax purposes
- A child shall not be deemed to be "totally and permanently disabled" if the child is engaged in regular employment or occupation of remuneration or profit which exceeds $10,000 annually

Marital Status

Children **must** be unmarried.

Enrollment and Effective Dates

Coverage for totally and permanently disabled children is effective on the later of the effective date of your coverage or the date they first meet the eligibility criteria.

Call the NESC at 1-800-248-4444 to initiate the enrollment of the totally and permanently disabled child. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage.

Note:

- Failure to furnish any required documentation will result in denial of coverage.
- A dependent may not be covered by more than one Ford employee.

Your Identification Card

Once you and your sponsored dependent are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans in which you enroll. These cards should be presented to health care providers as confirmation of coverage. Sponsored dependents will receive their own ID cards.

Termination

Your totally and permanently disabled child shall lose eligibility for coverage on the earliest to occur of:

- The date a child over age 26 is deemed no longer to be totally and permanently disabled by the Company
- The marriage date of the child (age 26 and older)
- The date the child ceases to be dependent upon you or your spouse for Federal Income Tax purposes and/or earns more than $10,000 per year from regular employment (age 26 and older)
- The date the child no longer meets the residency requirement (age 26 and older)
- The date you or your spouse, 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
- The date of the child's death
- The date the child no longer meets any other eligibility requirements of the Plan

Documentation supporting a dependent's Totally and Permanently Disabled status will be accepted up to 90 days following a dependent's termination.

Important: If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to *COBRA* in the *Other Non-Ford Group Health Care Plan Information* section of this handbook for information about self-pay continuation of coverage options.

Optional Sponsored Dependent Coverage

You may obtain optional employee-paid medical and prescription drug coverage (but not dental and vision) for certain eligible dependents through the Sponsored Dependent Program. The employee pays the full cost of the coverage for sponsored dependents.

Your sponsored dependent is eligible for coverage if you are eligible and enrolled for coverage, and meet all the following requirements:

Relationship

"Sponsored dependents" include:

- A dependent parent of an employee or employee's spouse
- An unmarried child or stepchild of an enrollee who resides with the enrollee, but is not eligible as a dependent child
- A blood relative who does not qualify as a dependent by legal guardianship
- A non-relative (such as a fiancée) who resides with you and is claimed as an exemption on your Federal Income Tax return

Age

There is no age requirement.

Residency

- The sponsored dependent **must** reside with you, the employee, as a member of your household.
- The sponsored dependent **must** be a resident of the United States for at least one full year, when applicable, prior to being enrolled for such coverage and be legally entitled to remain in the United States indefinitely before becoming eligible for coverage.

Tax Dependent

You, the employee, **must** claim an exemption for the sponsored dependent on your Federal Income Tax return.

Enrollment and Effective Dates

Call the NESC at 1-800-248-4444 to initiate the enrollment of your Sponsored Dependent. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage.

Note:

- Failure to furnish any required documentation will result in denial of coverage.
- A sponsored dependent may not be covered by more than one Ford employee.

Coverage for Optional Sponsored Dependents is effective on:

- The later of the effective date of your coverage or the first day of the month following the month of receipt by the Company of any supporting documentation required by the Company to prove eligibility
- The effective date of coverage for a sponsored dependent previously enrolled as such, and whose coverage as a sponsored dependent was discontinued, is the first day of the sixth month following the month in which a valid enrollment is completed

Your Identification Card

Once you and your sponsored dependent are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans in which you enroll. These cards should be presented to health care providers as confirmation of coverage. Sponsored dependents will receive their own ID cards.

Termination

Your sponsored dependent will lose eligibility for coverage on the earliest to occur of:

- The last day of the month in which the sponsored dependent ceases to meet the eligibility requirements shown above
- The last day of the month preceding the month for which a required contribution was due but not paid
- The date your coverage ends, except that in the case of your death, coverage for the sponsored dependent will end on the last day of the month following the month in which you die, unless the coverage is continued by your eligible Surviving Spouse
- The date of your sponsored dependent's death

Important: If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to *COBRA* in the *Other Non-Ford Group Health Care Plan Information* section of this handbook for information about self-pay continuation of coverage options.

Hospital-Surgical-Medical Coverage

UAW-Ford Health Care Plan Summary Plan Description, November 2021

For UAW-Ford Represented:

- **Legacy Employees**: Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees**: Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees**: Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

National PPO Plan Overview

The Hospital-Surgical-Medical Plan is called the BCBS National PPO Plan. The BCBS National PPO Plan has an in-network benefit level and an out-of-network benefit level.

The following chart provides a quick reference guide for frequently used services:

National PPO		
Member's Responsibility (deductibles, coinsurance, copays and dollar maximums)		
Benefits	**In-Network**	**Out-of-Network**
Deductibles — per calendar year	None	None
Coinsurance	0% (Covered at 100%)	10% (Covered at 90%)
Annual out-of-pocket maximums *After out-of-pocket maximum is reached, plan pays 100% allowed amount for covered services.* *Copayments do not apply to out-of-pocket maximum.*	Not applicable	$250 per member $500 per family
Copayments		
Office visit ***Office visit copay is $25 if hired or rehired on or after 11/18/19***	$20 copay*	**Not covered**
Telemedicine/Blue Cross online visit *Copay waived for first visit, per member, per lifetime*	$10 copay	**Not covered**
Retail health visit ***Retail health visit copay is $12.50 if hired or rehired on or after 11/18/19***	$10 copay**	**Not covered**
Urgent care visit	$50 copay	$50 copay
Emergency room visit *Copay waived if admitted, placed into observation care or sent by company medical*	$100 copay	$100 copay
Physician Office Services		
Benefits	**In-Network**	**Out-of-Network**
Office visits ***Office visit copay is $25 if hired or rehired on or after 11/18/19***	$20 copay*	**Not covered**
Medical services billed with an office visit	Covered — 100%	Covered — 90%
Retail health visit ***Retail health visit copay is $12.50 if hired or rehired on or after 11/18/19***	$10 copay**	**Not covered**

Preventive Care Services		
Benefits	**In-Network**	**Out-of-Network**
Health maintenance exam — one per calendar year	Covered — 100%	Covered — 90%
Annual gynecological exam — two per calendar year	Covered — 100%	Covered — 90%
Well baby/child care *8 visits under 12 months; 6 visits ages 13 – 23 months; 6 visits for ages 36 – 47 months; 1 per calendar year thereafter*	Covered — 100%	Covered — 90%
Pap smear screening — one per calendar year	Covered — 100%	Covered — 90%
Mammography screening — one per calendar year beginning at age 40 *Includes 3D mammography*	Covered — 100%	Covered — 90%
Prostate specific antigen (PSA) screening — one per calendar year; age 40 and older	Covered — 100%	Covered — 90%
Colorectal cancer screenings — one per calendar year age 50 and older	Covered — 100%	Covered — 90%
Cologuard —Once every 3 years; age 50 and older	Covered — 100%	Covered — 90%
Immunizations *Following Advisory Committee on Immunization Practices (ACIP) guidelines*	Covered — 100%	Covered — 90%
Additional preventive services as mandated by National Health Care Reform *Coverage may vary on services; contact customer service at 1-800-482-5146 for full details*	Covered — 100%	Covered — 90%
Emergency Medical Care		
Benefits	**In-Network**	**Out-of-Network**
Emergency room visit —*health threatening or disabling condition*	Covered — $100 copay *(Copay waived if admitted, placed into observation care or sent by company medical)*	Covered — $100 copay *(Copay waived if admitted, placed into observation care or sent by company medical)*
Non-emergency visit to emergency room	**Not covered**	**Not covered**
Urgent care visit	Covered — $50 copay	Covered — $50 copay
Ambulance services *Ground, air and boat transportation are covered when medical criteria are met and includes ambulance treatment without transport*	Covered — 100%	Covered — 90%
Diagnostic Services		
Benefits	**In-Network**	**Out-of-Network**
Specialty/advanced imaging (MRI, MRA, PET and CAT scans) and nuclear medicine *Preauthorization required in Michigan only*	Covered — 100%	Covered — 90%
X-rays	Covered — 100%	Covered — 90%
Laboratory and pathology *Quest Diagnostics is the preferred provider network in Michigan only.*	Covered — 100%	Covered — 90%

Maternity Services		
Benefits	**In-Network**	**Out-of-Network**
Prenatal care visits	Covered — 100%	Covered — 90%
Postnatal care visits	Covered — 100%	Covered — 90%
Delivery and nursey care	Covered — 100%	Covered — 90%
Infertility treatment	**Not covered**	**Not covered**
Hospital Care		
Benefits	**In-Network**	**Out-of-Network**
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies *Preauthorization required for hospital admission*	Covered — 100%	Covered — 90% *Nonparticipating hospital rates = $500 per day for room and board and $50 per day for ancillaries*
Inpatient medical care	Covered — 100%	Covered — 90%
Observation care *Includes care immediately following surgery or diagnostic testing*	Covered — 100%	Covered — 90%
Alternatives to Hospital Care		
Benefits	**In-Network**	**Out-of-Network**
Skilled nursing facility care *Must use participating providers* *Contact customer service for assistance at 1-800-482-5146*	Covered — 100%	Covered — 100%
Home health care *Must use participating providers* *Contact customer service for assistance at 1-800-482-5146*	Covered — 100%	Covered — 100%
Hospice care *Must use participating providers* *Contact customer service for assistance at 1-800-482-5146*	Covered — 100%	Covered — 100%
Private duty nursing	**Not covered**	**Not covered**
Surgical Services		
Benefits	**In-Network**	**Out-of-Network**
Surgery (includes related surgical services)	Covered — 100%	Covered — 90%
Voluntary sterilization — males	Covered — 100%	Covered — 90%
Voluntary sterilization — females	Covered — 100%	Covered — 90%
Bariatric surgery	Covered — 100%	Covered — 90%
Human Organ Transplants		
Benefits	**In-Network**	**Out-of-Network**
Specified organ transplants *Preauthorization required for organic material and services through the Human Organ Transplant Program* *Preauthorization required for hospital admission*	Covered — 100%	Covered — 90%
Kidney, cornea, bone marrow and skin *Preauthorization required for hospital admission*	Covered — 100%	Covered — 90%

Behavioral Health Services (Mental Health and Substance Use Disorder)		
Benefits	**In-Network**	**Out-of-Network**
Inpatient mental health care *Preauthorization required; contact customer service at 1-800-482-5146 for assistance*	Covered — 100%	Covered — 90%
Outpatient mental health care ***Visit (maximum) copays are $25 if hired or rehired on or after 11/18/2019***	**Visits 1–20:** covered 100% **Visits 21–35:** covered at 75% up to $20 maximum copay **Visits 36+:** covered with $20 copay* *Visit count resets every calendar year*	**Not covered**
Inpatient substance use disorder treatment *Preauthorization required; contact customer service at 1-800-482-5146 for assistance*	Covered — 100%	Covered — 90%
Outpatient substance use disorder treatment ***Visit copay is $25 if hired or rehired on or after 11/18/2019***	**Visits 1–35:** covered 100% **Visits 36+:** covered with $20 copay *Visit count resets every calendar year*	**Not covered**
Autism Spectrum Disorders, Diagnoses and Treatment — Up to and including age 18		
Benefits	**In-Network**	**Out-of-Network**
Applied Behavioral Analysis (ABA) treatment *Preauthorization required; contact customer service at 1-800-482-5146 for assistance* **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered — 100%	Covered — 90%
Occupational and speech therapy *Occupational and speech therapy with an autism diagnosis is unlimited*	Covered — 100%	Covered — 90%
Therapy Services — Outpatient coverage limited to 60 combined visits, per condition, per calendar year		
Benefits	**In-Network**	**Out-of-Network**
Inpatient physical, speech and occupational therapy	Covered — 100%	Covered — 90%
Outpatient speech and occupational therapy	Covered — 100%	Covered — 90%
Outpatient physical therapy ***Benefit administered by TheraMatrix***	Services through TheraMatrix covered at 100% **Contact TheraMatrix at 888-638-8786**	Preapproval from TheraMatrix required **Contact TheraMatrix at 888-638-8786**

Chiropractic Services		
Benefits	**In-Network**	**Out-of-Network**
Spinal X-rays	Covered — 100%	Covered — 90%
Chiropractic office visits ***Office visit copay is $25 if hired or rehired on or after 11/18/2018***	Covered — $20 copay	**Not covered**
Spinal or osteopathic manipulations	**Not covered**	**Not covered**
Medical Equipment, Supplies and Appliances		
Benefits	**In-Network**	**Out-of-Network**
Durable medical equipment (DME)/medical supplies	Covered — 100%	Covered — 80% until $500 out-of-pocket maximum per family is met, then covered at 100%
Diabetic supplies (glucose meter, diabetic test strips, lancets, etc.)	Covered — 100%	Covered — 80% until $500 out-of-pocket maximum per family is met, then covered at 100%
Prosthetic and orthotic (P&O) appliances	Covered — 100%	Covered — 80% until $500 out-of-pocket maximum per family is met, then covered at 100%
Shoe inserts and arch supports — one pair per calendar year	Covered — 100%	Covered — 80% until $500 out-of-pocket maximum per family is met, then covered at 100%
Continuous glucose monitoring systems (CGMS) *Covered with appropriate clinical indicators* *Contact customer service at 1-800-482-5146 for assistance*	Covered — 100%	Covered — 90%
Other Services		
Benefits	**In-Network**	**Out-of-Network**
Allergy testing and allergy injections	Covered — 100%	Covered — 90%
Allergy serum *Contact customer service at 1-800-482-5146 for assistance*	***Covered under prescription drug program***	***Covered under prescription drug program***
Cardiac rehabilitation	Covered — 100%	Covered — 90%
Diabetic education	Covered — 100%	Covered — 90%
Clinical trials *Routine services associated with approved clinical trials are covered consistent with Medicare policy*	Covered — 100%	Covered — 90%
Chemotherapy	Covered — 100%	Covered — 90%
Hyperbaric oxygen treatment	Covered — 100%	Covered — 90%
Injections	Covered — 100%	Covered — 90%
Prescription Drugs — See Prescription Drug section of this Handbook		

In-Network Benefit Level

The BCBS National PPO Plan provides a higher benefit if you receive covered services from an in-network provider.

To determine whether your physician participates in the BCBS National PPO Plan network, you may call BCBSM at **1-800-482-5146**, or search the BCBSM website at **bcbsm.com/doctors** for information. Outside of the U.S. you may call Blue Cross Blue Shield at **1-800-810-2583** or search the BCBSM website at **bcbsglobalcore.com**.

Out-of-Network Benefit Level

If you receive covered services from an out-of-network provider, you will be required to pay a 10% coinsurance for those covered services. Some services are not covered when provided by an out-of-network provider.

Note:

- If you use an **out-of-network** provider who does not **participate** with the BCBS National PPO Plan, you may be charged for amounts above the maximum allowable payment amount.
- If, however, you receive covered services from an **out-of-network** provider who **participates** with the BCBS National PPO Plan, covered charges will be subject to the 10% out-of-network coinsurance, but you should not be balance-billed for charges above the BCBS maximum allowable payment amount (and if you are balance billed in this case, you are not responsible to pay those additional charges above the BCBS maximum allowable amount).

Out-of-Network Referrals

Covered referrals can be made only by in-network providers. If your in-network BCBS National PPO provider refers you to an out-of-network provider and obtains approval from BCBSM, covered approved services from the out-of-network provider will be paid at the in-network benefit levels.

You may pay out-of-pocket cost for services received out-of-network without an approved referral as described in the previous section.

Hospital-Surgical-Medical Benefits

Hospital-Surgical-Medical benefits cover most medically necessary health care services for you and your eligible dependents.

Coverage Overview

Hospital-Surgical-Medical benefits are provided for covered hospital, surgical and medical expenses for you and your eligible dependents. Covered services include hospital room and board charges, along with customary hospital-related services and supplies and some outpatient and home care services. Surgical-Medical benefits cover the maximum allowable payment as defined below, for physicians' services, surgery, tests and most other health-related expenses.

Information relating to your eligibility for Hospital-Surgical-Medical coverage is provided in the *Health Care Benefit Eligibility* section of this handbook.

Maximum Payment

Reimbursement is based on the lower of the provider's charges or the BCBS maximum allowable payment for a covered service.

Predetermination (Prior Authorization)

Your Hospital-Surgical-Medical coverage has a special feature, "predetermination." Predetermination determines whether hospital admission is appropriate. Once the hospital admission is approved, an appropriate length of stay is established and your physician and the hospital will be notified. Your covered charges then will be paid according to your plan's provisions.

The predetermination feature requires physicians and hospitals, not you, to notify and obtain approval from the claims processor before non-emergency hospitalization can occur. Emergency admissions must be reported within 24 hours by providers. Predetermination is not required for a maternity admission.

While you are in the hospital, the length of your stay will continue to be reviewed.

If you are admitted to the hospital but are not notified that your hospital admission has been denied, you will not be held responsible for the extra predetermination charges in the paragraph above incurred for covered services. You will be held harmless from the provider's errors of commission or omission.

Voluntary Second Surgical Opinion

The second opinion program is strictly voluntary and is described as follows.

The voluntary second surgical opinion feature is designed to enhance quality of care and to reduce unnecessary inpatient surgery. This feature provides you and your eligible dependents with additional information on the risks and benefits of the surgery as well as available treatment alternatives.

When you and your eligible dependents are faced with covered surgery, a second surgical opinion may help you decide:

- If an operation is necessary
- If a different treatment is more appropriate

If you decide to seek a voluntary second surgical opinion, benefits will be provided under the Plan for the cost of the second opinion, including the physician's consultation and any necessary X-ray and laboratory tests. When the second opinion does not agree with the first, a third opinion also is covered under the Plan. Non-surgical medical consultations also are covered under the Plan when recommended by the second opinion physician because of medical complications which may affect your surgery.

Second and third opinions are covered only when they relate to covered surgeries that take place in an inpatient or outpatient hospital setting or approved ambulatory surgery facility. They are covered only when performed by a M.D., D.O., D.P.M. or oral surgeon. Second and third opinions are not covered when performed by a Chiropractor, Psychologist or Dentist. Also, the second and third opinions cannot be sought from the physician who performed your initial diagnosis.

BCBS National PPO Plan members must utilize in-network providers for surgical opinions to be paid under the plan. Opinions performed by out-of-network providers will be subject to the 10% out-of-network coinsurance amount. You may also be responsible for any charges above the maximum payment allowed when you utilize an out-of-network provider who does not participate in the BCBS National PPO Plan.

No matter what the second or third opinions are, you're still free to choose whether or not to have the surgery. Even if the second opinion states that surgery is unnecessary, your Hospital-Surgical-Medical coverage still provides benefits for the surgery, as long as the surgery is a covered procedure.

Coordinated Care Program

Care Management, Complex Care Management and Disease Management

The Blue Cross Blue Shield (BCBS) Coordinated Care Program can help coordinate your care and connect you to the right services at the right time. This is a voluntary and confidential program for you and your covered dependents that includes care coordination, case management, complex case management and disease management. This coordinated care program may include working with your provider and helping you with your chronic conditions or may help you avoid developing chronic conditions.

If your provider or the BCBS Coordinated Care program identifies you as a potential participant, a registered nurse will reach out to you to develop a plan to help manage your conditions. The registered nurse leads a team of resources for you that may include doctors, dietitians, pharmacists and social workers. This team may help:

- Identify your health risks
- Provide you with health care information and support you and your family in your decision-making process
- Educate and help you better understand your treatment options
- Work with health plan, physicians and/or other providers to coordinate treatment
- Act as a central point of contact to coordinate medical and other services

Hospital Related Services

Generally, when you or your eligible dependents are confined in a hospital, most services are covered. Benefits also are paid for approved outpatient care.

Inpatient Hospital Services

Hospital benefits are paid under the plan for covered services for up to 365 days while you or your eligible dependents are confined in a hospital. A new 365-day period begins when you have not been in the hospital or a similar facility (e.g., a skilled nursing facility, a day or night care center or residential substance abuse treatment facility) for 60 consecutive days. The BCBS National PPO in-network and out-of-network benefit levels apply.

Covered services include:

- Semiprivate room and board charges, including all regular daily services. Charges for a private room are covered at the hospital's standard rate for a semiprivate room, unless you need a private room for intensive care or isolation. If you choose a private room, you pay the amount over the semiprivate room rate
- Hospital services and supplies, including general nursing care, meals and special diets
- Intensive care
- Drugs and medicines
- Oxygen and gas therapy
- Use of operating rooms, other surgical treatment rooms and delivery rooms
- Anesthesia given by a qualified hospital employee
- Certain blood services and their administration, including whole blood and packed red blood cells
- Hemodialysis when provided by a qualified hospital
- Dressings and casts
- Physical and electroshock therapy provided by the hospital
- Use of the hospital's radium, cobalt and radioactive isotopes
- Chemotherapy and its administration, including most oral chemotherapy and drug injections, but not experimental chemotherapy drugs (similar chemotherapy administered in the physician's office or the patient's home also is covered)
- Use of durable medical equipment, as described under "Durable Medical Equipment" later in this section
- X-rays, two-dimensional echocardiography EKGs, and digital subtraction angiography
- Prosthetic appliances
- Laboratory services
- Intermittent positive breathing therapy
- Rehabilitation care such as physical, occupational, and speech therapy
- Pulmonary function evaluation
- Hyperbaric oxygenation including:
    - Acute posthemorrhagic anemia (Anemia due to acute blood loss)
    - Inflammatory conditions such as:
        - Abscess of jaw (acute) (chronic) (suppurative)
        - Osteitis of jaw (acute) (chronic) (suppurative)
        - Osteomyelitis (acute) (chronic) (suppurative) (neonatal)
        - Periostitis of jaw (acute) (chronic) (suppurative)
        - Sequestrum of jaw bone
- Psychological testing administered by a qualified hospital employee

- Skin bank, bone bank and soft tissue bank
- Costs for human organ transplants, including:
  - Locating, evaluating, removing, preserving and transplanting human organs and tissues
  - Care of potential and actual donors, to the extent not covered by any other medical plan
- Maternity care: Your coverage does not restrict benefits to, or require authorization for, any hospital length of stay of less than:
  - 48 hours following vaginal delivery
  - 96 hours following caesarean delivery
  - Additional information is provided in the Newborns' and Mothers' Health Protection Act Notice, in the Health Care Legal Notices section
- Routine nursery care of newborns is covered when the newborn is added to coverage. Newborn care includes, but is not limited to, the initial inpatient examination of the newborn when provided and billed by a physician other than the delivering physician or the physician who administered the anesthesia during the delivery, routine nursery care, medical care, hospital services and circumcision.

Outpatient Hospital Benefits

The benefits listed above in "Inpatient Hospital Services" are covered under the BCBS National PPO Plan benefit structure when you receive them on an outpatient basis from a hospital when ordered by the attending physician, with the exception of outpatient physical therapy, which is covered by TheraMatrix, and infusion therapy, explained below.

Some outpatient services are provided outside of the hospital in a physician's office or another facility (e.g., a skilled nursing facility). Information relating to these benefits is explained in this section under the following headings: *Surgical and Medical Services, Skilled Nursing Facility, Coordinated Home Care, and Mental Health Care and Substance Use Disorder*.

- **Physical Therapy**
  Outpatient Physical Therapy is covered when obtained at a participating facility within the TheraMatrix network. Up to 60 treatments per calendar year (per condition) are covered for outpatient physical therapy in an **approved** physical therapy facility. The limit may be renewed after surgery or a distinct aggravation of the original condition. 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). Before starting treatment, you will need to contact TheraMatrix (**1-888-638-8786**) to verify if a facility or planned treatment is approved. Please see *Outpatient Physical Therapy – TheraMatrix Program* in this section for additional details.
- **Infusion Therapy**
  Infusion therapy services that are rendered in the hospital outpatient setting will require prior authorization. No prior authorization is required when provided in the home, in a freestanding infusion center or in a physician's office.
- **Ambulatory Surgical Facility or Freestanding Ambulatory Surgical Center**
  Outpatient services for covered surgery at an Ambulatory Surgical Facility (ASF) or Freestanding Ambulatory Surgical Center (FASC) approved by the Plan are covered. To be approved by the Plan, an ASF or FASC must meet certain

licensing, accreditation, and similar criteria, and also satisfy Plan standards, which may consider whether more facility capacity is needed in a given area.

Check with the Plan before you are treated at such a facility to find out if it is an approved facility.

- **Outpatient Dental Services — for Special Needs**
  Outpatient hospital charges related to dental services are covered under the Hospital-Surgical-Medical plan based on BCBSM guidelines for enrollees with special needs (e.g., Down Syndrome, autism, spastic conditions), medical conditions that are marginally controlled, or dental conditions that may adversely impact their medical conditions (e.g., uncontrolled diabetes with periodontal disease). Charges for the actual dental services will continue to be paid by your dental plan.
- **Hyperbaric Oxygenation**
  Following documentation of no measurable signs of healing, following at least 30 days of standard wound therapy, up to 60 hospital outpatient hyperbaric oxygenation treatments per condition per calendar year are covered for conditions that are covered by Medicare and that meet criteria established by BCBSM. Treatment must be administered in a chamber and for the treatment of wounds and must be used in addition to standard wound care.

  Continued treatment with hyperbaric oxygen therapy is not covered if measurable signs of healing have not been documented within any 60-day period of treatment (within any 30-day period for diabetic wounds).

Ambulance Services

Ambulance services are a covered benefit under the following conditions:

- Ambulance services must be medically necessary.
- The provider of the ambulance service must meet Medicare criteria for approval.

Benefits include treatment provided by qualified ambulance personnel in lieu of transportation to a hospital.

Ground Transportation Between Facilities

A physician must prescribe services that necessitate use of ground ambulance transportation between facilities.

Ambulance benefits are provided for local ground transportation within the greater metropolitan area when the need for services arises and for purposes of:

- Transferring (one-way or round trip) of a hospital inpatient, or patient seen in the emergency room, to another local hospital when a lack of needed treatment facilities, equipment or staff physicians exists at the first hospital, or
- Transporting (one-way or round trip) of a hospital inpatient to a non-hospital facility for examination with a covered CAT, MRI or PET scan and the following conditions are met:
  - The services are not available in the hospital where the member is inpatient and are not available in a closer local hospital, and
  - The free-standing facility providing the treatment is approved by any applicable State planning agency or comparable approval process.

Emergency Transportation: Ground/Air/Water

Benefits for emergency transportation services are provided for ground, air and water ambulances. Services are covered for emergency transportation for:

- 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
    - o Medical emergency/accidental injury patients are provided one-way transportation from the home to the facility. The return trip following stabilization is not covered.
    - o Home-bound patients are provided round trip transportation from the home to the facility and back when medically necessary and when other means of transportation could not be used without endangering the patient's health.

Coverage at Nonparticipating Hospitals

If you are covered by the BCBS National PPO Plan and receive services at a nonparticipating hospital, some special hospitalization rules apply. A hospital that has not signed a participation agreement with BCBS to accept their payment as payment in full is designated as nonparticipating.

If you receive services at a nonparticipating hospital with the exception for treatment of certain accidental injuries and medical emergencies, hospital coverage will pay up to a maximum benefit of:

- $500 a day toward covered hospital services (including $50 for ancillary services) you receive as an inpatient in an acute care hospital
- $15 per day for services in other than an acute care hospital (e.g., a mental health facility), and
- $35 for each condition for services received on an outpatient basis

Emergency services immediately following a serious (e.g., life threatening) bodily injury or medical emergencies are covered, not to exceed the average amount paid to nonparticipating hospitals within the Plan area.

Please see the National PPO Plan Overview section for information on in-network and out-of-network coverage.

Surgical and Medical Services

Surgical-Medical benefits cover many surgical and medical services you and your eligible dependents receive. BCBS National PPO Plan in-network and out-of-network benefit levels may apply.

Your Surgical-Medical benefits cover the maximum allowable payment amount for certain medical and surgical services, which include:

- Allergy testing and immunotherapy services for medically necessary and non-experimental allergy testing.
- Injections in a provider's office where therapeutically appropriate and consistent with BCBSM medical policy.
- In-network office visits for BCBS National PPO members will be regarded as a covered service, but with a designated copay. Out-of-network visits not covered without an approved referral.
- In-network urgent care visits are covered after a $50 copay per visit.
- In-network telemedicine (24/7 online health care visit) through BCBSM Online Visits are covered after a $10 copay; first visit covered in full, per member, per lifetime.

- Coverage for a combined 60 visits per calendar year per condition for outpatient physical therapy, occupational therapy and speech therapy. Please see *Outpatient Physical Therapy – TheraMatrix Program* in this section for additional details.
- A separate series of 60 treatments may also be available for speech therapy to treat congenital and severe developmental speech disorders for children. To qualify, therapy must not be available through a public agency.
- Applied Behavioral Analysis (ABA) for children under the age of 19, with autism, when authorized; contact BCBSM at **1-800-482-5146**.
- Outpatient observation care is covered under the BCBS National PPO Plan when it meets plan criteria.
- Cosmetic bonding of eight front teeth for children age eight (8) through the end of the calendar year in which they become age 19 because of severe tetracycline staining, severe fluorosis, hereditary opalescent dentin, or amelogenesis imperfecta, but not more frequently than once in any period of three consecutive years.
- General inpatient care for medical and non-pulmonary tubercular conditions by the physician rendering the service for hospital bed patients for an unlimited number of days.
- Surgical fees for all generally accepted operative and cutting procedures, including laser surgery for covered procedures necessary for the diagnosis and treatment of diseases, injuries, fractures, dislocations and reconstructive surgery for the following:
    - The correction of conditions resulting from accidental injuries or traumatic scars
    - The correction of congenital anomalies
    - Reconstructive plastic surgery to correct deformities resulting from medically necessary surgery due to malignancy or fibrocystic disease and reconstructive surgery when there is a visual impairment
- Physician services to donors and potential donors for medically recognized human organ or tissue transplants to the extent not covered by any other medical plan.
- Assistant surgical physicians' fees for certain procedures, if an intern, resident or staff physician is not available.

Necessary surgical, medical or obstetrical consultation by another physician, if requested by the physician in charge of your case when you are an inpatient.

- Delivery of a child or children, necessary pre-and post-natal care and routine laboratory services in connection with normal maternity care.
- Routine medical care of the newborn and a separate benefit for initial inpatient examination of the newborn when provided by:
    - A physician other than the delivering physician
    - The physician who administered the anesthesia during delivery
- Charges for anesthesia and its administration in connection with surgical, medical or obstetrical care when administered by a physician other than the one in charge of the case.
- General anesthesia services when performed and billed directly by a nurse anesthetist where legally permitted.

- Continuous passive motion (CPM) will be covered after knee surgery or surgery of the elbow and articular tissues of the shoulder if initiated within the first 48 hours following surgery, and utilized a maximum of 21 days immediately following surgery.
- Physicians' services for hemodialysis.
- Therapeutic radiological services, if necessary, for the treatment of an illness or injury.
- Physicians' services to administer chemotherapy.
- Pulmonary function tests provided in accordance with BCBSM criteria for location of service, including the hospital outpatient and physician office setting.

CAT scans and MRI services are covered benefits when ordered by a physician and performed on approved equipment. Prior authorization may be required.

- Continuous passive motion (CPM) will be covered after knee surgery or surgery of the elbow and articular tissues of the shoulder if initiated within the first 48 hours following surgery, and utilized a maximum of 21 days immediately following surgery
- Physicians' services for hemodialysis
- Therapeutic radiological services, if necessary, for the treatment of an illness or injury
- Physicians' services to administer chemotherapy
- Pulmonary function tests provided in accordance with BCBSM criteria for location of service, including the hospital outpatient and physician office setting
- CAT scans and MRI services are covered benefits when ordered by a physician, and performed on approved equipment. Prior authorization may be required.
- Diagnostic X-rays, laboratory and pathology tests when related to diagnosis of an illness or injury (miniature plates, screening procedures and diagnostic X-rays related to a routine physical exam are not covered)
- Physician services during covered hospital outpatient observation bed care
- Administration of rabies vaccines necessitated by recent exposure to a rabid or potentially rabid animal. Regardless of where initial treatment is performed, follow-up treatments may be performed in a physician's office or a hospital outpatient setting
- Benefits are provided for treatment of accidental injuries and health-threatening or disabling medical emergencies. A "health-threatening" or disabling medical emergency is a condition that:
    - Could place your health in danger or cause significant impairment of bodily functions
    - Requires professional medical attention and treatment
    - Has symptoms that occur suddenly and unexpectedly
    - Has signs or symptoms, verified by a physician at the time of treatment, confirming the health-threatening or disabling condition

    Benefits are provided in full after a $100 copay (both in-network and out-of-network) for hospital emergency room services in participating hospitals, if your condition is a medical emergency or accidental injury. Physicians' services for the initial examination and treatment also are covered wherever administered. Follow-up care is not covered under the emergency benefit.

The emergency room copay is waived if an employee is sent to the emergency room in an ambulance by the Company's Medical Department (whether admitted or not admitted) or if placed into observation care. In all other situations the employee emergency room copay will only be waived if admitted.

- Lactation counseling is covered, with an in-network provider, as part of Health Care Reform. To access the network of lactation counseling providers, visit **bcbsm.com/doctors** or call **1-800-482-5146**.

Preventive Services

All preventive screening services defined under Health Care Reform are covered under the BCBSM National PPO Plan at 100% when obtained from an in-network provider. Covered preventive services include your annual health maintenance exam (HME) (one per calendar year), annual OB/GYN visit (in addition to your health maintenance exam) and annual mammogram for women age 40 and over or those considered high risk, age 25 and older.

A chart listing preventive services (including frequency and limitations) provided through BCBSM begins below. Please see later section for preventive services under BPP.

Note: The chart is updated annually and available at **myfordbenefits.com**.

Preventive Services for 2021

BCBS National PPO Plan

Preventive Service	Frequency/Limitations
Physical Examinations	
Well adult — health maintenance exam (HME) (routine physical)	• 1 per calendar year ages 18 and older
Well baby/child exam	• 8 visits for children from birth to 12 months • 6 visits for children from 13 months to 23 months • 6 visits for children from 24 to 35 months • 2 visits for children from 36 months to 47 months • 1 visit per calendar year age 4 through 17 years
Laboratory Screening Services	
Lipid disorder screenings	• 1 per calendar year; Males and females 18 and older
Type II diabetes mellitus screening	• 2 per calendar year; Males and females 18 and older
Tuberculin test	• 1 per calendar year; Males and females any age if at risk; children 1 month to 21 years
Hypothyroid screening (does not include TSH)	• 1 per calendar year; Males and females any age
Other Screenings	
High blood pressure screening	• 1 per calendar year with diagnosis restrictions; Males and females 18 and older
High blood pressure monitor (Purchase or rental)	• 1 per year/once every 5 years; diagnosis restrictions; Males and females 18 and older
Lung cancer, low dose lung tomography scan	• 1 per calendar year; Males and females 55 – 80 years
Infectious Disease Screening	
Chlamydia screening	• 1 per calendar year; Females any age; children age 11 – 21 years
HIV screening	• 1 per calendar year; Males and females any age; children age 11 – 21 years
Syphilis screening	• 1 per calendar year; Males and females any age; children age 11 – 21 years
Gonorrhea screening	• 1 per calendar year; Males and females any age; children age 11 – 21 years
Hepatitis B screening	• 1 per calendar year; Males and females any age; children age 11 – 21 years

Preventive Service	Frequency/Limitations
Hepatitis C screening	• 1 per calendar year; Males and females any age; children age 11 – 21 years
Herpes simplex virus (HSV) screening	• 1 per calendar year; Males and females any age; children age 11 – 21 years
Human papillomavirus (HPV) screening	• 1 per calendar year; Males and females any age; children age 11 – 21 years
Newborn and Children's Health	
Adrenoleukodystrophy	• 1 per calendar year; birth to 60 days
Congenital hypothyroidism	• 1 per calendar year; birth to 30 days
Phenylketonuria (PKU) screening	• 1 per calendar year; birth to 30 days
Sickle cell disease screening	• 1 per calendar year; birth to 30 days
Hematocrit/hemoglobin	• 2 per calendar year; 4 months to 21 years old
Metabolic/hemoglobin screening	• 1 per calendar year; birth to 60 days
Lead screening	• 1 per calendar year; 6 months to 6 years old
Heritable disorders in newborns	• 1 per calendar year; birth to 60 days
Glycogen storage disease type II (Pompe) – GSDII	• 1 per calendar year; birth to 60 days
Tuberculin test	• 1 per calendar year; age 1 month to 21 years
Dyslipidemia	• 1 per calendar year; age 24 months to 21 years • 2 per calendar year age 9 – 11 years
Critical congenital heart disease screening	• 1 per calendar year; birth to 30 days
Hearing loss screening	• 1 per calendar year; birth to 21 years
Visual impairment screening	• 1 per calendar year; Children birth up to age 5
Visual acuity screening	• 1 per calendar year; birth to 21 years
Developmental screening	• 2 per calendar year, Children at 9, 18 and 30 months
Fluoride varnish	• 2 per calendar year, Children birth through 5 years
Topical gonorrhea prophylactic medication	• 1 per calendar year; birth to 30 days
Spinal muscular atrophy screening	• 1 per calendar year; birth to 60 days

Preventive Service	Frequency/Limitations
Men's Health	
Prostate specific antigen (PSA)	• 1 per calendar year; Males age 40 and older
Digital rectal exam	• 1 per calendar year; Males age 40 and older
Abdominal aortic aneurysm (AAA) ultrasound screening	• 1 per lifetime; Males age 65 – 75 years
Women's Health	
OB/GYN exam	• 2 per calendar year; Females at any age
Cervical cancer and dysplasia screening Papanicolaou (PAP) smear	• 1 per calendar year; Females at any age
Procurement of PAP smear	• 1 per calendar year; Females at any age
Mammogram/breast cancer screening	• 1 per calendar year; Females age 40 and over or at any age if at risk
BRCA (breast cancer) mutation testing	• Once per lifetime; Females any age; if family history
Osteoporosis screening for postmenopausal females	• 1 per calendar year; Females age 65 and over or at any age if at risk
Women's Health — Contraceptive Methods	
Non-biodegradable drug delivery implant, insertion and removal	• Unlimited with diagnosis restrictions; Females any age
Removal, implantable contraceptive capsules	• Unlimited; Females any age
Diaphragm or cervical cap fitting with instruction	• Unlimited; Females any age
Cervical cap for contraceptive use	• Unlimited; Females any age
Diaphragm for contraceptive use	• Unlimited; Females any age
Insertion of IUD	• Unlimited; Females any age
Removal of IUD	• Unlimited; Females any age
Hysteroscopy/ligation or transection/ laparoscopy	• 1 per calendar year; Females any age
Hysterosalpingography (HSG) — no anesthesia	• Payable one time when billed within 366 days if Hysteroscopy; Females any age
Transvaginal ultrasound	• 2 per calendar year with diagnosis restrictions; Females any age
IUD Copper implant	• Unlimited; Females any age

Preventive Service	Frequency/Limitations
Anesthesia for contraceptive surgeries	• 1 per calendar year when billed with applicable surgical codes; Females any age
Permanent implantable contraceptive intratubal occlusion devices and delivery system	• 1 per calendar year; Females any age
Injection Medroxyprogesterone Acetate for contraceptive use (Depo Provera)	• Unlimited with diagnosis restrictions; Females any age
Levonorgestrel-releasing intrauterine contraceptive	• 1 per calendar year; Females any age
Insertion of levonorgestrel-releasing intrauterine contraceptive	• 1 per calendar year; Females any age
Etonogestreal implant system	• 1 per calendar year; Females any age
Contraceptive intrauterine device Including implants and supplies	• 1 per calendar year; Females any age
Contraceptive supply — hormone with patch	• 3 per month/36 per year; Females any age
Contraceptive supply — hormone with vaginal ring	• 1 every 20 days; Females any age
Women's Health — Breastfeeding	
Breast pump (Electric or battery powered non-hospital grade pump from approved DME provider)	• Once per pregnancy; unlimited rental or purchase; Females any age
Supplies: Tubing, adapter, breast shield and splash protector, lock ring	• 1 per calendar year; Females any age
Supplies: Cap for breast pump bottle, polycarbonate bottle	• 2 per calendar year; Females any age
Prenatal Services	
Prenatal (antepartum) visits	• Unlimited visits or 3 visits or less with maternity diagnosis (based on billed procedure code); pregnant females any age
Prenatal pediatrician visit	• 2 per day/1 per calendar year; diagnosis restrictions; pregnant females any age
Hepatitis B screening	• 2 per calendar year with maternity diagnosis; pregnant females any age
Asymptomatic bacteriuria (AB) screening	• 2 per calendar year with maternity diagnosis; pregnant females any age
Rh (d) incompatibility screening	• 2 per calendar year with maternity diagnosis; pregnant females any age
Screening for gestational diabetes	• 2 per calendar year with maternity diagnosis; pregnant females any age

Preventive Service	Frequency/Limitations
Colorectal Cancer Screening	
Colonoscopy	• 1 per calendar year; Males and females age 50 – 75 or younger if high risk
Barium enema	• 1 every 5 calendar years; Males and females age 50 and over
Sigmoidoscopy	• 1 per calendar year; Males and females age 50 – 75 or younger if high risk
Pathology microscopic exam (Biopsy associated w/colonoscopy)	• 1 per calendar year; Males and females age 50 – 75 or younger if high risk
Fecal occult blood test	• 1 per calendar year; Males and females age 50 and over (or at any age if risk factors present)
Cologuard	• 1 every 3 years; Males and females age 50 and over
Colonoscopy consult	• 1 per calendar year; Males and females age 50 – 75 or younger if high risk
Immunizations*	
Cholera vaccine Ebola vaccine Hepatitis A vaccine Hepatitis B vaccine HPV Influenza type B (HIB) Japanese Encephalitis virus vaccine Meningococcal vaccine MMR/MMRV Pneumococcal vaccine Poliovirus vaccine Rabies vaccine Rotavirus vaccine Tetanus, Diphtheria, Pertussis vaccine Typhoid vaccine Varicella virus vaccine (chicken pox) Yellow Fever vaccine	• Follow CDC/Advisory Committee on Immunization Practices (ACIP) guidelines for age and frequency limitations: www.cdc.gov/vaccines/schedules/ *Effective 1/1/2020, all listed immunizations are covered at a pharmacy (both through the medical and pharmacy benefit). Immunizations remain covered at a doctor's office and retail health clinics.
Influenza (Flu)	• 1 per calendar year
Shingles (Shingrix)	• Age 50 and older

Preventive Service	Frequency/Limitations
Counseling Services	
Alcohol misuse screening and behavioral counseling interventions	• 1 per calendar year with diagnosis restrictions; Males and females age 18 and older
Alcohol and drug use assessment	• 1 per calendar year; Males and females age 18 and older; children 11 – 21 years
BRCA genetic counseling	• 8 times per day equivalent to 2 hours per day • 2 times per calendar year • Females any age with personal or family history
Breastfeeding counseling/support	• 1 to 2 times per calendar year; Females any age
Diet/behavioral counseling	• 6 per calendar year with diagnosis restrictions; Males, females and children age 6 and older
Obesity screening and counseling	• Intensive behavioral counseling; 26 per calendar year • Face-to-face counseling (group); 12 per calendar year • Males, females and children; diagnosis restrictions
Tobacco use and tobacco-caused disease counseling	• Unlimited with diagnosis restrictions; Males, females and children any age
Depression screening	• 1 per calendar year; Males, females and children any age
Aspirin counseling for prevention of cardiovascular disease	• 1 per calendar year; Males and females age 50 – 69
Sexually transmitted infection counseling	• 2 per calendar year; Males, females and children any age
Blood glucose – abnormal blood glucose in adults who are overweight or obese	• 26 behavioral counseling visits per year • 12 face-to-face counseling visits per year • 2 glucose tests per calendar year • Males and females age 40 – 70
Intimate partner violence screening	• Once per calendar year; Females of childbearing age
Counseling for contraceptive use	• 2 per calendar year; diagnosis restrictions; Females at any age

Note: This is intended as an easy-to-read summary and provides only a general overview of your preventive benefits. This is not an all-inclusive list. Additional restrictions, including diagnosis, location and provider type, may apply to all listed services. ***For a complete description of benefits, please contact the customer service number on the back of your ID card.***

In addition to the preventive services identified on the previous page, the following are covered under the BCBS National PPO Plan:

- Psychosocial/Behavioral Assessment — included as part of the well-baby/child and adult visits/health maintenance exam
- Oral health and anticipatory guidance are included as part of the well-baby/child visits

Skilled Nursing Facility

Benefits are paid if you receive care from an approved skilled nursing facility (sometimes referred to as a convalescent or long-term illness care facility).

In some situations, your physician may find it appropriate to discharge you from the hospital and transfer you to a skilled nursing facility for further treatment. Or your physician may admit you directly into an approved skilled nursing facility without prior hospitalization, if it is an appropriate site for treatment.

If you receive services from a skilled nursing facility, Hospital-Surgical-Medical benefits will be provided for:

- Semi-private room and board charges and related services
- A maximum number of physicians' visits equal to two visits per week

Benefits for general conditions are provided for up to 730 days or two days for every one day of unused hospital care. For example, if you are admitted to a skilled nursing facility after spending 100 days in the hospital, you can receive benefits for up to 530 days while you are in the skilled nursing facility. A new 730-day period begins when you have not been in the hospital, a skilled nursing facility, a day or night care center or residential substance abuse treatment facility for 60 consecutive days.

No benefits are provided for custodial care or treatment of tuberculosis.

Coordinated Home Care

If you receive care at home, instead of a hospital or other facility, certain services are covered.

Under certain circumstances, your physician, with your approval, may have you receive continuing care from an approved home health care agency (if one is available in your area), if you are discharged early from a hospital or other approved facility. Your physician also may recommend that you receive home health care services without prior hospitalization.

Hospital-Surgical-Medical benefits are provided for up to three home care visits for each remaining hospital or convalescent care day as long as you remain medically eligible. Charges for the following services received during a home care visit are covered:

- Necessary nursing care
- Drugs, supplies, laboratory tests and other related services
- Necessary services of a part-time health aide employed by the agency
- Physical therapy, speech therapy and occupational therapy

These benefits are available only through an **approved** home health care agency. Custodial care and physicians' visits to your home are not covered.

Home Care Kidney Machines

Hospital-Surgical-Medical benefits cover the use of an artificial kidney machine in your home for hemodialysis treatment. Included are reasonable and necessary expenses for supplies and for installing and maintaining the equipment.

If you use such a machine, you may be eligible for Medicare benefits, regardless of your age. Your local Social Security office has more information.

Infusion Therapy

Infusion therapy is covered under coordinated home care.

Hospice Care

Hospital-Surgical-Medical benefits are available for hospice care in approved programs in most locations.

Focusing on the patient and the patient's family as the unit of care, Hospital-Surgical-Medical benefits are available for hospice care through approved hospice care programs in most locations for persons having a life expectancy of twelve (12) months or less. Participation in the program is voluntary and requires concurrence of the attending physician.

Generally, five (5) levels of care are provided by the hospice care program:

1. Routine home care to maintain the terminally ill patient at home

2. Continuous home care for periods of crisis where predominantly skilled continuous care is necessary to manage the patient's acute medical symptoms

3. Inpatient respite care in an approved inpatient facility to provide caring family members or other persons caring for the patient a short period of relief

4. General inpatient care for pain control or acute or chronic symptom management of the patient

5. Nursing home care with hospice support for hospice patients who are medically stable but unable to return home because no primary care support is available

Hospice care programs within specific areas will be based on available resources. Consequently, hospice care coverage may differ between areas. Contact BCBSM for coverage available in your area and to determine any lifetime maximum benefit amount.

Note: If you anticipate meeting the limit, authorization may be obtained from the Plan's utilization management program.

Durable Medical Equipment (DME)

Coverage for durable medical equipment is based on categories of equipment covered by Medicare, and certain other equipment, as provided below.

Durable medical equipment, medical supplies, prosthetics, orthotics and mail order equipment are covered by the Plan when received from a participating supplier when received in a hospital or outpatient setting. If you obtain equipment or supplies out-of-network, you will be subject to 20% coinsurance up to an annual $500 out-of-pocket maximum.

You can locate a participating supplier by using *Find a Doctor or Hospital* at **bcbsm.com/doctors** and searching by specialty and your ZIP code. You can also call the number listed on the back of your member ID card.

Generally, DME benefits pay for a wide range of non-hospital durable medical equipment services including those approved by Medicare Part B, or as collectively bargained. Examples of durable medical equipment covered by Medicare Part B are as follows:

- Hospital beds and related equipment
- Equipment used to increase mobility
- Certain bathroom aids and therapeutic equipment
- Oxygen and breathing apparatus
- Health monitoring devices
- Repair (but not routine maintenance) of approved equipment
- Certain nutritional tube feedings

The following are examples of additional equipment also covered:

- Type I portable insulin infusion pumps and blood sugar monitoring devices for diabetics
- Blanket supports
- Neuromuscular stimulators
- Electromagnetic bone growth stimulators
- Positional transportation chairs
- Pressure gradient supports when prescribed for circulatory insufficiency conditions to promote and restore normal fluid circulation in the extremities and when prescribed to enhance and prevent scarring of burn patients
- Home glucose monitors, continuous glucose monitor systems and related supplies, which are Medicare-approved durable medical equipment, will be covered on the same basis as portable insulin infusion pumps for patients with appropriate clinical indicators
- Phototherapy (bilirubin) light with photometer, for infants under the age of one who have a diagnosis of hyperbilirubinemia
- Special features that are necessary to adapt otherwise covered equipment for use by children.
- Continuous passive motion (CPM) devices for use on elbow and shoulder after surgery and after a total knee replacement. CPM will be covered after surgery if initiated within the first 48 hours following surgery, and utilized a maximum of 21 days immediately following surgery.
- Automatic external defibrillator with integrated electrocardiogram analysis
- Intermittent limb compression device and accessories

Prosthetic and Orthotic Appliances

Hospital-Surgical-Medical benefits are provided for prosthetic and orthotic appliances approved by Medicare Part B and certain other items.

A prosthetic or orthotic appliance is, generally, artificial equipment needed to replace a nonfunctioning or missing part of the human body. Appliances must be medically necessary, and prescribed by your physician. If you obtain orthotics out-of-network, you will be subject to 20% coinsurance up to an annual $500 out-of-pocket maximum.

Benefits are payable for prosthetic and orthotic appliances, including external appliances and excluding experimental or research appliances or devices, generally based on the categories covered by Medicare Part B.

In addition, the following items are covered, subject to any stated conditions and to the other provisions of the plan and this section, even if not Medicare approved:

- Any style of orthopedic footwear, other than a basic oxford, when the shoes are an integral part of a covered brace.
- All orthopedic shoe inserts and arch supports, limited to one pair per calendar year with diagnoses established by BCBSM.
- Individually fitted arch supports used with a shoe that is not attached to a brace. Coverage is limited to arch supports that are prescribed in writing by a physician for an orthopedic, neuromuscular, vascular or insensate foot condition approved by BCBSM (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 arch supports as part of post-surgical care. No additional payment will be made for separately billed charges for fitting the arch support. Adult enrollees are eligible for replacement arch supports, limited to one pair per calendar year, based on medically necessary diagnosis as established by BCBSM. Arch supports for children may be replaced after 12 months if required by growth of the child.
- Wigs are covered for enrollees who lose their hair as a result of undergoing chemotherapy or radiation therapy. Up to $250 is available to cover the wig, wig stand and tape in the first year, and up to $125 is available in subsequent years.

Mastectomy

Surgery, reconstruction and prostheses following a mastectomy are covered. In-network and out-of-network benefit levels may apply.

Additional information is provided in the Women's Health and Cancer Rights Act of 1998 (WHCRA) Notice, in the *Health Care Legal Notices* section.

Outpatient Physical Therapy TheraMatrix Program

If you are enrolled in the BCBS National PPO Plan or Blue Preferred Plus PPO, outpatient physical therapy benefits are provided under the Outpatient Physical Therapy Program administered by TheraMatrix. Affected members will **not** receive a separate ID card for TheraMatrix and should continue to use their present BCBSM ID card for all covered services.

The TheraMatrix Program applies **only** to outpatient physical therapy services.

Outpatient functional, occupational, speech and language therapy services will continue to be provided through the BCBS National PPO Plan or Blue Preferred Plus PPO medical plans under the medical plan's regular benefit provisions.

The TheraMatrix Program covers up to 60 outpatient physical therapy treatments for each non-chronic condition per plan year. The limit may be renewed following surgery or a definite aggravation of the condition that initially required the therapy. Outpatient physical therapy services under the TheraMatrix Program are also coordinated with any separately billed speech, language and/or function occupational therapy services when calculating the 60 treatments per calendar year (per condition) limitation.

The Plan will cover up to 10 treatments each plan year for chronic conditions, and these 10 treatments will also count toward the 60-treatment limit.

Outpatient physical therapy benefits are covered under the TheraMatrix Program as follows:

TheraMatrix In-Network Benefit Level

Covered outpatient physical therapy services provided by TheraMatrix participating network providers are covered in full. The plan will cover outpatient physical therapy performed by a chiropractor who participates in the TheraMatrix network. There are no out-of-pocket costs to covered members when medically necessary services are rendered by TheraMatrix network providers.

Contact TheraMatrix at **1-888-638-8786** to find a TheraMatrix network provider near you to avoid out-of-pocket expenses.

TheraMatrix Out-of-Network Benefit Level

Covered outpatient physical therapy services obtained from providers who are not in the TheraMatrix network are **not covered at all**, except in the following situation:

- If there are no TheraMatrix network providers within 25 miles of your home, covered outpatient physical therapy services will be paid at the in-network benefit level. You must contact TheraMatrix at **1-888-638-8786** prior to treatment so that TheraMatrix can arrange for you to see a provider to avoid out-of-network penalties.

Be sure to contact TheraMatrix for any questions regarding current or planned future outpatient physical therapy treatment, or with questions regarding the Program in general.

IMPORTANT! To obtain coverage for outpatient physical therapy, you MUST use a TheraMatrix network provider.

Mental Health Care and Substance Use Disorder

If you are enrolled in the BCBS National PPO Plan or Blue Preferred Plus PPO, benefits for mental health care and substance use disorder treatment are provided through the plan. Services for mental health and substance use disorder may include assessment, diagnosis, treatment or counseling in a professional relationship, to assist in alleviating mental or emotional symptoms, conditions or disorders.

To receive full benefits, covered services must be received through BCBS participating facilities and providers.

Participating providers include:

Facilities

- Hospitals
- Outpatient facilities
- Detoxification facilities
- Residential care facilities
- Day care and night care facilities
- Halfway houses
- Skilled nursing facilities

Providers

- Psychiatrists
- Ph.D. psychologists
- Limited-licensed psychologists (LLP)
- Clinical licensed master's level social workers (CLMSW)
- Clinical nurse specialists (CNS)
- Licensed professional counselors (LPC)
- Physician assistants (PA)
- Certified nurse practitioners (CNP)
- MD/DO — all specialties

Prior Authorization

Prior authorization is required for inpatient care for a mental health condition or substance use disorder. Prior authorization is provided through your assigned Central Diagnostic and Referral Agency (CDR). For assistance on identifying your assigned CDR, contact BCBSM at **1-800-482-5146** for assistance.

Central Diagnostic and Review Agency (CDR)

The CDR also offers services to you on a voluntary basis. The CDR will evaluate and help coordinate care for you and your covered dependents. Services through the CDR are available regardless of the medical plan you choose, including alternative plans, and include the following services:

- Assessment
- Differential diagnosis
- Treatment plan development
- Referral to a provider
- Follow-up for after care

You are encouraged to contact your local Employee Support Services Program (ESSP) for assistance in accessing CDR services.

Benefits Received from Participating Providers

The following mental health and substance use disorder benefit coverages will be provided under the Mental Health Care and Substance Use Disorder program if you are enrolled in the BCBS National PPO Plan or Blue Preferred Plus PPO:

- Inpatient Care: Benefits for inpatient treatment of a mental health or substance use disorder condition are paid in full for up to 365 days of care, including any necessary detoxification days. The 365 days are renewable when you have been out of facility care for a continuous period of sixty (60) days. This 60-day provision applies to hospital and any residential facilities.
- Outpatient Care: Hospital-Surgical-Medical coverage provides for mental health care and for substance use disorder treatment. There are no lifetime visit limits.

  If you are enrolled in the BCBSM National PPO Plan, the first 20 outpatient visits, whether for mental health care or substance use disorder treatment, are paid in full. For visits 21–35, if services are provided for substance use disorder treatment, benefits also are paid in full. However, for visits 21–35 for mental health care, the Plan covers 75%; you pay 25% with a maximum of $20 ($25 if hired or rehired after 11/18/2019) of Program costs. Visits 36 and over for both mental health and substance use disorder are covered with a $20 copayment ($25 if hired or rehired after 11/18/2019) per visit per calendar year. Visits with the CDR for an initial assessment, diagnosis and referral, or for short-term problem solving, do not count against the limits outlined above.
- Other benefits: Program benefits also include:
  - Up to 730 visits to a night care or day care treatment facility for mental health care; each visit reduces the number of remaining inpatient days by one-half day
  - A lifetime maximum benefit of 120 days in a halfway house; no more than 90 days are provided in any one calendar year
  - Psychological testing
  - Applied Behavioral Analysis (ABA) for children under the age of 19, with autism, when authorized; contact BCBSM at **1-800-482-5146**

Benefits Received from Nonparticipating Providers

Benefits can be covered as defined above when received from nonparticipating providers in the following situations:

- If you receive mental health care services from nonparticipating providers other than as described above, you will receive the following reduced benefits:
  - Non-approved inpatient services are not covered
  - For approved inpatient services in a general acute care hospital or psychiatric hospital, the Plan pays at the in-network level.
  - For physician (either M.D. or D.O.) or non-physician services for mental health care provided on an inpatient basis, the Plan pays the in-network level for approved admissions. Services provided during non-approved admissions are not covered.
  - No benefits are payable for outpatient services received from nonparticipating physician and non-physician providers.
- If you receive substance use disorder services from nonparticipating providers (whether physicians or non-physicians), no benefits are payable except as described above in cases of emergency.

Services Not Covered

No benefits are paid for the Hospital-Surgical-Medical services below.

Hospital-Surgical-Medical benefits provided under the BCBS National PPO Plan do not cover certain services. These services include but are not limited to:

- Admissions and treatment before your coverage starts
- Hospitalization principally for dental care or other dental services, except for multiple extractions or removal of unerupted teeth under general anesthesia for hospital patients when another hazardous medical condition exists, except for dental treatment within a hospital on an outpatient setting based on BCBSM guidelines, for enrollees with special needs (e.g., Down's Syndrome, autism, spastic conditions), medical conditions that are marginally controlled, or dental conditions that may adversely impact their medical conditions (e.g., uncontrolled diabetes with periodontal disease)
- Custodial or domiciliary care (care that doesn't require continuous skilled medical or nursing services)
- Care, services, supplies or devices that are experimental or research in nature; Federal Drug Administration (FDA) approval does not necessarily mean a procedure or supply has been removed from the plan's experimental list
- Premarital, pre-employment or preschool exams, similar exams or tests not directly related to a diagnosis except for preventive services as outlined in the surgical medical services section of this manual.
- Admission and treatment for weight reduction or diet control unless plan criteria are met
- Outpatient care for regular treatment of chronic conditions which require repeated visits, except as specifically provided for mental health conditions, drug and alcohol abuse and hemodialysis
- Hospitalization principally for observation or diagnostic evaluation, diagnostic X-rays, laboratory tests or physical therapy
- Surgical-Medical or other professional charges for sterilization reversals of either sex, or for abortion, except when medically necessary

- Removal of routine corns, calluses, and clavus and nail trimming
- Removal of wax from ear
- Services or supplies available under public plans or programs such as Workers' Compensation
- Services or supplies furnished in a United States government hospital not operated for the public at large, or elsewhere at government expense
- Surgery for cosmetic or beautifying purposes, except that reconstructive surgery for the following is covered:
    - The correction of conditions resulting from accidental injuries or traumatic scars
    - The correction of congenital abnormalities or
    - Reconstructive plastic surgery to correct deformities resulting from medically necessary surgery due to malignancy or fibrocystic disease and reconstructive surgery when there is a visual impairment
        - Chiropractic and osteopathic manipulations
        - Office visits out-of-network

Alternative to the BCBS National PPO Plan

In some areas of the country, you may choose to receive health care from an alternative plan. If you live or work in an area served by an alternative plan such as a "Health Maintenance Organization" (HMO) or "Preferred Provider Organization" (PPO) which is made available by the mutual agreement of Ford and the UAW, you may elect HMO or PPO coverage in place of the BCBS National PPO Plan for Hospital-Surgical-Medical and Prescription Drug coverage. You also may be covered for Vision Care under an HMO or PPO. If you are enrolled in any HMO or PPO that does not provide vision coverage, your vision care provider is SVS (Single Vision Solution, Inc.).

You may elect an HMO or PPO alternative, if one is available in your area (if you have been enrolled in your current plan for at least 12 months) by calling the NESC at **1-800-248-4444**.

For more information about the HMO or PPO options, visit **myfordbenefits.com** or contact the NESC (1-800-248-4444) to request a summary of benefits and coverage (SBC). You may contact the health plan carriers directly for detailed information about the plan.

Health Maintenance Organizations (HMOs)

When you belong to an HMO, most of your health care is covered in full. In order to receive benefits, you must obtain all your health care services from the group of physicians, hospitals or other providers affiliated with the HMO, except in the case of an emergency or upon referral by the HMO.

If you are enrolled in an HMO and are seeking mental health care and/or substance use disorder treatment benefits, you may use the Central Diagnostic and Referral Agencies (CDR) to obtain an assessment, differential diagnosis and a recommended treatment plan as well. This is a voluntary option available to you.

Blue Preferred Plus PPO Plan

Employees in Michigan may select the Blue Preferred Plus (BPP) Plan through BCBSM as an alternative option to the BCBS National PPO Plan. Under the BPP Plan, members pay for the cost of most services until the Plan deductible is met. Once the deductible is met, members continue to have responsibility for any copay amounts associated with the BPP Plan, such as office visits and prescriptions.

Some services, such as office visits and treatment for behavioral health or substance use disorder are not covered if obtained from an out-of-network provider. If a member is referred to an out-of-network provider and the BPP network provider obtains approval from BCBSM, covered and approved services will be paid at the in-network benefit level.

For services received out-of-network, members are responsible for any charge over the BPP Plans maximum reimbursement rate with an unlimited out-of-pocket maximum.

The chart below provides an overview of BPP Plan design and frequently used services.

Blue Preferred Plus PPO Plan Overview

The BPP PPO Plan has an in-network benefit level and an out-of-network benefit level.

Member's Responsibility (deductibles, coinsurance, copays and dollar maximums)		
Benefits	**In-Network**	**Out-of-Network**
Deductibles – per calendar year	$150 per member $300 per family	$500 per member $1,000 per family
Coinsurance	0% (Covered at 100% after deductible)	20% (Covered at 80% after deductible)
Annual out-of-pocket maximums *After out-of-pocket maximum is reached, plan pays 100% allowed amount for covered services.* *Copayments do not apply to out-of-pocket maximum.*	Not applicable	Unlimited per member Unlimited per family
Copayments		
Office visit	50% copay	**Not covered**
Telemedicine/Blue Cross online visit *Copay waived for 1st visit, per member, per lifetime*	$10 copay	**Not covered**
Retail health visit	25% copay	**Not covered**
Urgent care visit (billed as professional)	50% copay	**Not covered**
Emergency room visit *Copay waived if admitted, placed into observation care or sent by company medical*	$100 copay	$100 copay
Physician Office Services		
Benefits	**In-Network**	**Out-of-Network**
Office visits	50% copay	**Not covered**
Medical services billed with an office visit	Covered – 100% after deductible	Covered – 80% after deductible
Retail health visit	25% copay	**Not covered**

Preventive Care Services		
Benefits	**In-Network**	**Out-of-Network**
Health maintenance exam – one per calendar year	Covered – 50% copay	**Not covered**
Annual gynecological exam – one per calendar year	Covered – 50% copay	**Not covered**
Well baby care – up to 6 visits prior to age 2	Covered – 100%	Covered – 80% after deductible
Well child-care – age 2 and over	Covered – 50% copay	**Not covered**
Pap smear screening – one per calendar year	Covered – 100%	Covered – 80% after deductible
Mammography screening – one baseline at age 40; Covered annually at age 50 *Includes 3D mammography*	Covered – 100%	Covered – 80% after deductible
Prostate specific antigen (PSA) screening – one per calendar year; age 40 and older	Covered – 100%	Covered – 80% after deductible
Colorectal cancer screenings – once every 5 to 10 years; age 50 and older	Covered – 100%	Covered – 80% after deductible
Cologuard – Once every 3 years; age 50 and older	Covered – 100%	Covered – 80% after deductible
Immunizations *Following Advisory Committee on Immunization Practices (ACIP) guidelines*	Covered – 100%	Covered – 80% after deductible
Emergency Medical Care		
Benefits	**In-Network**	**Out-of-Network**
Emergency room visit – health threatening or disabling condition	Covered – $100 copay *(Copay waived if admitted, placed into observation care or sent by company medical)*	Covered – $100 copay *(Copay waived if admitted, placed into observation care or sent by company medical)*
Non-emergency visit to emergency room	**Not covered**	**Not covered**
Urgent care visit – billed as a professional service	Covered – 50% copay	**Not covered**
Urgent care visit – billed as a facility service	Covered – 100% after deductible	Covered – 80% after deductible
Ambulance services *Ground, air, and boat transportation are covered when medical criteria are met and includes ambulance treatment without transport*	Covered – 100% after deductible	Covered – 80% after deductible

Diagnostic Services		
Benefits	**In-Network**	**Out-of-Network**
Specialty/advanced imaging (MRI, MRA, PET and CAT scans) and nuclear medicine *Preauthorization required in Michigan only*	Covered – 100% after deductible	Covered – 80% after deductible
X-rays	Covered – 100% after deductible	Covered – 80% after deductible
Laboratory and pathology *Quest Diagnostics is the preferred provider network in Michigan only*	Covered – 100% after deductible	Covered – 80% after deductible
Maternity Services		
Benefits	**In-Network**	**Out-of-Network**
Prenatal care visits	Covered – 100% after deductible	Covered – 80% after deductible
Postnatal care visits	Covered – 100% after deductible	Covered – 80% after deductible
Delivery and nursery care	Covered – 100% after deductible	Covered – 80% after deductible
Infertility treatment	**Not covered**	**Not covered**
Hospital Care		
Benefits	**In-Network**	**Out-of-Network**
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies *Preauthorization required for hospital admission*	Covered – 100% after deductible	Covered – 80% after deductible *Nonparticipating hospital rates = $500 per day for room and board and $50 per day for ancillaries*
Inpatient medical care	Covered – 100% after deductible	Covered – 80% after deductible
Observation care *Includes care immediately following surgery or diagnostic testing*	Covered – 100% after deductible	Covered – 80% after deductible
Alternatives to Hospital Care		
Benefits	**In-Network**	**Out-of-Network**
Skilled nursing facility care *Must use participating providers* *Contact customer service for assistance at 1-800-482-5146*	Covered – 100% after deductible	Covered – 100% after deductible
Home health care *Must use participating providers* *Contact customer service for assistance at 1-800-482-5146*	Covered – 100% after deductible	Covered – 100% after deductible
Hospice care *Must use participating providers* *Contact customer service for assistance at 1-800-482-5146*	Covered – 100% after deductible	Covered – 100% after deductible
Private duty nursing	**Not covered**	**Not covered**

Surgical Services		
Benefits	**In-Network**	**Out-of-Network**
Surgery (includes related surgical services)	Covered – 100% after deductible	Covered – 80% after deductible
Voluntary sterilization – males	Covered – 100% after deductible	Covered – 80% after deductible
Voluntary sterilization – females	Covered – 100% after deductible	Covered – 80% after deductible
Bariatric surgery	Covered – 100% after deductible	Covered – 80% after deductible
Human Organ Transplants		
Benefits	**In-Network**	**Out-of-Network**
Specified organ transplants *Preauthorization required for organic material and services through the Human Organ Transplant Program* *Preauthorization required for hospital admission*	Covered – 100% after deductible	Covered – 80% after deductible
Kidney, cornea, bone marrow and skin *Preauthorization required for hospital admission*	Covered – 100% after deductible	Covered – 80% after deductible
Behavioral Health Services (Mental Health Substance Use Disorder)		
Benefits	**In-Network**	**Out-of-Network**
Inpatient mental health care *Preauthorization required, contact customer service at 1-800-482-5146 for assistance*	Covered – 100% after deductible	Covered – 80% after deductible
Outpatient mental health care	Covered – 100% after deductible	**Not covered**
Inpatient substance use disorder treatment *Preauthorization required, contact customer service at 1-800-482-5146 for assistance*	Covered – 100% after deductible	Covered – 80% after deductible
Outpatient substance use disorder treatment	Covered – 100% after deductible	**Not covered**
Autism Spectrum Disorders, Diagnoses and Treatment (Up to and including age 18)		
Benefits	**In-Network**	**Out-of-Network**
Applied Behavioral Analysis (ABA) treatment *Preauthorization required, contact customer service at 1-800-482-5146 for assistance* *Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.*	Covered – 100% after deductible	Covered – 80% after deductible
Occupational and speech therapy *Occupational and speech therapy with an autism diagnosis is unlimited*	Covered – 100% after deductible	Covered – 80% after deductible

Therapy Services — Outpatient coverage limited to 60 combined visits, per condition, per calendar year		
Benefits	**In-Network**	**Out-of-Network**
Inpatient physical, speech and occupational therapy	Covered – 100% after deductible	Covered – 80% after deductible
Outpatient speech and occupational therapy	Covered – 100% after deductible	Covered – 80% after deductible
Outpatient physical therapy ***Benefit administered by TheraMatrix***	Services through TheraMatrix covered at 100% **Contact TheraMatrix at 888-638-8786 for details[1]**	Preapproval from TheraMatrix required **Contact TheraMatrix at 888-638-8786 for details[1]**
Chiropractic Services		
Benefits	**In-Network**	**Out-of-Network**
Spinal X-rays	Covered – 100% after deductible	Covered – 80% after deductible
Chiropractic office visits	**Not covered**	**Not covered**
Spinal or osteopathic manipulations	**Not covered**	**Not covered**
Medical Equipment, Supplies and Appliances		
Benefits	**In-Network**	**Out-of-Network**
Durable medical equipment (DME)/medical supplies	Covered – 100% after deductible	Covered – 80% until $500 out-of-pocket maximum, per family is met, then covered at 100%
Diabetic supplies *(glucose meter, diabetic test strips, lancets, etc.)*	Covered – 100% after deductible	Covered – 80% until $500 out-of-pocket maximum, per family is met, then covered at 100%
Prosthetic and orthotic (P&O) appliances	Covered – 100% after deductible	Covered – 80% until $500 out-of-pocket maximum, per family is met, then covered at 100%
Shoe inserts and arch supports – one pair per calendar year	Covered – 100% after deductible	Covered – 80% until $500 out-of-pocket maximum, per family is met, then covered at 100%
Continuous glucose monitoring systems (CGMS) *Covered with appropriate clinical indicators* *Contact customer service at 1-800-482-5146 for assistance*	Covered – 100% after deductible	Covered – 80% after deductible

Other Services		
Benefits	**In-Network**	**Out-of-Network**
Allergy testing and allergy injections	Covered – 100% after deductible	Covered – 80% after deductible
Allergy serum *Contact customer service for assistance at 1-800-482-5146*	***Covered under prescription drug program***	***Covered under prescription drug program***
Cardiac rehabilitation	Covered – 100% after deductible	Covered – 80% after deductible
Diabetic education	Covered – 100% after deductible	Covered – 80% after deductible
Clinical trials *Routine services associated with approved clinical trials are covered consistent with Medicare policy*	Covered – 100% after deductible	Covered – 80% after deductible
Chemotherapy	Covered – 100% after deductible	Covered – 80% after deductible
Hyperbaric oxygen treatment	Covered – 100% after deductible	Covered – 80% after deductible
Injections	Covered – 100% after deductible	Covered – 80% after deductible
Prescription Drugs — See Prescription Drug section of this Handbook		

Preventive Services for 2021 Blue Preferred Plus (BPP) Plan

Blue Preferred Plus is a grandfathered plan and is not required to provide coverage consistent with the National Health Care Reform Patient Protection and Affordable Care Act (PPACA). Preventive Services available under BPP Plus for 2021 are outlined below.

Note: The chart is updated annually and available at **myfordbenefits.com**.

Preventive Service	Frequency/Limitations
Physical Examinations	
Well adult – health maintenance exam (HME) (routine physical)	• 1 per calendar year • *Subject to 50% copay*
Well baby/child exam	• 6 visits prior to age 2
Laboratory Screening Services	
Lipid disorder screenings	• 1 every 5 years; males and females age 20 and over
Fecal occult blood test	• 1 per calendar year; males and females age 50 and over
Infectious Disease Screening	
Hepatitis C (HCV) screening	• 1 per calendar year • Males, females and children at any age at risk

Preventive Service	Frequency/Limitations
Men's Health	
Prostate specific antigen (PSA)	• Males age 40 and over • 1 per calendar year • 2nd screening test allowed if first test indicates a level 4.0 or higher
Women's Health	
GYN Exam	• 1 per calendar year • Females at any age • *Subject to 50% copay*
Cervical cancer and dysplasia screening Papanicolaou (PAP) smear	• 1 per calendar year • Females at any age
Procurement of PAP smear	• 1 per calendar year • Females at any age
Mammogram – screening (includes 3D – tomosynthesis)	• 1 baseline at age 40 • 1 per calendar year age 50 and over • 1 per calendar year Age 25 + if at high risk
Colorectal Cancer Screening	
Colonoscopy	• Males and females age 50 and over • 1 every 10 years
Cologuard	• Males and females age 50 and over • 1 every 3 years
Barium Enema	• Males and females age 50 and over • 1 every 5 years unless received colonoscopy in past 10 years
Sigmoidoscopy	• Males and females age 50 and over • 1 every 5 years unless received colonoscopy in past 10 years
Proctoscopic Exam (without biopsy)	• Males and females age 40 and over • 1 every 3 years

Preventive Service	Frequency/Limitations
Immunizations*	
Cholera vaccine Ebola vaccine Hepatitis A vaccine Hepatitis B vaccine HPV Influenza (flu) Influenza type B (HIB) Japanese Encephalitis virus vaccine Meningococcal vaccine MMR/MMRV Pneumococcal vaccine Poliovirus vaccine Rabies vaccine Rotavirus vaccine Shingles (Shingrix) – Age 50+ Tetanus, Diphtheria, Pertussis vaccine Typhoid vaccine Varicella virus vaccine (chicken pox) Yellow Fever vaccine	• Follow CDC/Advisory Committee on Immunization Practices (ACIP) guidelines for age and frequency limitations: **www.cdc.gov/vaccines/schedules/** *Effective 1/1/2020, all listed immunizations are covered at a pharmacy (both through the medical and pharmacy benefit). Immunizations remain covered at a doctor's office and retail health clinics.

*This is intended as an easy-to-read summary and provides an overview of your **in-network** preventive benefits. This is not an all-inclusive list and is subject to change. This list is updated and posted on an annual basis only. Additional restrictions, including diagnosis, location, age limitations and provider type may apply to all listed services.* ***For a complete description of current benefits, please contact the customer service number on the back of your ID card***

Prescription Drug Coverage

UAW-Ford Health Care Plan Summary Plan Description, November 2021

For UAW-Ford Represented:

- **Legacy Employees**: Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees**: Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees**: Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Prescription Drug Coverage Overview

***Prescription Drug coverage is part of the BCBS National PPO Plan and Blue Preferred Plus PPO Plan. If you are enrolled in an alternative plan, this description does not apply to you*.**

Contact your alternative plan for benefit information.

Prescription Drug coverage helps you pay the cost of covered prescription drugs you or your family may need. You, your spouse and your eligible dependents may have prescriptions filled at a participating or nonparticipating pharmacy, the home delivery program or the Walgreens Smart90 program. You pay less if you go through a participating pharmacy, and even less if you go through the home delivery program through Express Scripts or utilize the Smart90 Program at a retail Walgreens pharmacy. You also pay less for generic rather than brand-name drugs.

Coverage

Medication

Prescription Drug benefits cover the initial fill and refills for prescription medications. To qualify, the drug label must read "Rx Only." In addition, injectable insulin, which may not require a prescription, is covered by the plan. Allergy serums which are prescribed for you on an ongoing basis are covered. Also, the retail price or home delivery price of the quantity prescribed must be more than the copay amount.

The following chart provides a quick reference guide for your prescription coverage under BCBS National PPO/Blue Preferred Plus PPO plans, co-administered by BCBSM and Express Scripts, Inc.

	In-Network	Out-of-Network
Retail — 34-day Supply		
Generic drugs	$6 copay	Covered at 75% after $6 copay
Brand-name drugs	$12 copay	Covered at 75% after $12 copay
Erectile dysfunction	$17 copay	Covered at 75% after $17 copay
Home Delivery or Walgreens Smart90 Program — 90-day		
Generic drugs	$12 copay	Not covered
Brand-name drugs	$17 copay	Not covered
Erectile dysfunction	$21 copay	Not covered

Vaccines and diabetes supplies are covered at any network pharmacy or medical setting/supply company.

Insulin

Benefits are provided for a one-month or 90-day supply of disposable syringes and needles for injection of insulin if you have a history of filling a prescription for insulin.

One copay applies to the total prescription when insulin, needles and syringes are filled at the same time.

Insulin is a maintenance drug available in a 90-day supply to you through the mail or at a Walgreens pharmacy through the Walgreens Smart90 Program. Review the section *Maintenance Drugs and the Home Delivery Program or Walgreens Smart90* later in this section.

Dosage Quantities

You can receive up to a 34-day supply of medication if purchased from a retail pharmacy. Through the home delivery prescription drug program, you can receive up to a 90-day supply of any covered prescription drugs.

Administrator

If you are enrolled in the BCBS National PPO Plan or the Blue Preferred Plus PPO Plan, your prescription drug coverage is administered by BCBSM and Express Scripts. BCBSM and Express Scripts are responsible for drug utilization review functions and quality assurance mechanisms.

Retail Pharmacies

To receive the maximum benefits available for retail pharmacies, you must have your prescription filled at a participating pharmacy. To locate a participating pharmacy near your home or workplace or while traveling, call BCBSM at 1-800-482-5146 or go to **express-scripts.com**.

Participating Retail Pharmacies

You must present your BCBSM ID card and prescription to the retail pharmacist. You pay a copay for each covered prescription or refill. You do not have to submit a claim form when you use a participating pharmacy. Express Scripts will automatically reimburse the participating provider for the remaining cost.

If you or an eligible member needs to take a prescription drug on a long-term basis, you may need to obtain it through the Express Scripts home delivery or a Walgreens pharmacy (Smart90). Review the section *Maintenance Drugs and the Home Delivery Program or Walgreens Smart90* later in this section.

Nonparticipating Retail Pharmacies

You pay the full price (100%) of the prescription at the time of purchase and obtain a receipt. Call BCBSM at 1-800-482-5146 to obtain a claim form. Once received, submit your completed claim form to:

Express Scripts, Inc.
P.O. Box 14711
Lexington, KY 40512

The prescription receipt must be attached to the form. For your records, make a photocopy of your claim and receipt. You will be reimbursed 75% of the allowed amount after deducting the copay. You will not be reimbursed for the pharmacy's retail drug charges above the allowed amount, if applicable.

Physician or Dentist-Filled Prescriptions

If your prescription is filled at your physician's or dentist's office, or if you receive medication from anyone (other than a pharmacy) licensed to fill prescriptions, you pay the entire cost and file a claim with the claims processor. You will be reimbursed up to the amounts described above for use of a nonparticipating retail pharmacy.

Maintenance Drugs and the Home Delivery Program or Walgreens Smart90

The home delivery program is a convenient way to get your prescription medications.

You save money by getting a 90-day supply of your prescriptions, available through the home delivery program. You also have the option of receiving long-term medications (90-day supply) at a retail Walgreens pharmacy through the Smart90 program.

You are required to use the home delivery program or Walgreens Smart90 if you or your covered dependent is prescribed a "maintenance drug" to treat a long-term health condition such as high blood pressure, arthritis, diabetes or asthma.

Generally, any medication that may be used for over a year is considered a maintenance drug. You will receive notice from Express Scripts if you are using a maintenance drug.

For maintenance drug medications, the first three times you fill a prescription, you may go through a retail pharmacy (see "Maintenance Drugs" on the following page for information about maintenance drugs). Beginning with the fourth fill, you **must** obtain a 90-day supply of the drug and use the home delivery program or a Walgreens pharmacy (Smart90) in order to have the drug covered. For questions on a specific medicine, call BCBSM at 1-800-482-5146.

You may use the home delivery program and Walgreens Smart90 for other long-term medications that Express Scripts had not categorized as "maintenance drugs." This will save you time and money.

Note: The Generic Prescription Drug Program described later in this section also applies to the home delivery program administered by Express Scripts as well as retail.

Follow these steps to get started using the home delivery program or Walgreens Smart90:

Step 1	Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to one year. If you are going to use the home delivery program, make sure that you have at least a two-week supply on hand. If not, ask your doctor for a prescription for up to a 34-day supply that you can fill at a participating retail pharmacy while you wait for your home delivery prescription to arrive.	
	Home Delivery Program	**Walgreens Smart90**
Step 2	You may either: • Have your doctor e-prescribe a new prescription for your 90-day supply to Express Scripts **OR** • Complete a home delivery order form and attach the original prescription (you may want to retain a copy for your records). You may obtain an order form and envelope by calling Express Scripts at 1-800-778-0735 or BCBSM at 1-800-482-5146. You also can obtain or print a home delivery order form online, once you have registered at **express-scripts.com**, or from your Union Benefits Representative. Mail the new prescription in the envelope provided **OR** • Provide your doctor with your contract number located on your BCBSM ID card. Ask your doctor to call 1-888-327-9791 for instructions on how to fax a prescription*	You may either: • Have your doctor e-prescribe a new prescription for your 90-day supply to your preferred Walgreens pharmacy location **OR** • Take the prescription provided by your doctor for the 90-day supply to your preferred Walgreens pharmacy location
Step 3	You may pay the home delivery copay by credit card, check, money order, or e-check. E-check is an electronic funds transfer system that automatically deducts your copay from your checking account. If you prefer to pay for all your orders by credit card, you may want to join the Express Scripts automatic payment program. You can enroll by visiting the Express Scripts website, **express-scripts.com**, or by calling Express Scripts toll-free at 1-800-948-8779	Payment for your prescriptions is made when you pick up your prescription at Walgreens

**Only your doctor's office is permitted, by law, to fax your prescriptions to Express Scripts.*

When you order your prescriptions through the home delivery program, your prescriptions are delivered via standard delivery, postage-paid, generally within eight days from the date you mailed your order.

If you are a first-time visitor to **express-scripts.com**, please take a moment to register your contract number (located on your BCBSM ID card). ***Do not enter the letters that appear in front of your contract number. Entering the letters will cause an error and prevent you from registering.*** A recent retail or mail order prescription number is also needed to complete the registration.

For questions about your home delivery or the Walgreens Smart90 program (such as order status, account balance or shipment information), call Express Scripts at 1-800-778-0735.

Pharmacy Management Tools

Coverage management tools help bring greater patient safety by protecting against potentially dangerous dosing that does not meet FDA-approved guidelines or national physician best practice guidelines. Some medications, for example, are not covered unless you receive prior authorization through a coverage review. Express Scripts must review prescriptions for these medications with your doctor before they can be filled under your plan, since more information than what is on a prescription is needed. The review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.

In most cases, you will not realize the drug you have been prescribed is subject to review. If there is a delay, the pharmacist processing your prescription will let you know your physician will be contacted for more information. The following coverage management tools (also known as Drug Tools or Rx Tools) may apply:

- **Prior authorization:** This program requires that you obtain prior approval through a coverage review. The review will determine whether your plan covers your medication.
- **Step therapy/preferred coverage review:** These programs allow for coverage of certain medication only when the patient has first tried another “first-line” medication or therapy.
- **Authorization for additional quantity of medication:** For some medications, your plan covers a limited quantity within a specified period of time. A coverage review may be available to request additional quantities of these medications. Please note that Express Scripts does not automatically initiate a coverage review process for additional quantities. Your doctor can initiate this request by calling Express Scripts at 1-800-778-0735. Express Scripts will send you and your doctor written notification of the decision.
- **Dose optimization**: For certain medications, this program lets patients take one pill a day at a higher dose instead of two pills a day of a lower dose.

For information on specific drugs impacted by the pharmacy management tools, contact BCBSM at 1-800-482-5146.

Your doctor may contact Express Scripts at 1-800-778-0735, 8 a.m. to 9 p.m. ET, Monday through Friday regarding a coverage management rule.

Generic Prescription Drug Program

Note: The Generic Prescription Drug Program applies to the home delivery program as well as the retail program.

The Generic Prescription Drug Program is designed to require the use of generic drugs. Generic equivalent drugs provide the same potency and effectiveness as brand-name drugs.

At retail pharmacies and through the home delivery program through Express Scripts, where legally permissible, your pharmacist will automatically dispense generic equivalent drugs in place of brand-name drugs when a generic exists. You will receive the generic drug and pay the generic copay instead of the brand-name copay.

If your physician prescribes a specific drug for which there is no generic available, you get the brand-name drug, and pay the brand-name copay.

If **YOU** request a brand-name drug for which there is a generic available, you will get the brand-name drug. However, you will be responsible for the generic copay, **PLUS** the full cost difference between the brand and generic drug.

If **YOUR DOCTOR** prescribes a brand-name drug when a generic drug equivalent is available, and your doctor indicates on your prescription that a generic drug is not permitted (for example, by writing DAW, Dispense as Written), then for your first prescription fill, you will pay the brand-name drug copay, plus up to $10 of the cost difference between the brand-name and generic drug. Your doctor will need to request a review if you need to continue receiving this drug. Follow these instructions:

Should your doctor feel there are special circumstances for which you need the brand-name drug, ask your doctor to request a review by calling Express Scripts at 1-800-841-5409. Express Scripts will send you and your doctor written notification of the decision. If your review is approved, you will receive authorization to purchase the brand-name drug for the brand-name drug copay for as long as you remain on that medication. If your review is approved, you will also receive a refund on the most recent fill for the cost difference that you paid in excess of the brand-name copay. If the review is not approved, you must pay the generic copay, plus the full difference in cost between the brand-name and generic drug for all future refills. For additional information see the *Health Care Claims and Appeals* section later in this handbook.

Affordable Care Act (ACA) — Preventive Generic Drugs

Under the Affordable Care Act (ACA), the following preventive prescription drugs will be covered at 100% when the defined guidelines are met as described below and you are enrolled in the BCBS National PPO Plan.

Aspirin

- **Guideline:** Adults; 50 to 59 years who have a 10% or greater 10-year CVD risk, have a life expectancy of at least 10 years; and after 12 weeks' gestation in pregnant persons who are at high risk for preeclampsia.
- **Rule:** Coverage for Aspirin (over-the-counter (OTC)) through age 69.

Bowel Prep

- **Guideline:** Screening for colorectal cancer using colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years.
- **Rule:** Coverage for certain agents for adults 50 through 74 years of age.

Breast Cancer Primary Prevention

- **Guideline:** Medications prescribed for the primary prevention of breast cancer in women who are at high risk.
- **Rule:** Covered at $0 copay for adults 35 years or older who meet criteria.

Contraception — Women's Health Care Preventive Services

- **Guideline:** Women with reproductive capacity may receive the following FDA-approved female contraceptives with prescription. Only generic, and single-source brand medications that do not have a generic equivalent available, will fall under the $0 copay. Multi-source brands which do have generic equivalents available are not included in this category.
- **Rule:** Coverage for adults under 51 years of age.

Contraception Method	Example of Contraception Product Type
Barrier	Diaphragm
Hormonal	Oral Contraceptive Injectable Hormone Vaginal Ring
Emergency Contraceptives	Plan B and Generics (Rx only)
Non-Surgical Permanent Contraceptives	IUD

Fluoride

- **Guideline:** Primary care clinicians may prescribe oral fluoride supplementation at currently recommended doses to preschool children older than six months of age whose primary water source is deficient in fluoride.
- **Rule:** Coverage for Fluoride (Rx) for ages six months through 16 years.

Folic Acid

- **Guideline:** All women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
- **Rule:** Coverage for Folic Acid (OTC) for women through age 50.

Smoking Cessation

- **Guideline:** Clinicians should ask all adults about tobacco use and provide cessation interventions for those who use tobacco products. For non-pregnant adults (18 years or older) therapy includes nicotine replacement therapy (gum, lozenge, patch, inhaler and nasal spray) and sustained-release bupropion and varenicline.
- **Rule:** Coverage for (Rx and OTC) smoking deterrents for adults 18 years or older.

Statin — Prevention of Cardiovascular Disease

- **Guideline:** The recommendation specifies that adults 40–75 years old without a history of cardiovascular disease should use a low to moderate dose statin for the prevention of cardiovascular events when the individual has one or more cardiovascular disease risk factors (i.e., dyslipidemia, diabetes, hypertension or smoking) and a calculated 10-year cardiovascular disease event risk of 10% or greater.
- **Rule:** Coverage for low dose generic statin for adults age 40–75 without a history of cardiovascular disease if diagnosed with cardiovascular risk factor.

HIV Pre-Exposure Prophylaxis (PrEP)

- **Guideline:** Emtricitabine/Tenofovir Disoproxil Fumarate 200mg/300mg (Generic Truvada) prescribed for PrEP is effective antiretroviral therapy to persons who are at high risk of HIV acquisition.
- **Rule:** Covered for patients with no prescription claims history for HIV treatment.

The list of generic preventive drugs covered at 100% under the Affordable Care Act (ACA) is updated annually. Please refer to the updated $0 Generic Preventive Drug List available on **myfordbenefits.com** for the most up-to-date list.

What Is Not Covered

Under the BCBS National PPO Plan and Blue Preferred Plus PPO Plan, the following services, supplies and medications are not a covered benefit:

- Drugs for which the provider's charge is less than the applicable copay
- Drugs requiring a prescription by State but not by Federal law
- Covered drugs that are consumed entirely at the time and place where the prescription is written*
- Non-prescription contraceptive medication, devices, appliances or supplies, except as required by the Affordable Care Act (ACA)
- Reusable syringes and needles, multi-use syringes and disposable needles
- Charges for administering a covered drug*
- Charges for more than a 34-day supply of a covered drug through a retail pharmacy, except for certain insulin and syringes and for medications pre-packaged in supplies greater than 34 by the manufacturer
- Charges for more than a 90-day supply of a drug filled through the Express Scripts prescription drug home delivery program
- Charges for more refills than your physician or dentist specifies or refills after a year from the original date the prescription was written.
- Charges for medication furnished on an inpatient or outpatient basis, if the charge is covered by any other health care coverage
- Medication provided under Workers' Compensation or other government plans (if you are enrolled in the Medicare Part D prescription drug plan, you are ineligible for prescription drug coverage with the Company while enrolled in Medicare Part D)
- Medication prescribed by a non-licensed provider
- Drugs that are not medically necessary
- Investigational or experimental drugs
- Medications received before you or your dependent was covered under the Plan or after coverage ends
- Maintenance drugs filled at a retail pharmacy after receiving the same prescription drug at the same therapeutic strength three times at a retail pharmacy
- All non-sedating antihistamines
- All vitamins and minerals with the exception of:
    - 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
    - Potassium Chloride

**Certain items may be covered under your medical/surgical program.*

Contact Information

Contact BCBSM/Express Scripts:

By internet or mobile app at express-scripts.com, Express Scripts mobile app or BCSBM mobile app

- Order and track the status of your refills
- Download mail order forms
- Request envelopes
- Check prescription coverage and pricing
- Request order forms and envelopes
- Locate an in-network retail pharmacy

By telephone

You can reach BCBSM/Express Scripts at the numbers listed below.

Member Services

BCBSM: For questions about the Prescription Drug Program, such as benefits, copays and eligibility, call 1-800-482-5146.

For questions about your mail order prescriptions, such as order status, account balance or when and how an order was shipped, call Express Scripts at 1-800-778-0735.

Braille

To request braille labels for mail order prescriptions, call Express Scripts at 1-800-778-0735.

Dental Coverage

UAW-Ford Health Care Plan Summary Plan Description, November 2021

For UAW-Ford Represented:

- **Legacy Employees**: Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees**: Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees**: Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Dental Coverage Overview

The Traditional Dental benefits provide coverage for most dental services.

Traditional Dental benefits are administered by Delta Dental Preferred Provider Organization (PPO) and cover most dental services for you, your spouse and your eligible dependents. Benefits are paid at 100%, 90%, 70% or 50% of the covered expense (up to the allowed amount) depending on the service you receive and your dentist's participation status with Delta Dental. You do not have to satisfy a deductible. The maximum amount the dental plan will pay in a calendar year is $1,850 for each individual.

Most orthodontic services are covered at 60% or 50% depending on your dentist's participation status with Delta Dental. There is a lifetime maximum of $2,200 for orthodontia for each covered person who begins treatment prior to age 19.

Note: 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 copays will be required for all such services.

The Delta Dental PPO (Point of Service) Plan offers two nationwide dental provider networks: Delta Dental PPO and Delta Dental Premier. When you receive services from a Delta Dental PPO provider, your out-of-pocket expenses will likely be lower than those you would incur if you received services from a Premier or Nonparticipating provider.

The Delta Dental PPO Provider Network is a network of dentists in all 50 States, the District of Columbia and Puerto Rico who have agreed to accept a discounted fee as full payment for covered services. Use of the Delta Dental PPO network is voluntary, but you may save money if you use a Delta Dental PPO dentist. There is no commitment required, and family members can switch back and forth at will. Since the Delta Dental PPO dentists accept less for covered services, the amount you pay may be lower, and you will not be billed for the balance of the charges above the Delta Dental PPO approved amount. This schedule is typically 30–40% below average submitted charges. You also save money because Delta Dental PPO provides a higher level of coverage for certain services. If you seek treatment from a Delta Dental Premier provider, you may still save money compared to going to a Nonparticipating provider.

Delta Dental Premier providers agree to accept a discount off of submitted covered services; however, the amount you pay may be higher than if you went to a Delta Dental PPO provider. The Delta Dental Premier fee schedule is typically 10–15% below average submitted charges. For example:

	Delta Dental PPO	Delta Dental Premier	Delta Dental Nonparticipating*
Fillings	100%	90%	90%
Root Canals	100%	90%	90%
Gum Treatments	100%	90%	90%
Extractions	100%	90%	90%
Oral Surgery (other than Extractions)	90%	90%	90%
Bridgework	70%	50%	50%
Dentures	70%	50%	50%
Orthodontics	60%	50%	50%

**Reimbursement for Nonparticipating dentists will be based on Delta Dental's approved Nonparticipating dentist fees. This fee may be less than what your dentist charges and you may have to pay the remaining balance.*

Please refer to your Delta Dental Certificate of Coverage for full details of the specific benefits of your Delta Dental program and how to use them, including limitations and exclusions.

For a copy of the certificate please call 1-844-223-8520.

Outpatient Dental Services

Refer to the *Hospital-Surgical-Medical Benefits* section for information on dental services received at an outpatient hospital setting.

Information relating to your eligibility for Dental coverage is provided in the *Health Care Plan Eligibility* section.

Coverage

Covered dental expenses are a percentage of the "allowable amounts" that a dentist charges for services and supplies that are "necessary" for treatment of a dental condition customarily employed for treatment of that condition, and which are rendered in accordance with accepted standards of dental practice.

If you have a dental problem that can be treated in more than one way, the procedure that provides a cost-effective, professionally satisfactory result is covered.

Expenses for dental services are covered at 100%, 90%, 70% or 50% of the allowable amount depending on your dentist's participation status with Delta Dental (PPO, Premier or Nonparticipating).

Allowable Amounts

Services Covered at 100%

These services are paid at 100% of the allowable amount:

- Routine oral exams and cleaning and scaling, but not more than twice for each covered person during any calendar year
- Four cleanings per calendar year if you have a documented history of periodontal disease
- One topical application of fluoride, provided that such treatment is only for enrollees under 15 years of age unless a specific dental condition makes such treatment necessary
- Space maintainers to replace prematurely lost teeth for covered children under age 19 (coverage will terminate the end of the day immediately preceding the covered child's 19th birthday)
- Emergency treatment to relieve dental pain
- Fabrication of fluoride gel carrier trays including the topical fluoride for cancer patients undergoing radiation therapy of the head and neck
- Fluoride gel carrier trays used in the delivery of topical fluoride for enrollees undergoing radiation therapy of the head and neck due to cancer, payable once with the initial cancer diagnosis and thereafter once with each subsequent recurrence of cancer, as medically necessary
- Oral brush biopsy procedure and laboratory analysis necessary to detect oral cancer
- One oral exfoliative cytology sample collection will be covered per calendar year for enrollees presenting with an un-resolving oral lesion/ulceration, or an enrollee with an oral lesion/ulceration having a history of behaviors that places the enrollee at risk for oral cancer. Covered services will include the collection of the biopsy specimen and its laboratory interpretation

Services Covered at 100% when seeking treatment from a Delta Dental PPO provider or 90% when seeking treatment from a Delta Dental Premier or Nonparticipating provider

These services are paid at 100% (90% for a Premier or Nonparticipating provider) of the allowable amount:

- Dental X-rays, including full mouth X-rays once in a five-year period, supplementary bitewing X-rays once in any calendar year for enrollees age 14 and younger; and once every two years for enrollees age 15 and older, and such other dental X-rays as required for the diagnosis of a specific treatment
- Simple extractions
- Surgical extractions

- Amalgam, synthetic porcelain, resin-based composite and other American Dental Association (ADA) approved direct restorative materials that meet program standards and are used to restore diseased or accidentally injured teeth
- Resin-based composite for all fillings when restoring posterior teeth regardless of the surface
- General anesthetics and intravenous sedation when necessary and used with oral or dental surgery
- Periodontics and treatment of other gum or mouth tissue diseases
- Endodontics, including root canal therapy
- Injection of antibiotics by the attending dentist
- Repair or recementing of crowns, inlays, onlays, bridgework and dentures; or relining or rebasing dentures more than six months after installation, but not more than once in any period of 36 consecutive months

Services Covered at 90% when seeking treatment from a Delta Dental PPO, Delta Dental Premier or Nonparticipating provider

These services are covered at 90% of the allowable amount:

- Oral surgery other than extractions
- Initial installation of inlays, onlays, gold fillings or crown restorations but only when a tooth, as a result of extensive caries or fractures, cannot be restored with the filling materials described above
- Replacement of crowns more than three (3) years after installation of an initial or replacement crown if the crown has been damaged and cannot be made serviceable, or if there is recurrent decay under the existing crown or decay at a crown-to-natural-tooth margin that cannot be repaired by a direct-fill restoration
- An occlusal guard (maxillary or mandibular) is a covered supply only for the palliative treatment of bruxism and/or acute pain of the muscles of mastication. The benefit will be payable for one occlusal guard in a five-year period.

Services covered at 70% when seeking treatment from a Delta Dental PPO provider or 50% when seeking treatment from a Delta Dental Premier or Nonparticipating provider

These services are paid at 70% (50% for Premier or Nonparticipating provider) of the allowable amount:

- Initial installation of fixed bridgework, including inlays and crowns as abutments
- Initial installation of partial or full removable dentures, including any attachments and adjustments during the six (6) months after installation
- Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or bridgework, or the addition of teeth to an existing partial removable denture or to bridgework if:
    - The replacement or addition of teeth is necessary to replace teeth extracted after the existing denture or bridgework was installed
    - The existing denture or bridgework cannot be made serviceable and, if installed under this Plan, at least five years have passed since its installation
    - The existing denture is an immediate temporary denture, and replacement of a permanent denture occurs within 12 months of the first installation of the immediate temporary denture

- The placement of an endosteal, single tooth, implant, the implant abutment, and crown, including any supportive services with the exception of IV sedation and/or general anesthesia is covered. Coverage does not include bone grafts or specialized implant surgical techniques.

You should always ask your dentist if he or she participates with Delta Dental PPO because using a PPO dentist will save you additional money and stretch your annual and lifetime maximums, as illustrated below:

		Delta Dental PPO	Delta Dental Premier	Out-of-Network
Adult Cleaning	Submitted fee	$100.00	$100.00	$100.00
	Maximum allowed fee	$67.00	$81.00	$76.00
	Amount Delta Dental Pays	$67.00	$81.00	$76.00
	Amount You Would Pay:	**$0.00**	**$0.00**	**$24.00**
Filling	Submitted fee	$225.00	$225.00	$225.00
	Maximum allowed fee	$151.00	$180.00	$170.00
	Amount Delta Dental Pays	$129.00	$162.00	$153.00
	Amount You Would Pay:	**$0.00**	**$18.00**	**$72.00**
Crown	Submitted fee	$1,200.00	$1,200.00	$1,200.00
	Maximum allowed fee	$800.00	$980.00	$910.00
	Amount Delta Dental Pays	$720.00	$162.00	$153.00
	Amount You Would Pay:	**$80.00**	**$98.00**	**$381.00**

Note: Payment examples above are illustrative only. Fees and reimbursements can vary by location and dentist. They do, however, represent how payment is determined.

Hospital-Surgical-Medical

Benefits are provided under Hospital-Surgical-Medical coverage for cosmetic bonding of eight front teeth for children age eight through the end of the calendar year in which they become age 19 if required because of severe staining, but not more frequently than once in any period of three consecutive years.

Pre-Treatment Estimate

A pre-treatment estimate is a voluntary and optional process where Delta Dental issues a written estimate of dental benefits that may be available under your coverage for your proposed dental treatment. Your dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.

A pre-treatment estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same benefit under this plan whether or not a pre-treatment estimate is requested. The benefit estimate provided on a pre-treatment estimate notice is based on benefits available on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility, your available annual or lifetime maximum payments, any coordination of benefits, the status of your dentist, this Plan's limitation and any other provisions, together with any additional information or changes to your dental treatment. A request for pre-treatment estimate is not a claim for benefits or a preauthorization, precertification or other reservation of future benefits.

Network Dentists

There are generalist and specialist Delta Dental PPO network dentists nationwide. Ask your current dentist if he or she is in the Delta Dental PPO network. If the dentist is not in the Delta Dental PPO network, you may still save money by visiting a Delta Dental Premier dentist. You may locate a network dentist or nominate your dentist by submitting the dentist's name, address and phone number by calling Delta Dental at 1-844-223-8520 or online at **deltadentalmi.com**.

Orthodontia

For eligible persons under age 19, Traditional Dental covered orthodontic benefits are paid at 60% of the allowable amount with a Delta Dental PPO dentist and 50% of the allowable amount with a Delta Dental Premier or Nonparticipating provider up to an annual maximum per covered person. Benefits are provided for teeth-straightening programs for eligible persons, as long as continuous treatment begins before age 19.

Dental benefits are paid at 60% or 50% of the allowable amount for all covered services relating to orthodontic treatment, up to a $2,200 lifetime maximum per covered person. "Orthodontic treatment" includes preventive and corrective treatment of dental irregularities resulting from injury or the abnormal growth and development of teeth.

Covered services include:

- Diagnostic procedures and treatment, including oral exams related to orthodontia
- Appliance therapy
- Functional/myofunctional therapy (when provided by a dentist in conjunction with appliance therapy)

You should always ask your orthodontist if he or she participates with Delta Dental PPO because using a PPO orthodontist may save you additional money and stretch your annual and lifetime maximums, as illustrated below:

		Delta Dental PPO dentist	Delta Dental Premier dentist	Out-of-Network dentist
Comprehensive Orthodontic Treatment	Submitted fee	$6,000.00	$6,000.00	$6,000.00
	Maximum allowed fee	$4,635.00	$5,530.00	$4,610.00
	Orthodontic Lifetime Maximum per Member	$2,200.00	$2,200.00	$2,200.00
	Amount You Would Pay:	**$2,435.00**	**$3,330.00**	**$3,800.00**

Note: Payment examples above are illustrative only. Fees and reimbursements can vary by location and dentist. They do, however, represent how payment is determined. Payment for Orthodontic Services up to your Lifetime Maximum will be made based on a scheduled payment plan between Delta Dental and your provider.

Orthodontic Treatment Plans

Delta Dental requires your dentist to submit an orthodontic treatment plan. When orthodontic treatment starts, Delta Dental will pay a percentage of the total fee. Delta will continue to make payments based on the type of treatment (18 months for comprehensive, 10 months for interceptive and 8 months for limited) or until the lifetime orthodontic maximum is reached. Payments will be made quarterly and automatically.

Services Not Covered

Under the Traditional Plan, certain dental expenses are not covered. These include:

- Benefits payable by your other health care coverages
- Work not done by a dentist, except scaling and cleaning of teeth and topical application of fluoride by a licensed dental hygienist under a dentist's supervision
- Veneers for crowns or pontics on teeth, other than the 10 upper and lower anterior teeth
- Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures
- Prosthetic devices (including bridges), crowns, inlays, onlays and their fitting, if you were not covered when they were ordered or if they are not installed or delivered within 60 days after the day your coverage ends
- Replacement of lost, missing or stolen prosthetic devices
- Failure to keep a scheduled visit with the dentist
- Replacement or repair of an orthodontic appliance
- Charges for services that are compensated under Workers' Compensation
- Charges for services rendered through a medical department, clinic or similar facility provided or maintained by the patient's employer
- 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
- Charges for services or supplies that are not necessary, according to accepted standards of dental practice, or that are not recommended or approved by the attending dentist
- Charges for services or supplies that do not meet accepted standards of dental practice and that are considered experimental
- Services or supplies received as a result of war, declared or undeclared
- Services or supplies furnished or payable by any government or governmental agency, or any governmental program or law under which you could be covered, unless payment is legally required
- Duplicate appliances
- Charges for completion of any insurance forms
- Sealants and oral hygiene and dietary instruction
- A plaque control program
- Services or supplies for periodontal splinting

Nationwide Dental Health Maintenance Organization (DHMO)

DeltaCare USA is a DHMO plan and is available as an alternative to the Delta Dental PPO (Point of Service) dental program. DeltaCare USA is available in all 50 States.

You may elect dental coverage under the DeltaCare USA DHMO plan in place of the Traditional Plan's coverage.

With the Hourly Rolling Enrollment, there is no longer a specific enrollment period. You may change your dental plan election during any month of the year (provided 12 months have elapsed since your last change).

To make a plan change, call the NESC at 1-800-248-4444 or go to **myfordbenefits.com.** You will receive a confirmation statement in the mail anytime you make a change. Your election takes effect on the first day of the month following your election.

Under this HMO-type plan, you and your family will be required to choose a primary care dentist who participates in the DeltaCare USA DHMO network. Every member of your family may choose a different participating primary care dentist, if they prefer. If you do not select a participating DeltaCare USA dentist at the time of enrollment, one will be assigned to you based on your home address.

You must visit your selected DeltaCare USA primary care dentist to receive benefits under this plan. If you require treatment from a specialist, your primary care dentist will coordinate a referral for you. You are not required to use one primary care provider for your whole family.

To find a participating DeltaCare USA dentist, please visit **www.deltadentalins.com/deltacare** and search "find a dentist," or call DeltaCare USA's customer service department at 1-800-422-4234.

You have the flexibility to change your assigned primary care dentist at any time throughout the year. If you change your dentist by the 21st day of the month, it will go into effect the first day of the following month. To change your dentist please visit **www.deltadentalins.com/deltacare** or call DeltaCare USA customer service at 1-800-422-4234.

Your payment responsibility for covered dental services is based on a pre-set copayment schedule (determined dollar amounts, by service); there are no annual maximums or deductibles. At the time of service, you will pay the dentist only the listed copayment found in your plan booklet for covered services.

Coverage

You must receive services from your assigned DeltaCare USA dentist, or you will not be covered.

	DeltaCare USA DHMO
Annual deductible	None
Annual maximum coverage per person	None
Routine oral exams	Covered 100%; no limit
Dental cleanings	Covered 100%; 2 per calendar year
Basic services (amalgam fillings, routine extractions, endodontics, periodontics)	Covered 100%
Major services	Inlays/onlays: You pay $45 Crowns: You pay $0 – $45
Implants	Not covered
Orthodontia	Children (up to age 19): No lifetime maximum, covered 100% for 24 months of comprehensive treatment Adults: No lifetime maximum, enrollee pays $1,995

If you experience a dental emergency and are in a location where you cannot reach your assigned dentist, benefits for emergency treatment received from any dentist other than your assigned dentist are limited to a maximum of $100 per emergency, per person. You are responsible for your copayment as well as any charges over the $100 benefit maximum.

Please refer to the DeltaCare copayment schedule and plan documents for complete coverage details including limitations and exclusions that may apply to certain services.

For detailed information on the availability of and the coverage provided by an alternative dental plan, contact the NESC or go to **myfordbenefits.com** to review the benefit summaries and determine which plans you are eligible to choose from.

Detailed information related to the plan can be provided by the dental carrier. The benefit summaries include the phone number to the carrier. Refer to “Plan Election Changes” in the *Health Care Plan Eligibility* section earlier in this handbook for more details on changing your election.

Vision Care Coverage

UAW-Ford Health Care Plan Summary Plan Description, November 2021

For UAW-Ford Represented:

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- **New Traditional Employees**: Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Vision Care Overview

If you are enrolled in the BCBS National PPO Plan for health care coverage, or in a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) that does not provide vision care coverage, this section describes your Vision Care Program. If you are enrolled in an HMO or PPO that provides vision care coverage, your HMO or PPO will mail you information on your vision care coverage.

Information relating to your eligibility for vision care coverage is provided in the *Health Care Plan Eligibility* section of this handbook.

Program Administrator

Single Vision Solution, Inc. (SVS) insures vision care benefits and provides a network consisting of SVS Vision and other affiliated providers (the “Network”). You and your eligible dependents receive the most comprehensive vision care expense coverage when you receive services from a Network provider. You generally incur greater out-of-pocket expenses when you obtain services from a non-Network provider.

Coverage

Corrective Eye Surgery

Corrective eye surgery (for example, Lasik surgery) is covered as follows:

- Up to $295, through reimbursement, once in any four-year period, by contacting SVS (1-800-225-3095) and submitting proof of payment.
- A participant may not receive benefits for both corrective eye surgery and for frames/lenses (including contact lenses) in the same calendar year and three subsequent years. For example, a participant undergoing corrective eye surgery in 2019 would be eligible for lens and/or frame benefits in 2023.
- A participant will continue to be covered for a vision exam each year.

Network Providers

The following expenses are covered when services are obtained from a Network (SVS) provider.

SCHEDULE 1

NETWORK PROVIDER SCHEDULE

Services:	Coverage:
Vision Testing Exam	Full coverage
Reexamination (by an Ophthalmologist)	$45
Regular Lenses (glass or plastic) • Single vision • Bifocal • Trifocal • Special (lenticular, aspheric, etc.)	Full coverage
Lens Options: • Tints equal to Rose 1 and 2 • Scratch resistant coating for those age 13 and under • Lenses less than 65 millimeters in diameter • Photochromic/Transition	Full coverage
Frames: • Standard frames • Designer frames	• Full coverage • $40
Contact Lenses (instead of eyeglasses) • Not medically necessary o Hard or soft contact lenses o Professional fees (fitting and follow-up) • Medically necessary to achieve 20/70 in better eye or to correct keratoconus, irregular astigmatism, or irregular corneal curvature as diagnosed by an M.D., O.D. or D.O., includes professional fees and contact lenses	• $75 • $40 • Up to $350
Corrective Eye Surgery	$295 reimbursement (see "Corrective Eye Surgery" section above for more details)

Network Provider Warranty

Most lenses or frames received from a Network provider are under warranty for two years (there is a one-year warranty for rimless frames.) The warranty begins the day you receive your lenses and/or frames and works according to a point system.

During the two-year warranty period (or one-year period for rimless frames), a total of 10 replacement points are provided for services received. When any eyeglass part is repaired or replaced, the point value of the replaced part, as described below, will be subtracted from the total number of points remaining.

10 Replacement Points	
Each lens	2 points
Each temple	2 points
Frame front	2 points

Broken parts must be submitted to qualify for this replacement plan. Scratched lenses are not covered. If you use all 10 replacement points before the end of the warranty period, you will be responsible for paying any additional repair or replacement costs. For more information on the warranty, call SVS's toll-free number: 1-800-225-3095.

How to Obtain Network Provider Services

Contact a Network provider for an appointment and let them know that you are an hourly UAW-Ford employee with SVS coverage. To obtain the location of the nearest Network provider, call this toll-free number: 1-800-225-3095.

Ophthalmologist Services

Normally, you will be seen by a Doctor of Optometry for your vision examination. If you prefer, or if your optometrist suggests it for medical reasons, you may have an ophthalmologist perform your vision exam. You may choose any licensed ophthalmologist. You will be reimbursed for the exam based on the following "Schedule 2" coverage levels (regardless of where you live or where your ophthalmologist is located).

If you have your vision exam performed by an optometrist, your optometrist may refer you to an ophthalmologist for medical reasons. Your reexamination by an ophthalmologist is covered if performed by a Network provider within 60 days from the date of your initial examination. You may receive partial coverage under the following "Schedule 2" (on the next page) if you go to a non-Network provider, and you live more than 25 miles from a Network provider. (For those residing within 25 miles of a Network provider, referral must be made by a Network provider.)

Non-Network Providers

If You Live More than 25 Miles

If you live more than 25 miles from a Network provider, and you choose to receive services from a non-Network provider, you will be reimbursed up to the lesser of the actual charge or the following amounts:

SCHEDULE 2

NON-NETWORK PROVIDER SCHEDULE

(If you live MORE than 25 miles from a Network provider)

Services:	Coverage:
Vision Testing Exam	$45
Reexamination (by an Ophthalmologist)	$45
Regular Lenses (glass or plastic) • Single vision • Bifocal • Trifocal • Special (lenticular, aspheric, etc.)	 • $59 • $79 • $99 • $99
Lens Options: • Tints equal to Rose 1 and 2 • Scratch resistant coating for those age 13 and under • Lenses less than 65 millimeters in diameter • Photochromic/Transition	Not Covered
Frames (standard or designer frame)	$49
Contact Lenses (instead of eyeglasses) • Not medically necessary; including hard or soft contact lenses and professional fees (fitting and follow-up) • Medically necessary to achieve 20/70 in better eye or to correct keratoconus, irregular astigmatism, or irregular corneal curvature as diagnosed by an M.D., O.D. or D.O., includes professional fees and contact lenses	 • $89 • $200
Corrective Eye Surgery	$295 reimbursement (see "Corrective Eye Surgery" section above for more details)

If You Live Within 25 Miles

If you live within 25 miles of a Network provider, and you choose a non-Network provider, you will be reimbursed up to the lesser of the actual charge or the following amounts:

SCHEDULE 3

NON-NETWORK PROVIDER SCHEDULE

(If you live WITHIN 25 miles of a Network provider)

Services:	Coverage:
Vision Testing Exam	Not Covered
Reexamination (by an Ophthalmologist)	Not Covered
Regular Lenses (glass or plastic) • Single vision • Bifocal • Trifocal • Special (lenticular, aspheric, etc.)	$13
Lens Options: • Tints equal to Rose 1 and 2 • Scratch resistant coating for those age 13 and under • Lenses less than 65 millimeters in diameter • Photochromic/Transition	Not Covered
Frames (standard or designer frame)	$13
Contact Lenses (instead of eyeglasses) • Not medically necessary; including hard or soft contact lenses and professional fees (fitting and follow-up) • Medically necessary to achieve 20/70 in better eye or to correct keratoconus, irregular astigmatism, or irregular corneal curvature as diagnosed by an M.D., O.D. or D.O., includes professional fees and contact lenses	 • $37 • $52.50
Corrective Eye Surgery	$295 reimbursement (see "Corrective Eye Surgery" section above for more details)

Emergency Services

If you have an emergency and you are unable to reach a Network provider, you may receive covered emergency services from a non-Network provider (subject to program limits). For this purpose, an “emergency” is considered a permanent visual impairment of such nature that failure to replace lost or broken lenses and/or frames could jeopardize your safety or wellbeing. You will be reimbursed up to the amounts listed under “Schedule 2.”

Limitations

Program benefits are limited to:

- One vision testing examination in any period of 12 months plus one referral, when medically necessary, to an ophthalmologist for reexamination within 60 days from the date of initial examination. For those residing within 25 miles of a Network provider, referral must be made by the Network provider.
- One pair of lenses and frames or contact lenses in any period of 24 months.
- Children, to the end of the calendar year in which they become 16 years of age, who are diagnosed as having severe, progressive myopia (i.e., nearsightedness with myopia of 2.00 diopters or greater and progressing at the rate of 1.00 diopter or more per year in the meridian of greatest change) who have a change of 1.00 diopter or more during the preceding 12 months, will be eligible for appropriate corrective lenses (but not frames) payable by the program.
- If a covered person has received lenses or frames for which benefits were payable under the program, benefits will be payable for lenses or frames only if received more than 24 months after receipt of the most recent lenses or frames for which benefits were payable under the program.
- If you (or your eligible dependent) are insulin-dependent diabetics and if a change of .5 diopter or 10 degree axis occurs during the preceding 12 months, you may receive one pair of new lenses on an annual basis at the new prescription (but not frames).
- In order to receive these benefits, insulin-dependent enrollees must provide a letter from their personal physician to the optometrist or ophthalmologist, stating they (or their eligible dependent) are insulin-dependent. For those enrolled in an HMO or PPO plan and who are covered under the SVS Program, the annual eye exam will be provided at an HMO or PPO location as a plan benefit and the lenses, if necessary, would be obtained from an SVS location as a SVS plan benefit.
- When eligible for lenses, and until the enrollee’s 13th birthday, coverage will be provided for scratch-guard coating on plastic lenses when received from a Network provider. Scratch-guard coating will be covered under the program not more frequently than once every two calendar years.

What is Not Covered

This Vision Care Program does not provide coverage for any of the following services or procedures:

- Visual training, orthoptics, visual therapy for learning disorders, low vision aids, aniseikonic lenses, aphakic lenses (if for condition of surgical aphakia) and tonography
- Medical or surgical treatment (these benefits may be provided by your Hospital-Surgical-Medical coverage)
- Drugs or any other medication not administered for the purpose of a vision testing exam
- Vision testing exams, lenses or frames provided for any condition, disease, ailment or injury arising out of and in the course of employment
- Vision testing exams, lenses or frames ordered before you were eligible or after coverage terminated
- Lenses or frames that are not necessary according to accepted standards of ophthalmic practice, or that are not ordered or prescribed by your physician or optometrist
- Charges for vision testing exams, lenses or frames if covered by a government health care program
- Charges for vision testing exams, lenses or frames that are payable under any other group coverage
- Lenses or frames ordered while coverage is in effect but delivered more than 60 days after coverage terminates
- Charges that exceed the reimbursement levels stated above or that otherwise exceed Plan benefits

Hearing Aid Coverage

UAW-Ford Health Care Plan Summary Plan Description, November 2021

For UAW-Ford Represented:

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Hearing Aid Coverage Overview

Under the BCBS National PPO Plan, benefits are provided for hearing aid service when obtained from participating providers.

Under the BCBS National PPO Plan, benefits are provided for audiometric exams, hearing aid evaluations, hearing aids and replacement ear molds for children up to age seven, when services are obtained from participating providers. If necessary, the same benefits will be provided again after 36 months have passed since the last examination for a hearing problem. Up to four replacement ear molds are covered annually for children up to age three and up to two ear molds for children ages three to seven.

Information relating to your eligibility for Hearing Aid coverage is provided in the *Health Care Plan Eligibility* section.

Coverage

For benefits to be paid, Hearing Aid services must be obtained from a participating provider.

Your claims processor has a list of participating providers and suppliers.

An allowance of up to $2,200 every three years will be provided for each eligible enrollee for the acquisition cost and dispensing fee to purchase hearing aids and ear molds, as applicable, plus replacements, adjustments and repairs as required.

For the initial hearing aid payable under this Plan or for a person under age 18, you must first obtain a medical examination of the ear by a physician. This physician's examination is not a covered benefit.

Requirements

To receive benefits, you must obtain:

- **An audiometric exam** performed by a participating physician or audiologist to measure the extent of hearing loss. An "audiometric" exam measures hearing acuity or sharpness. This exam must be performed after or in conjunction with a physician's most recent medical exam of the ear if for an initial hearing aid or for a person under age 18 and must result in a determination that a hearing aid would compensate for the loss of hearing. The lesser of the billed charge or the allowed amount for this exam is covered.
- **A hearing aid evaluation** test to prescribe the make and model of the hearing aid which will best improve hearing. This test must be performed by a participating physician or audiologist when indicated by the most recent audiometric exam.

  The carrier allowed amount will be adjusted on October 1 of each year to reflect increases in the Consumer Price Index. Your hearing aid evaluation test coverage pays the lesser of billed charge or the carrier allowed amount. Your claims processor can tell you how much the coverage currently pays for the hearing aid evaluation test.
- **A hearing aid prescription** filled and fitted by a participating dealer. A prescription from the participating physician or audiologist is required when a hearing aid is purchased.

If the initial exam reveals that the hearing loss may be corrected by ear surgery, that surgery could be covered by Hospital-Surgical-Medical benefits. See the *Hospital-Surgical-Medical Benefits* section for more details.

To be covered, your audiometric and evaluation test must be performed by a participating physician or licensed audiologist. "Physician" means an otologist, otolaryngologist or otorhinolaryngologist who is certified to perform a medical examination of the ear to determine whether there is a loss of hearing acuity.

An "audiologist" is a person who has an advanced college degree in audiology or speech pathology, is certified by the American Speech-Language-Hearing Association and is qualified in the State where he or she practices. Audiologists are also preauthorized to dispense hearing aids.

You should present your health care identification card to the participating provider at the time covered services are obtained. Participating providers will bill your claims processor directly for covered services.

What is Not Covered

Under the BCBS National PPO Plan, no hearing aid benefits are paid for the services below:

- Services and equipment obtained from nonparticipating providers
- Medical or surgical treatment (this may be covered by your Hospital-Surgical-Medical benefits)
- Drugs or other medications (this may be covered by your Prescription Drug benefits)
- Audiometric exams and hearing aid evaluation tests performed, and hearing aids ordered, before coverage becomes effective or after coverage ends, unless a hearing aid is prescribed before coverage ends and is delivered and fitted within 60 days
- Replacement of lost or broken hearing aids
- Replacement parts for, and repairs of, hearing aids once the $2,200 allowance for an individual enrollee has been utilized during any period of 36 consecutive months
- Eyeglass-type hearing aids, to the extent the charge for such hearing aids exceeds the standard covered hearing aid expense
- The cost for more than one audiometric exam, one hearing aid evaluation test and one $2,200 allowance for hearing aids and/or ear molds for an individual enrollee during any period of 36 consecutive months
- Audiometric exams, hearing aid evaluation tests and hearing aids that are not necessary, do not meet accepted standards of practice or are not recommended by a physician or for any other condition other than the loss of hearing acuity
- In the case of an initial hearing aid or any hearing aid for a person under age 18, charges for hearing aid evaluation tests and hearing aids that are not recommended or approved by an audiologist or physician
- Experimental services or supplies
- Services provided under Workers' Compensation or other government plans
- Services or supplies provided in a United States government hospital not operated for the general public

Health Care Claims and Appeals

UAW-Ford Health Care Plan Summary Plan Description, November 2021
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Hospital-Surgical-Medical-Drug-Dental-Vision (HSMDDV) Claims and Appeals Overview

The following pages describe how benefit claims and appeals are made and decided under the Ford Motor Company Hourly HSMDDV Plan. Please note that separate claim and appeal procedures apply to Alternative Coverage Options, which are included in the materials describing those Alternative Coverage Options you will receive from them.

Introduction

Claimants are entitled to full and fair review of any claims made under Ford Motor Company Heath Care Plan (the "Plan"). Ford has delegated all Claims and Internal Appeals determinations relating to Plan benefits to those third-party vendors who process claims for benefits provided by the Ford PPO Options, who are referred to as Claims Processors.

Eligibility for Plan participation is determined by Ford's Master of Eligibility, Alight Solutions. Notice of an eligibility denial, including a Rescission of coverage, will be provided by Alight. Any such denial may be appealed to, and will be determined by, Alight.

Note: Words and phrases that are used frequently throughout appear with initial capital letters and are either defined in the later *Definitions* section or in the text of these procedures.

Procedures

These procedures cover:

- Claims for Plan benefits
- Claims relating to Plan eligibility
- Internal Appeals of Adverse Benefit Determinations on a claim for benefits or eligibility issue
- External Appeals of Final Internal Adverse Benefit Determination involving Medical Judgment or a Rescission of Plan coverage to an Independent Review Organization (IRO)
- A voluntary Ford appeal process for eligibility issues (other than a Rescission of coverage) and benefit claims that are not subject to External Review after a Final Internal Adverse Benefit Determination

Types of Claims

As described below, there are different categories of claims that can be made under the Plan, each with somewhat different Claims and Internal Appeals rules. The primary difference is the timeframe within which the Claims and Internal Appeals must be determined. In addition, different Claims Processors are responsible for Claims and Internal Appeals, depending on the category of benefits involved. Please see the last few pages of this document for a current list of Claims Processors and their contact information.

Pre-Service Claim (Prior Authorization Required)

A claim is a pre-service claim if a Claimant's ability to receive a Plan benefit is specifically conditioned, in whole or in part, on receiving approval in advance of obtaining the medical care — unless the claim involves urgent care, as defined below. Benefits under the Plan that require approval in advance are specifically noted in the Plan's Summary Plan Description as being “subject to pre-service authorization,” or “prior authorization."

The Claims Processor must make an initial pre-service claim decision within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Urgent Care Claim

An urgent care claim is a special type of pre-service claim, where the time periods that otherwise apply to pre-service claims:

- Could seriously jeopardize the Claimant’s life, health or ability to regain maximum function, or
- Would — in the opinion of a physician with knowledge of the Claimant’s medical condition — subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim

On receipt of a pre-service claim, the Claims Processor will determine whether it involves urgent care. However, if a physician with knowledge of the Claimant’s medical condition determines that a claim involves urgent care, the Claims Processor will treat it as an urgent care claim.

Urgent care claims must be determined as soon as possible, taking into account the medical urgency, but no later than 72 hours after receipt of the claim. Please be sure to leave contact information with the Claims Processor.

Post-Service Claim

A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim or an urgent care claim.

A Claims Processor must decide a post-service claim within a reasonable time but no later than 30 days after receipt of the claim.

Concurrent Care Claims

A concurrent care decision occurs where the Claims Processor had approved an ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

There are two types of concurrent care claims:

- Where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and
- Where an extension is requested beyond the initially approved period of time or number of treatments.

Notification to the Claimant of a decision by a Claims Processor to reduce or terminate an initially approved course of treatment will be provided sufficiently in advance of the reduction or termination to allow the Claimant to Appeal the Adverse Benefit Determination and receive a decision on review under these procedures prior to the reduction or termination.

If a claim is a request to extend a concurrent care decision involving Urgent Care and if the Claim is made at least 72 hours prior to the end of the initially approved period of time or number of treatments, the claim will be decided within no more than 24 hours after receipt of the claim. Any other request to extend a Concurrent Care decision will be decided in the otherwise applicable timeframes for pre-service, urgent care or post-service claims.

Eligibility Claims

Claims related to eligibility to participate in the Plan are treated like post-service claims, and the same time limits apply (to be determined no later than 30 days after the claim is received).

Permitted Extensions

Despite the specified timeframes, nothing prevents the Claimant from voluntarily agreeing to extend the above timeframes. In addition, if the Plan's Claims Processor is not able to decide a pre-service or post-service claim within the above timeframes, due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the Claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The extension notice will include a description of the matters beyond the Claims Processor's control that justify the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

Change in Claim Type

The claim type initially determines when it is filed. However, if the nature of the claim changes, it may be re-characterized. For example, a claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim.

Questions about Claim Type

It's important to follow the requirements that apply to your particular type of claim.

If you have any questions regarding what type of claim and/or what claims procedure to follow, contact the appropriate Claims Processor listed at the end of this section.

Receipt of Claims Processor Notices

A Claimant is presumed to have received a notice from a Claims Processor three days after the date the notice is post marked (if sent through the U.S. Postal Service), on the delivery date recorded by a courier service, or on the date and time of a telephone call, fax, or email, where notice in such manner is permitted.

Filing a Claim

General Filing Rules

Except for pre-service and urgent care claims, discussed below, a claim for Plan benefits is made when a Claimant (or Authorized Representative) submits a written claim for benefits to the Claims Processor or when a request for payment is received from a network provider.

When using a network provider, a claim will be submitted for you by that provider. If you use a nonparticipating provider, you may need to file the claim yourself. Claim forms may be obtained by contacting your Claims Processor.

A claim for Plan eligibility is made when a request to participate in the Plan is made by a Claimant, for the Claimant or a dependent; in such manner as such elections are required to be made by the Plan.

Post-Service Claims

A claim for benefits is treated as received by the Claims Processor on the date it is received by the Claims Processor or the Master of Eligibility at the address listed at the end of this section.

Pre-Service Claims (Prior Authorization Required)

Claims for services or supplies (including prescription drugs) that are provided only if approval is first obtained are made by calling the number or writing to the address specified in the Contact Listing for Claims Processors at the end of this section. Telephone claims are treated as having been filed on the date of the call to the appropriate Claims Processor.

Urgent Care Claims

In light of the expedited timeframes for decision of urgent care Claims, an urgent care Claim for benefits may be submitted to the appropriate Claims Processor by telephone or other means acceptable to the Claims Processor listed at the end of the section.

The Claim should include at least the following information:

- The identity of the Claimant (name, contract number, date of birth);
- A specific medical condition or symptom; and
- A specific treatment, service or product for which approval or payment is requested.

Urgent care claims are treated as filed on the date and at the hour the claim is submitted to the Claims Processor.

Incorrect Filing

These claims procedures do not apply to any request for benefits that is not made in accordance with these documented procedures, except that:

- In the case of an incorrectly filed pre-service claim, the Claimant will be notified as soon as possible but no later than five days following receipt by the Plan of the Incorrectly Filed Claim; and
- In the case of an incorrectly filed urgent care claim, the Claimant will be notified as soon as possible but no later than 24 hours following receipt by the Plan of the Incorrectly Filed Claim.

The notice will explain that the request is not a claim and will describe the proper procedures for filing a claim. The notice may be oral unless written notice is specifically requested by the Claimant.

Other Incomplete Claims

If a pre-service or post-service claim is incomplete, the Claims Processor may deny the claim or may take an extension of time, as described above. If an extension of time is to be taken, the extension notice will include a description of the missing information and will specify a timeframe, no less than 45 days, in which the necessary information must be provided.

The timeframe for deciding the claim will be suspended from the date the extension notice is received by the Claimant until the date the missing necessary information is provided. If the requested information is provided, the Claims Processor will decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim will be decided without that information.

Time Limit

All member-submitted claims must be filed withing 24 months of the date that a service or supply was provided, or the date on which a claimant believes eligibility should have begun.

Benefit Claim Decisions

Notification of benefit decisions by claims processor or the Master of Eligibility are as follows:

Pre-Service and Urgent Care

Written notification of the determination of a pre-service or urgent care claim will be provided to the Claimant by the Claims Processor whether the decision is adverse or not. Notification of an Adverse Benefit Determination on an urgent care claim may be provided orally, but written notification will be furnished no later than three days after the oral notice.

Notice of an Adverse Benefit Determination

A written Notice of Adverse Benefit Determination will be provided to the Claimant within the timeframes noted above and will include the following, in a culturally and linguistically appropriate manner calculated to be understood by the Claimant:

- Information sufficient to identify the claim, including the date of service, health care provider and the claim amount;
- A statement that the Claimant may request the diagnosis and treatment codes, and their meaning, for the services pertaining to the claim;
- A statement of the specific reason(s) for the decision, which will include the denial code and its meaning;
- A description of the standard, if any, used to deny the claim;
- Reference(s) to the specific Plan provision(s) on which the decision is based;
- A description of any additional material or information necessary to perfect the claim and why such information is necessary;
- A description of the procedures and time limits for an Internal Appeal of the decision as well as the right to an External Review by an Independent Review Organization or a Ford voluntary appeal, and the right to obtain information about those procedures and the right to sue in Federal court;
- A statement disclosing any internal rule, guidelines, protocol or similar criteria relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request;
- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims; and
- In the case of an Adverse Benefit Determination relating to Plan eligibility, including a Rescission, the effective date that coverage will end.

Adverse Benefit Determination — Internal Appeal

Filing

An appeal of an Adverse Benefit Determination with respect to Plan benefits is made when a Claimant (or Authorized Representative) submits a written request for review to the appropriate Claims Processor at the address (or by calling the telephone number for urgent care claims) listed at the end of this section.

For an appeal of an Adverse Benefit Determination involving Plan eligibility (including a Rescission of Plan participation), the Claimant should contact the Master of Eligibility listed at the end of this section.

A request for review will be treated as received by a Claims Processor responsible for the Internal Appeal (a) on the date it is hand-delivered to the appropriate address and room; or (b) on the date that it is delivered by U.S. Mail, for first-class delivery, in a properly stamped envelope containing the Claims Processor's name and address. A request for review of an urgent care claim is treated as having been filed at the time and on the date the call to the appropriate Claims Processor is made, as indicated by its call log.

Deadlines

Except as otherwise provided, the appeal of an adverse benefit decision must be filed within 190 days following the Claimant's receipt of the notification of Adverse Benefit Determination. An exception is that the appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision) must be filed within 30 days of the Claimant's receipt of the notification of the Plan's decision to reduce or terminate. An appeal of a Rescission of eligibility must be filed within 30 days of receipt of a Notice of Rescission.

Failure to comply with this important deadline may cause the Claimant to forfeit any right to any further review of an Adverse Benefit Determination under these procedures or in a court of law.

Urgent Care Appeals

In light of the expedited timeframes for decision of urgent care claims, an urgent care appeal may be submitted to the appropriate Claims Processor by telephone, fax or email, as listed at the end of this section. The claim should include at least the following information:

- The identity of the Claimant (name, contract number, date of birth);
- A specific medical condition or symptom;
- A specific treatment, service or product for which approval or payment is requested; and
- Any reasons the appeal should be processed on an expedited basis.

Decision Process

The appeal of an Adverse Benefit Determination will be reviewed and decided by the appropriate Claims Processer (or Master of Eligibility), acting for this purpose only as a Named Fiduciary under the Plan. The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of the person who made the initial benefit decision.

Consideration of Comments

The review will take into account all information submitted by the Claimant, whether or not presented or available at the initial benefit decision and will give no deference to the initial benefit decision.

The Claims Processor (and Master of Eligibility) will confirm that all claims and Internal Appeals are judged in a manner that ensures the independence and impartiality of the person making a decision. Any Claim Processor (or the Master of Eligibility) must not make decisions regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that a person hearing a claim or appeal will deny benefits or eligibility.

Consultations with Experts

In the case of a claim denied on the grounds of a Medical Judgment, the Claims Processor will consult with a health care professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same individual who was consulted, if any, regarding the initial benefit decision or a subordinate of that health care professional.

Access to Relevant Information

A Claimant will, on request and free of charge, be given reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert will be provided on request by the Claimant, regardless of whether the advice was relied on by the Claims Processor.

The Claims Processor must provide a Claimant, free of charge, with any new or additional evidence, or any new rationale, to be considered for an appeal. This information must be provided to the Claimant in time for a response prior to the time that a determination of the appeal is made, within the required time frames or permitted extensions of those time limits.

Expedited Methods for Urgent Care

All necessary information in connection with an urgent care appeal will be transmitted between the Plan and the Claimant or Authorized Representative by telephone, fax or email.

Timing of Decisions

Pre-Service Claims

A Claims Processor will decide the Internal Appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of a request for review.

Urgent Care Claims

Claims Processors will decide the appeal of an urgent care claim as soon as possible, taking into account the medical urgency, but no later than 72 hours after receipt by the Plan of the request for review.

Post-Service Claims

Claims Processors (or the Master of Eligibility) will decide the appeal of a post-service claim (including an eligibility claim) within a reasonable period, but no later than 60 days after receipt of the request for review.

Concurrent Care Claims

The Claims Processor will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. A Claims Processor will decide the appeal of a denied request to extend any concurrent care decision in the appeal timeframe for pre-service, urgent care or post-service claims described above, as appropriate to the request.

Eligibility Issues

The Master of Eligibility will respond to appeals of a denial of eligibility within 30 days of receiving the request for appeal.

Determination

Notice of Appeal Decision

Written notification of the decision on appeal will be provided to the Claimant whether or not the decision is an Adverse Benefit Determination.

Notification of Final Internal Adverse Benefit Decision

Written notification will be provided to the Claimant of an adverse decision on appeal and will include the following, written in a manner calculated to be understood by the Claimant:

- A written discussion of the specific reason(s) for the appeal decision;
- A reference to the specific Plan provision(s) on which the decision is based;
- A statement disclosing any internal rule, guidelines, protocol or similar criteria relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- A statement of the right to sue in Federal court;
- A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- If the decision involves scientific or clinical judgment, disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge on request.

Notification of an adverse decision on appeal of an urgent care claim may be provided orally, but written notification will be furnished not later than three days after the oral notice.

External Review of Adverse Internal Appeals

Only Final Internal Adverse Benefit Determinations involving (a) "Medical Judgment" (excluding those that involve only contractual or legal interpretation without the use of medical judgment) as determined by the Independent Review Organization (IRO), or (b) Rescissions of coverage (whether or not the Rescission has any effect on any particular benefit at the time) are subject to External Review.

Requesting a Review — Timing

Claimants must request an External Review from the Claims Processor who made the Adverse Determination of an Appeal within four months (120 days) after the date of receipt of the benefits denial notice. However, if a Claims Processor fails to follow these Claims and Appeals Procedures, a Claimant may immediately request an External Review. The External Review will be provided unless the IRO determines that the non-compliance did not cause, and was not likely to cause, prejudice or harm to the Claimant and the Claims Processor can demonstrate that the violation was for good cause or due to matters beyond the control of the Claims Processor and occurred in the context of an ongoing exchange of information with the Claimant.

Preliminary Review

The Claims Processor will complete a preliminary review of an External Review request within five Business Days after receiving the request. The preliminary review will determine whether:

- The Claimant is (or was) covered under the Plan when the health care item or service was requested; for retroactive reviews, the Claims Processor must determine whether the Claimant was covered under the Plan when the health care item or service was provided.
- The benefit denial does not relate to the Claimant's failure to meet the Plan's eligibility requirements (except with respect to a Rescission).
- The Claimant has exhausted the Plan's internal appeals process (unless the Claimant is not required to do so under the appeals regulations).
- The Claimant has provided all the information and forms needed to process the External Review.

The Claims Processor will provide the Claimant written notice of its preliminary review determination within one business day after completing its review. If the request is complete but not eligible for External Review, the notice must state the reasons for the ineligibility and provide Employee Benefits Security Administration contact information (1-866-444-EBSA [3272]). If the request is incomplete, the notice must describe the information or materials needed to complete the request. A Claimant will be permitted to "perfect" (i.e., complete) the External Review request within the four-month (120 days) filing period or, if later, 48 hours after receipt of the notice.

Referral to Independent Review Organization (IRO)

The Claims Processor will assign an accredited IRO to perform the External Review. To ensure against bias and ensure independence, the Claims Processor has contracted (under contract terms meeting legal requirements designed to have the IRO be independent) with at least three IROs for assignments, and rotate claims assignments among the IROs.

Notice of Acceptance for External Review

The IRO will provide the Claimant with written notice of the request's eligibility and acceptance for External Review. The notice must inform Claimants that they can submit additional information in writing to the IRO within ten business days following receipt of the notice and that the IRO must consider such additional information in its External Review. The IRO may also accept and consider additional information that is submitted after ten business days, though it is not required to do so.

Plan Must Provide Documents and Information to IRO

Within five business days after the date the IRO is assigned, the Plan's Claims Processor must provide the IRO the documents and any information considered in making the benefits denial. Failure to timely provide such documents and information is not cause for delaying the External Review. If the Plan's Claims Processor fails to timely provide the documents and information, the IRO may terminate the External Review and decide to reverse the benefits denial. If the IRO does so, it must notify the Claimant and the Plan within one business day after making the decision.

Reconsideration by Plan's Claims Processor

On receiving any information submitted by the Claimant, the IRO must forward the information to the Claims Processor within one business day. The Claims Processor may then reconsider its benefits denial, though any reconsideration will not delay the External Review. If the Claims Processor decides, on reconsideration, to reverse its benefits denial and provide coverage or payment, then the External Review can be terminated. The Claims Processor must provide written notice to the Claimant and IRO within one business day after making this decision. On receiving such a notice, the IRO must terminate its External Review.

Standard of Review

The IRO will review all information and documents timely received. In reaching its decision, the IRO must make its own review of the claim and is not bound by any decisions or conclusions reached by the Claims Processor under the internal claims and appeals process.

Other Documents Considered

In addition to documents and information provided by the Claimant, the IRO will consider the following items in reaching its decision (to the extent the information or documents are available and the IRO considers them appropriate):

- The Claimant's medical records;
- The recommendation of the attending health care professional;
- Reports from appropriate health care professionals and other documents submitted by the Plan or insurer, Claimant, or the Claimant's treating provider;
- The governing plan terms (to ensure that the IRO's decision isn't inconsistent with the Plan's terms — unless the Plan terms are contrary to governing law);
- Appropriate practice guidelines, which must include applicable evidence-based standards;
- Any applicable clinical review criteria developed and used by the Claims Processor (unless the criteria are inconsistent with the Plan terms or applicable law); and
- The opinion of the IRO's clinical reviewer(s).

Final Decision

Within 45 days after the IRO receives the External Review request, it must provide written notice of the final External Review decision. This notice must be delivered to both the Claimant and the Claims Processor. This notice must include the following information:

- A general description of the reason for the External Review request, including information sufficient to identify the Claim; this information includes the date(s) of service, the provider, Claim amount (if applicable), diagnosis and treatment codes (and their corresponding meanings), and the reason for the prior denial;
- The date the IRO received the assignment to conduct the External Review, and the date of the IRO's decision;
- References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards relied on in making the decision;
- A statement that the IRO's determination is binding, unless other remedies are available to the Plan or Claimant under State or Federal law;
- A statement that judicial review may be available to the Claimant; and
- The telephone number and other current contact information for any applicable office of health insurance consumer assistance or designated health insurance regulatory agency.

Compliance with IRO Decision

If the IRO's decision is to reverse the denial, the Plan must immediately provide coverage or payment for the claim. This includes immediately authorizing or paying benefits.

Expedited External Review Procedures

An expedited External Review is provided in certain circumstances.

Request for Expedited External Review

Claimants may request an expedited External Review when the Claimant receives:

- A benefits denial involving a Claimant's medical condition where the timeframe for completing an expedited *internal* appeal under the appeals regulations would seriously jeopardize the Claimant's life or health or jeopardize the Claimant's ability to regain maximum function and the Claimant has filed an expedited internal appeal request; or
- A Final Internal Adverse Benefits Determination involving (1) a Claimant's medical condition where the timeframe for completing standard External Review would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum function, or (2) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Preliminary Review by Claims Processor

Immediately upon receiving the External Review request, the Claims Processor must assess whether the request meets the reviewability requirements applicable under the standard External Review process. Then, the Claims Processor must immediately send the Claimant a notice regarding the reviewability assessment (this notice must meet the requirements applicable for standard External Review).

Referral to IRO

If the Claims Processor's preliminary review determines that a request is eligible for External Review, it will assign an IRO (using the process set out below for "standard" review) and will transmit all necessary documents and information considered in making the benefits denial to the assigned IRO. The documents and information are to be provided electronically, by telephone or fax, or any other "expeditious method" available. **Note:** If the Adverse Benefit Determination relates to the Claimant's failure to meet the requirements for eligibility under the Plan, it will not be referred for External Review. In such circumstances, the Claimant may follow the Voluntary Appeals to Ford process set forth below.

The IRO must consider the information or documents listed above under the procedures for standard review (e.g., the Claimant's medical records), to the extent the information or documents are available and the IRO considers them appropriate.

Standard of Review

In reaching its decision, the IRO will make its own review, and is not bound by any of the Claims Processor decisions or conclusions reached during the internal claims and appeals process.

Final External Review Decision

The IRO must provide a notice of its Final External Review decision (including all of the same requirements that apply to a standard review). The notice must be provided "as expeditiously as the Claimant's medical condition or circumstances require," but not more than 72 hours after the IRO receives the expedited External Review request.

Voluntary Appeals to Ford

Final Adverse Benefit Determinations concerning Plan eligibility (other than those involving a Rescission of eligibility) by the Master of Eligibility, Alight Solutions, or a benefits decision not involving a Medical Judgment may be appealed to the Ford Motor Company Benefit Committee which administers the Plan. Such an appeal must be filed within 60 days of the Final Internal Adverse Benefit Determination (the Claims Processor's written appeal response).

Submission

Ford has established an additional, voluntary level of appeal, after the Department of Labor (DOL)-required appeal process has been exhausted. You may submit a voluntary appeal to Ford if you are dissatisfied with the health care plan's determination of your appeal. You or your Authorized Representative may send the voluntary appeal with a copy of all previous correspondence (including a copy of the health care plan appeal response) and all available supporting documentation to:

Voluntary Health Care Appeals
P.O. Box 6214
Dearborn, MI 48121-6214

The voluntary appeal level has no timing requirements mandated by the DOL. However, the Company and the UAW have agreed to the following timing for the voluntary appeal process:

- **Pre-service urgent response time:** The Company has 25 calendar days from the date the request is received to respond to a request for a voluntary appeal.
- **Pre-service and post-service non-urgent response time:** The Company has 60 calendar days from the date the request is received to respond to a request for a voluntary appeal.

Note: If you are not satisfied with your BCBS National PPO Plan, Dental, Hearing, Prescription Drug or TheraMatrix Outpatient Physical Therapy Program Plan's response to your final appeal, you may either:

1. Submit a voluntary appeal to Ford and then initiate a civil action in the appropriate court if you are still not satisfied, or

2. Submit a voluntary appeal at the same time as civil action, or

3. Immediately initiate a civil action without using the voluntary appeal process.

Any legal action taken against the Plan must be filed in the United States District Court of Eastern District of Michigan.

Note: The BCBS National PPO Plan and Blue Preferred Plus PPO Claims and Appeals process (including the voluntary level of appeal) described above in this section does not currently apply to HMOs, DHMOs or fully insured PPOs. In the event this changes in the future, you will be notified in writing.

See the *Administrative, Employee Retirement Income Security Act (ERISA) and Family Medical Leave Act (FMLA)* section of this handbook for certain rights under ERISA.

Claims and Appeals Timelines and COVID-19

During the COVID-19 Outbreak Period (as defined by Federal law and regulations), the deadlines for you to file claims, appeals and External Review requests with the Plan have been modified. You will have until the earlier of (i) one year from the date you were eligible for the COVID relief or (ii) the time period from March 1, 2020 until 60 days after the end of the National Emergency. Neither period will be counted in determining whether any of the below actions are timely:

1. The 31-day period to request special enrollment in health care insurance coverage upon experiencing certain enrollment events (e.g., upon acquisition of a new spouse or dependent by marriage, birth, or adoption).

2. The date for individuals to notify the plan of a qualifying event or determination of disability.

For example, if you received a claim denial letter dated July 10, 2020 and wish to appeal the denial, you will have until January 6, 2021 (180 days from the date of the claim denial) or the date that is 60 days following the end of the COVID-19 Outbreak Period, whichever is later, to submit your appeal.

Definitions

Adverse Benefit Determination: Any denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction or termination, or failure to make payment that is based on a determination of a participant's or beneficiaries' eligibility to participate in the Plan or any Rescission of coverage.

Authorized Representative: An Authorized Representative may act on behalf of a Claimant with respect to a benefit claim or appeal under these claims procedures. However, no person (including a treating health care professional) will be recognized as an Authorized Representative until the Plan receives an Appointment of Authorized Representative form signed by the Claimant, except that for urgent care claims the Plan will, even in the absence of a signed Appointment of Authorized Representative form, recognize a health care professional with knowledge of the Claimant's medical condition (e.g., the treating physician) as the Claimant's Authorized Representative unless the Claimant provides specific written direction otherwise.

An "Appointment of Authorized Representative" form may be obtained from your Claims Processor.

An assignment for purposes of payment (e.g., to a health care professional) does not constitute appointment of an Authorized Representative under these claims procedures.

Claim: A claim is any request for a Plan benefit or benefits made in accordance with these claims procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim.

Claimant: A claimant is a Plan participant or beneficiary who made a request for a Plan benefit or benefits in accordance with these claims procedures. Any reference in these claims procedures to Claimant is intended to include the Authorized Representative of such Claimant appointed in compliance with the above procedures. Once an Authorized Representative is appointed, the Plan's Claims Processor will direct all information, notification, etc. regarding the claim to the Authorized Representative. The Claimant will be copied on all notifications regarding decisions, unless the Claimant provides specific written direction otherwise.

Claims Processor: The third-party service provider or providers, who are responsible for making determinations on claims and for conducting Internal Appeals, including such determinations with regard to eligibility.

Day(s)/Business Day(s): When used in these claims procedures, the term Day means a calendar day, unless use of Business Days is otherwise specifically provided.

External Review: The review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted according to the Federal External Review process.

Final External Review Decision: The determination made by an Independent Review Organization at the end of External Review.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by the applicable Plan Claims Processor at the completion of the internal appeals process (or an Adverse Benefit Determination for which the internal appeals procedure has been deemed to be exhausted).

Incorrectly Filed Claim: Any request for Plan benefits that is not made in accordance with these claims procedures is called an Incorrectly Filed Claim.

Independent Review Organization: An entity that performs an independent External Review of Final Internal Adverse Benefit Determinations.

Internal Appeal: An appeal considered by a Claims Processor or the Master of Eligibility.

Medical Judgment: Examples include determinations based on requirements for medical necessity, health care setting, levels of care, effectiveness of a covered benefit or determination that a treatment is experimental or investigational.

Plan: The Plan is the Ford Motor Company Health Care Plan.

Plan Administrator/Named Fiduciary: Ford Motor Company is the administrator of the Plan and a Named Fiduciary of the Plan. Each Claims Processor acts as a Named Fiduciary when it makes Claims and Appeals determinations. The Plan Administrator and the Claims Processor (where applicable) have discretionary authority to administer and interpret the terms and provisions of the Plan and its related documents, and make corresponding decisions regarding eligibility and benefit determinations. Their decisions will be given the most deference allowed by law, including case law.

Rescission: A cancellation or discontinuance of coverage that has a retroactive effect. Rescission of coverage will apply when an individual performs an act, practice or omission that constitutes fraud, or when the individual makes an intentional misrepresentation of material fact.

A cancellation or discontinuation of coverage is not a Rescission if:

- The cancellation or discontinuance of coverage has only a prospective effect; or
- The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Contact List

Hourly HSMDDV Plan Claims and Appeals Procedures Contact List

Medical		
BCBS National PPO Plan (Hospital-Surgical-Medical) and Blue Preferred Plus (Hospital-Surgical-Medical)	**Pre-Service Claims (Prior Authorization) and Urgent Pre-Service Claims**	Blue Cross Blue Shield of Michigan P.O. Box 2227 Detroit, MI 48231-2227 Fax: 1-866-311-9603
	Appeals **Concurrent Claims** **Pre-Service Claims and Urgent Pre-Service Claims (Prior Authorization Denial)** **Post-Service Claims**	Auto National Appeals Unit, Mail Code CS3A Blue Cross Blue Shield of Michigan 600 E. Lafayette Detroit, MI 48226 Fax: 1-877-522-4767
	Member Submitted Claims	Blue Cross Blue Shield of Michigan Ford Hourly Service Center P.O. Box 312089 Detroit, MI 48231-2089 1-800-482-5146
	Request for External Review/Appeals	BCBSM External Review Requests 600 E. Lafayette Mail Code CS3A Detroit, MI 48226-2998 Fax 1-877-522-4767
TheraMatrix (Physical Therapy Program)	**Pre-Service Claims (Prior Authorization)**	Phone: 1-888-638-8786 Fax: 1-248-333-7957
	Concurrent Care Claims	TheraMatrix Physical Therapy Network P.O. Box 321036 Detroit, MI 48232
	Post-Service Claims	TheraMatrix Physical Therapy Network P.O. Box 321036 Detroit, MI 48232
	Request for External Review/Appeals	TheraMatrix Physical Therapy Network 900 Auburn Road Pontiac, MI 48342 Attn: Health Services Director

Prescription Drugs		
	Pre-Service Claims (Prior Authorization) and Urgent Pre-Service Claims	Toll Free: 1-800-841-5409 (Copay Appeals) Toll Free: 1-800-753-2851 (Prior Authorization)
	Concurrent Care Claims	Express Scripts P.O. Box 14711 Lexington, KY 40512 Phone: 1-800-482-5146
	Post-Service Claims	Express Scripts P.O. Box 14711 Lexington, KY 40512 Phone: 1-800-482-5146
	Request for External Review/Appeals	Express Scripts P.O. Box 631850 Irving, TX 75063 Admin. Review Phone: 1-800-482-5146
Dental		
Delta Dental	**Formal Claims Appeals Procedure**	Dental Director Delta Dental P.O. Box 30416 Lansing, MI 48909-7916 Phone: 1-844-223-8520
Eligibility		
Alight Solutions (Master of Eligibility)	**Appeals**	Claims and Appeals Management — Ford P.O. Box 1407 Lincolnshire, IL 60069-1407

Health Care Legal Notices

- Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Practices,
- Women's Health and Cancer Rights Act of 1998 (WHCRA),
- Newborns' and Mothers' Health Protection Act, and
- Nondiscrimination and Accessibility Requirements
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

UAW-Ford Health Care Plan Summary Plan Description, November 2021

HIPAA Notice of Privacy Practices

Effective September 23, 2016, and revised January 1, 2020: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

What Is HIPAA?

Ford Motor Company ("Ford") offers its employees and their eligible family members a number of health care benefit options, which include coverage for medical care, prescription drugs, dental care, vision care and health care spending/savings accounts. This Notice of Privacy Practices applies to employees and their family members (referred to as "you" and/or "your") who participate in any Ford Health Plan (FHP) group health benefit offerings.

The Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, and the Health Information Technology for Economic and Clinical Health Act, also known as the HITECH ACT, are Federal laws enacted to protect your Personal Health Information (PHI). This Notice of Privacy Practices explains the legal obligations of the FHP and your legal rights regarding your PHI. This Notice of Privacy Practices also describes how your PHI may be used or disclosed to carry out treatment, payment or health care operations and for other purposes that are permitted or required by HIPAA.

What Is PHI?

PHI is your individually identifiable health information, including demographic data, that is:

- Transmitted by electronic media;
- Maintained in electronic media; or
- Transmitted or maintained in any other form or medium.

And, is in connection with the FHP and is defined as related to:

- Your past, present or future physical or mental condition;
- The provision of health care to you; or
- The past, present or future payments for the provision of health care to you.

PHI excludes individually identifiable health information, including, but not limited to:

- Information contained in education records covered by the Family Educational Rights and Privacy Act, also known as FERPA, another law not covered by this Notice of Privacy Practices;
- Information in employment records held by Ford in its role as "Employer"; and
- Information contained in your employee medical file located at any Ford medical office (for example, Plant Medical).

Note: While some items are excluded from HIPAA, there are other State privacy laws and/or Ford corporate policies in place to safeguard your data and maintain confidentiality.

What Are Your Rights?

When it comes to your health information, you have certain rights. The following explains your rights and some of our responsibilities to help you:

- Get an electronic or paper copy of your health and claims records. For example:
  - You can ask to see or get an electronic or paper copy of your health and claims records and other health information we have about you.
  - We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable fee.

- Ask us to correct your health and claims records. For example:
  - You can ask to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
  - We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- Request confidential communications. For example:
  - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
  - We will say “yes” to all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.
- Ask us to limit what we use or share. For example:
  - You can ask us not to use or share certain health information for treatment, payment or our operations.
  - We are not required to agree to your request, and we may say “no” if it would affect your care.
  - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. In this circumstance, we will agree unless a law requires us to share that information.
- Get a list of those with whom we’ve shared information. For example:
  - You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, including whom we shared it with, and why.
  - We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make or those required under HIPAA). We’ll provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice by:
  - Asking for a paper copy of this Notice of Privacy Practices at any time, even if you have agreed to receive the Notice of Privacy Practices electronically.
  - Obtaining a copy of this Notice of Privacy Practices via Ford’s website, at **myfordbenefits.com**, under **Other Resources**. On the right side of the home page, click on **Plan Documents**; then click on **Benefit Communications** for the Notice.
  - Contacting the NESC at: 1-800-248-4444.
- Choose someone to act for you:
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - We will make sure the person has this authority and can act for you before we take any action.
- Exercise your right to be notified of a breach:
  - You have the right to be notified in the event of a reportable breach of unsecured PHI.

- File a complaint if you feel your rights are violated:
  - You have the right to file a complaint if you feel we have violated your rights by contacting the FHP at:

    HIPAA Privacy & Security Officer
    World Headquarters Building
    1 American Road
    Dearborn, MI 48126-2798
    1-313-390-4734

    Or send an email to:
    fmchipaa@ford.com

    Questions about how to submit a complaint may be directed to **fmchipaa@ford.com**.

  You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, S.W.
  Room 509F, HHH Building
  Washington, D.C. 20201

  You may also call HHS at 1-877-696-6775, or visit **hhs.gov/ocr/privacy/hipaa/complaints/**

  Or, contact the Office of Civil Rights Customer Response Center:
  Phone: 1-800-368-1019
  Fax: 1-202-619-3818
  TDD: 1-800-537-7697
  Email: ocrmail@hhs.gov

  You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with the FHP.

What Are Your Choices?

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions:

- **In these cases, you have both the right and choice to tell us to:**
  - Share information with your family, close friends or others involved in your care
  - Share information in a disaster relief situation

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **We never share your information unless you give us written permission to for the following:**
  - Marketing purposes
  - Selling of your information

How Do We Typically Use or Share Your Health Information?

Under HIPAA, the FHP may disclose your PHI in certain circumstances without your permission. The following categories describe the different ways that the FHP may use and disclose your PHI. It is not possible to list every viable use or disclosure in each category. However, all of the ways the FHP is permitted to use and disclose information will fall within one of the categories. “Minimum Necessary” requirements apply to the uses and disclosures of your PHI. This means that reasonable efforts must be made to limit the use and disclosure of your PHI to the minimum necessary to accomplish the

compliant intended purpose of the use, disclosure or request.

We typically use or share your health information in the following ways:

- **Help manage the health care treatment you receive** — The FHP can disclose your health information and share it with professionals who are treating you.
- **Run our organization** — We can use and disclose your health information for operational purposes, including to administer the FHP, for quality improvement, general administrative activities and to contact you when necessary.
- **Pay for your services** — We can use and disclose your health information to verify eligibility for FHP benefits and/or authorize payment for covered services.
- **Administer your plan** — We may disclose your health information to Ford, as your health plan sponsor for plan administration.

How Else Can We Use or Share Your Health Information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for any of the following reasons:

- **Help with public health and safety issues** — We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- **For research** — We can use or share your information for health research.
- **Comply with the law** — We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.
- **Respond to organ and tissue donation requests** — We can share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director** — We can share health information with a coroner, medical examiner or funeral director when an individual dies.
- **Address workers' compensation, law enforcement and other government requests** — We can use or share health information about you, including but not limited to the following ways:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security and presidential protective services
- **Respond to lawsuits and legal actions** — We can share health information about you in response to a court or administrative order, or in response to a subpoena.

For more information see:
hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

How Does Ford, the Plan Sponsor, Protect PHI?

Ford, the Plan Sponsor ("Ford"), will:

- Not use or further disclose your PHI, other than as permitted or required by the plan documents, or by HIPAA.
- Ensure that any other organizations with access to your PHI agree to the same restrictions and conditions that apply to Ford.
- Not use or disclose the PHI for employment-related actions and decisions, or in connection with any other benefit plan offered by Ford, unless specifically provided for under HIPAA (for example, with regard to worker's compensation).
- Report to the FHP any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted by the FHP and/or under HIPAA.
- Maintain your right to access your own PHI.
- Comply with your right to request an amendment to your PHI.
- Make available to you an accounting of disclosures, if requested.
- Make its internal practices, books and records, relating to the use and disclosure of PHI received from the FHP, available to the Secretary of Health and Human Services (HHS) for purposes of determining compliance by the FHP with HIPAA.
- If feasible, return or destroy all PHI received from the FHP.

In no event will Ford be permitted to access, use or disclose PHI in a manner that is inconsistent with the regulations under HIPAA.

For any electronic PHI that is disclosed to Ford, Ford will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that is created, received, maintained or transmitted to or by Ford on behalf of the FHP;
- Ensure that the adequate separation between the FHP and Ford (i.e., the firewall), required under HIPAA, is supported by reasonable and appropriate security measures (see upcoming section *How Does Ford Satisfy the Requirement for Adequate Separation between the FHP and Ford?*); and
- Ensure that any agent to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information.

How Does Ford Satisfy the Requirement for Adequate Separation Between the FHP and Ford?

HIPAA requires that there is an adequate separation between the FHP and Ford, the Company. The following describes who at Ford may have access to PHI and why:

- For purposes of supporting the FHP in the areas of health care operations, payment and administration, employees may have access to PHI. Ford employees may also include employees of any of its affiliates or subsidiaries, any agency employees, and subcontractors ("Ford employees").
- Ford employees given access to PHI **may** include individuals from the following organizations:
  - Corporate Human Resources
  - Purchasing
  - Finance
  - Information Technology

- Internal Control
- Office of the General Counsel
- Global Data Analytics
- Other Department Plan Sponsor workforce members, as required

- Access to PHI by Ford is further restricted to only the Ford Employees, within the organizations above, who are essential to the performance of the administrative functions Ford performs for the FHP.
- In the event that any Ford Employee does not comply with the HIPAA provisions, the person will be subject to disciplinary action for non-compliance pursuant to the discipline and termination procedures.

What Are the FHP's Responsibilities?

We are required by law to maintain the privacy and security of your protected health information. As a result, we will:

- Accommodate reasonable requests to communicate PHI by alternative means or at alternative locations in the form and format you request, if possible.
- Notify you if the FHP is unable to agree to a requested restriction on how your information is used or disclosed.
- Let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Follow the duties and privacy practices described in this Notice of Privacy Practices and give you a copy of it.
- Not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Except for the privacy rights described in this Notice, nothing contained in this Notice will be construed to change any rights or obligations you may have under the FHP. You should refer to the FHP documents for complete information regarding any rights or obligations you may have under the FHP.

Changes to the Terms of this Notice of Privacy Practices

We can change the terms of this Notice of Privacy Practices, and the changes will apply to the protected health information we have about you. This revised Notice of Privacy Practices will be available upon request, in our office, and on our website. State law may provide for additional protection of your health information. Please contact the National Employee Services Center (NESC) at: 1-800-248-4444 for more information.

Nondiscrimination and Accessibility Requirements

Ford Motor Company (Company) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, national origin, age, disability, sexual orientation, gender identity or veteran status. The Company does not exclude people or treat them differently because of race, color, religion, national origin, age, disability, sexual orientation, gender identity or veteran status.

- The Company provides free aids and services to people with disabilities to communicate effectively with us.
- The Company also provides free language services to people whose primary language is not English.

If you need these services, contact the National Employee Services Center (NESC), contact information below. If you believe that the Company has failed to provide these services or discriminated in another way on the basis of race, color, religion, national origin, age, disability, sexual orientation, gender identity or veteran status, you can file a grievance. You can call the following hotline: 1-888-735-6650.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- Electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**.
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue,
  SW Room 509F, HHH Building
  Washington, D.C. 20201
- By phone at: 1-800-368-1019,
  (1-800-537-7697 (TDD))
- Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

If You Have Questions

- Visit **myfordbenefits.com**.

Call the NESC at 1-800-248-4444 Monday through Friday, 9 a.m. to 9 p.m. Eastern time. TIP: To avoid long wait times, call Tuesday through Friday between 11 a.m. and 7 p.m.

For Translation Services, call the NESC at 1-800-248-4444.

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-248-4444 (TTY: 1-800-248-4444).
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-248-4444 （TTY：1-800-248-4444）。
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-248-4444 (TTY: 1-800-248-4444).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-248-4444 (TTY: 1-800-248-4444)번으로 전화해 주십시오.
- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-248-4444 (TTY: 1-800-248-4444).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-248-4444 (телетайп: 1-800-248-4444).
- ملحوظة: إذا كنت تتحدثاذكر اللغة، فإن خدماتالمساعدة اللغوية تتوافرلك بالمجان. برقم اتصل 1-800-248-4444 (والبكم الصم رقمهاتف: 1-800-248-4444.
- ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-248-4444 (TTY: 1-800-248-4444).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-248-4444 (ATS : 1-800-248-4444).
- UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-248-4444 (TTY: 1-800-248-4444).
- ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-248-4444 (TTY: 1-800-248-4444).
- ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-248-4444 (TTY: 1-800-248-4444).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-248-4444 (TTY: 1-800-248-4444).
- 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-248-4444 （TTY:1-800-248-4444）まで、お電話にてご連絡ください。
- **توجه**: اگر به زبان فارسی گفتگومی کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می تماس بگیرید. 1-800-248-4444 (TTY: 1-800-248-4444) باشد

Women's Health and Cancer Rights Act of 1998 (WHCRA)

Consistent with the "Women's Health and Cancer Rights Act of 1998" (WHCRA), your benefits cover a member who undergoes a mastectomy and who elects breast reconstruction in connection with the mastectomy. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient. While the other benefits of the plan apply as well, coverage specifically includes:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Coverage is subject to all other plan provisions and requirements, including deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call the NESC.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	Health First Colorado Website: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
	CHP+: **https://www.colorado.gov/pacific/hcpf/child-health-plan-plus** CHP+ Customer Service: 1-800-359-1991/State Relay 711
	Health Insurance Buy-In Program (HIBI): **https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program** HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)	Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium payment (HIPP) Program **http://dhcs.ca.gov/hipp** Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19–64 Website: **http://www.in.gov/fssa/hip/** Phone: 1-877-438-4479 All other Medicaid Website: **https://www.in.gov/medicaid/** Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: **https://dhs.iowa.gov/ime/members** Medicaid Phone: 1-800-338-8366	Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084
Hawki Website: **http://dhs.iowa.gov/Hawki** Hawki Phone: 1-800-257-8563	
HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp** HIPP Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: **http://www.kancare.ks.gov/** Phone: 1-800-792-4884	Website: **http://www.ACCESSNebraska.ne.gov** Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

KENTUCKY – Medicaid	NEVADA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx** Phone: 1-877-524-4718 Kentucky Medicaid Website: **https://chfs.ky.gov**	Medicaid Website: **http://dhcfp.nv.gov** Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp** Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: **https://www.dhhs.nh.gov/oii/hipp.htm** Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-977-6740. TTY: Maine relay 711	Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** Medicaid Phone: 609-631-2392 CHIP Website: **http://www.njfamilycare.org/index.html** CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: **http://www.mass.gov/info-details/masshealth-premium-assistance-pa** Phone: 1-800-862-4840	Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp** Phone: 1-800-657-3739	Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp/htm** Phone: 573-751-2005	Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742	Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669

OREGON – Medicaid	VERMONT– Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

Medicare Information

UAW-Ford Health Care Plan Summary Plan Description, November 2021

For UAW-Ford Represented:

- **Legacy Employees**: Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees**: Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees**: Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Medicare Overview

Medicare is a health insurance program for people age 65 and older and people under age 65 with certain disabilities.

Two important parts of Medicare are:

- **Medicare Part A** – Hospital Insurance. Most people are not required to pay for Part A.
    - Medicare Part A helps pay for hospital stays, very limited skilled nursing care, some home health care and hospice care
    - Medicare Part A does **not** cover long-term nursing home care or most prescription drugs
- **Medicare Part B** – Medical Insurance. Most people pay a monthly premium for Part B which is adjusted each year by the Centers for Medicare and Medicaid Services (CMS). Medicare Part B helps pay for doctor's services, X-rays, diagnostic tests, ambulance services and outpatient hospital care.

Please consult **medicare.gov** for detailed information regarding what is covered under Medicare.

Eligibility

Most people age 65 or older, who are citizens or permanent residents of the United States, are eligible for Medicare based on their own (or their spouse's) employment history.

Before age 65, you are eligible for Medicare if you have been receiving Social Security disability benefits for 24 months.

If you have end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant), you may be eligible for Medicare at any age.

Cost

In almost all cases, there is no cost to you or your spouse for Medicare Part A. A Medicare tax deduction for Part A was taken from your or your spouse's paychecks during the years you worked.

However, there is a monthly premium (cost) for Medicare Part B; this premium is adjusted annually by CMS.

Enrollment

Medicare Part A

If you have been receiving Social Security Disability Benefits for 24 months or longer, you will automatically be enrolled in Medicare Part A at no cost to you.

If you misplace your Medicare card, you can request a new card from Social Security by calling 1-800-772-1213.

Medicare Identification Card

If you are eligible for Medicare Part A, the medical plan will check to see if Medicare has paid its share before processing your claim.

If Medicare is your primary coverage, any services that would have been paid by Medicare Part A will be rejected by your health care plan. This will cause a delay in payments to your providers and may require you to work with your provider to submit the claim to Medicare. For example, if you were admitted to a hospital as an inpatient and you did not present your Medicare I.D. card, your coverage would pay only the Medicare Part A deductible amount. You would be responsible for working with your provider to submit the balance of the hospital bill to Medicare.

Medicare Part B

You are automatically eligible for Medicare Part B if you are eligible for Medicare Part A.

If you are receiving a Social Security benefit and are eligible for Medicare coverage, you were enrolled automatically in Medicare Parts A and B at the same time.

The premium for Medicare Part B is deducted from your Social Security check.

Special Age 65 Benefit

Medicare Part B Reimbursement Benefit is also known as the Special Age 65 Benefit.

The Special Age 65 Benefit is a reimbursement of your Medicare Part B premium. Active employees with End Stage Renal Disease (ESRD) and employees in receipt of disability benefits are eligible to receive this special benefit, provided they are enrolled in Medicare Part B. Your spouse is not eligible for the Special Age 65 Benefit.

For more information, refer to the “How the Ford Medicare Enrollment Policy Applies to Eligible Employees” table at the end of this section.

Application

Active employees in receipt of disability benefits who are enrolled in Medicare Part B will automatically be enrolled in the Special Age 65 Benefit through the disability administrator (UniCare).

Active employees with ESRD who are actively working should contact the NESC to apply for the Special Age 65 Benefit.

Contact and Additional Information

The Social Security Administration and Medicare are available to answer your questions at the following:

The Social Security Administration Office
1-800-772-1213
Online at **ssa.gov**

Medicare
1-800-MEDICARE (1-800-633-4227)
Online at **medicare.gov**

How the Ford Medicare Enrollment Policy Applies to Eligible Employees				
Employment Status	**Is Medicare Part A Required?**	**Is Medicare Part B Required?**	**Eligible for Ford Special Age 65 Benefit?**	**How are my Benefits Coordinated with Medicare?**
You are actively working for the Company	No	No	No	The Ford health plan will continue to be the primary payer of eligible health care expenses and Medicare will be the secondary payer (if you are enrolled) as long as you are actively working.
You are actively working for the Company, you have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant) and you are receiving Social Security benefits	Yes, when first eligible*	No. While Medicare Part B is not required, it may be to your advantage to enroll. Visit **medicare.gov** for more information about your Medicare rights and responsibilities.	Yes. An employee with End Stage Renal Disease who is enrolled in Medicare Part B is eligible to receive the Special Age 65 benefit towards the Medicare Part B premium. You must apply for this benefit.	The Ford health plan will continue to be the primary payer of eligible health care expenses for an initial 30-month coordination period. At the end of the 30 months, Medicare becomes the primary payer.
You are on a medical leave, have been off work for six months or longer and you are receiving Social Security benefits	Yes, when first eligible*	No	Yes. An employee who is receiving Ford's UAW disability benefits and is enrolled in Medicare Part B is eligible to receive the Special Age 65 benefit towards the Medicare Part B premium.	If you have been off from work for more than six months and you are enrolled in Medicare, Medicare becomes the primary payer of eligible health care expenses for you and any of your Medicare eligible dependents (if they are enrolled in Medicare).

**Members who are eligible for Medicare Part A, whether or not they are actually enrolled, will have all benefits available under the Ford health plan reduced to the extent payment or benefit is available or would be available under Medicare Part A.*

Other Non-Ford Group Health Care Plan Information

UAW-Ford Health Care Plan Summary Plan Description, November 2021

For UAW-Ford Represented:

- **Legacy Employees**: Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees**: Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees**: Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Coordination of Benefits

Other Plans

Your Plan may be coordinated with other non-Ford group health care plans to which you or your eligible dependents are enrolled. This means that all plans together pay no more than 100% of allowable expenses for you or your dependents. An “allowable expense” is any expense covered at least in part by one of the plans.

For the employee, the Plan is the primary plan. For dependents, a plan without a coordinating provision is always the primary plan. If all plans have a coordinating provision, benefits will be coordinated as follows:

- If the dependent is covered by more than one plan, the plan of the employee whose birthday occurs first in the calendar year is primary
- If the birthdays are the same day, the plan that has covered the dependent for a longer period of time is primary

If you are separated or divorced, however, the plans pay in this order:

1. The plan of the parent with responsibility for health care is primary, if the court has established one parent as financially responsible for health care
2. The plan of the parent with custody of the child
3. The plan of the stepparent married to the parent with custody of the child
4. The plan of the parent that does not have custody of the child

When a determination cannot be made, the plan that has covered the patient for a longer period of time is primary, unless the patient is covered by both a retiree/laid off employee and an active employee. In this case, the active employee plan is primary.

When a health care claim is made, benefits are coordinated as follows:

- The primary plan pays benefits first, without regard to any other plan
- The secondary plan pays benefits so that the total benefits paid will not be greater than your allowable expense
- No plan pays more than it would without the coordination provision

The Plan will pay the benefits explained in this section when it is the primary plan. When it is the secondary plan, it will pay the difference between benefits paid from the primary plan and the benefits explained in the *Hospital-Surgical-Medical Coverage* section of this handbook. It’s important to indicate on your claim form if you have any other insurance coverage so that each pays the correct amount.

Coordination of benefits does not apply to other group coverage where you or a member of your family is paying one-half or more of the cost or to non-group coverage, which is privately purchased.

Auto Insurance Medical Coverage

The Plan also coordinates with personal injury protection coverage in those states with no-fault auto insurance laws. If you are enrolled under a self-insured Ford health care plan, benefits under this plan are secondary to no-fault auto insurance coverage.

Benefit Recovery

Right of Recovery/Subrogation

If benefits are paid under the Plan for an injury or condition caused by the actions of another person, the Plan may be entitled to recover payment from another insurance company, third party, or you if payment has been made to you by another insurance company or third party. This right of recovery is called Subrogation.

The Company has hired a subrogation administrator, Vengroff Williams & Associates, for the BCBS National PPO Plan and Blue Preferred Plus PPO Plan. The Subrogation Administrator will review certain claims when there is an indication that an injury or condition may have been the result of an accident.

If you are contacted by the subrogation administrator on behalf of the Company, you are required to complete any incident reports sent to you and provide copies of any documents requested.

In the event you fail to repay the Plan for payment made to you by another insurance company or third party, the Plan may offset future benefit payments by withholding payment until the entire amount due is reimbursed.

Additionally, the Plan's rights shall not be reduced by reason of the "make-whole doctrine," which is an insurance law principle that varies from state to state. Check with your state for the specific details.

Medicare

When you or your spouse are Medicare-eligible due to age, disability, or have End Stage Renal Disease and you are still working for Ford, you may have coverage under the Plan and Medicare.

When you or your spouse are age 65 or older, are still working for Ford and you or your spouse are eligible for Medicare, the Plan automatically will continue to be the primary payer of eligible Health Care expenses. You or your spouse are not required to enroll in Medicare while you are an active employee. However, if you do enroll, Medicare in most cases will be the secondary payer.

If you are enrolled in Medicare because of age or disability, Ford is the primary payer. If you are enrolled in Medicare and have End Stage Renal Disease, after thirty months of Medicare participation, Medicare becomes the primary payer. When Medicare becomes primary, your Ford coverage will be secondary and will pay only the allowable benefit amount over what Medicare would pay if you are enrolled.

Your claims should be submitted to your Ford Plan first and then to Medicare for possible additional benefits. Medicare may provide some additional benefits under Part B, which are not paid by the Ford Health Care Plans.

Hospital, surgical and medical benefits are coordinated while covered by both Ford and Medicare. Ford prescription drug, dental, vision care and hearing aid benefits are not coordinated with Medicare.

Refer to the section *Medicare Information* for further details.

Health Care in Retirement

For Employees Who are Eligible to Retire from the Company.

If you were hired or rehired before November 19, 2007, and retire from the Company, you, your spouse and eligible dependents may be eligible for health care benefits provided by the UAW Retiree Medical Benefits Trust (the Trust).

Your health care coverage, once you retire, is different from the health care coverage you had as an active employee. As an active employee, you are covered by the Ford Health Plan and once you retire, your health care coverage is through the Trust, if eligible.

You will not have a lapse in your coverage between the time you apply for retirement through the date of your retirement.

If you are preparing to retire, or have any questions regarding retiree health care, you may call Retiree Health Care Connect (the Trust) at: 1-866-637-7555.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

Overview

If you are not eligible for Company-paid continuation of coverage, you may be eligible to continue coverage at your own expense.

In addition to the Company's continuation of coverage provisions, you and your dependents may be entitled to continue individual health care coverage at your own expense under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

COBRA is a Federal law that gives certain eligible participants the right to temporarily continue health care coverage at group rates. If you or a covered family member should become ineligible for Company-paid coverage because of what COBRA calls a "Qualifying Event" (described below), you may be able to continue your coverage at 102% of group rates for a limited period of time.

This information is intended only as a summary of the COBRA law, eligibility under the law will be determined at the time you apply.

Note: Each individual covered under your contract has a separate individual right to COBRA continued coverage.

Qualifying Event

Qualifying Event	Qualifying Beneficiary			COBRA Max Duration
	Employee	Spouse	Child	
Reduction of hours of employment (including layoffs) *, **	X	X	X	18 months
Termination of Employee **	X	X	X	18 months
Death ***		X	X	36 months
Divorce ***		X	X	36 months
Child ceases to be a 'Dependent Child' ***		X	X	36 months

**While on layoff, Company paid coverage will be provided to you based on your years of seniority.*
***The Company will notify the COBRA Coordinator of the qualifying event within 30 days.*
****The Qualifying Beneficiary must notify the NESC at 1-800-248-4444 within 60 days of the qualifying event to elect COBRA coverage.*

Note: Failure to provide the notice will eliminate your right to elect continued coverage under COBRA.

If you do not choose to continue coverage, your Company's group health care coverage will end according to the provisions of that Plan.

Qualifying Events Notification

The covered employee, spouse or dependent child who wishes to elect to continue coverage at his/her own expense under COBRA must notify the NESC at 1-800-248-4444 **within 60 days** of the following qualifying events:

- Divorce
- A dependent child ceasing to be a "dependent child" as defined in the Company's group health care plan
- Death, if it results in loss of coverage

Failure to provide the notice will eliminate your right to elect continued coverage under COBRA.

For other Qualifying Events (termination of employment or reduced hours of employment), your employer will notify the COBRA Coordinator within 30 days.

Coordinator Responsibility

Upon receipt of appropriate notice of the occurrence of a Qualifying Event, the Ford COBRA Coordinator will, within 14 days, send an election notice to those individuals eligible to elect to continue coverage.

If you wish to continue group health care coverage under COBRA, you must return a completed election form to the COBRA Coordinator **within 60 days** after coverage terminates or if later, 60 days after the postmark date on the envelope of the election form.

If you do not choose to continue coverage, your Company's group health care coverage will end according to the provisions of that Plan.

Cost

Your cost to continue health care coverages under COBRA will be 102% of the full group rate in effect at the time continued coverage begins. Cost-of-coverage information will be provided by the COBRA Coordinator if a Qualifying Event occurs. If the group rate changes, you will be required to pay the revised amount. You are not required to make any COBRA payment until 45 days after the date on which you make the initial election to continue coverage. However, you will be required to pay for your coverage retroactively to the date the Company-paid coverage ended.

For those who are eligible, as described later, for such additional coverage because you are determined by the Social Security Administration to have been disabled (as defined by the Social Security Act) before the first 60 days of continuation coverage has elapsed, the cost to continue coverage for an additional 11 months for qualified beneficiaries is 150% of the full group rate for the 11 months of COBRA coverage following your initial 18 months of coverage (which was paid at 102% of the full group rate).

Company Continuation Provisions

Under the Company's health care plans, provisions exist for continuing Company-paid coverage for a period of time after you stop working, for example, when you are on a qualifying layoff. Periods of Company-paid continuation of coverage following a qualifying event will be counted as part of your COBRA continuation period. Please consult the above section of this handbook for specific details on Company-paid continuation provisions.

Health Care Provision

If you or your eligible dependents elect to continue your health care coverage under COBRA, it will be identical to the coverage you were eligible for before the Qualifying Event. You may choose to continue coverage under any or all of the following three categories of coverage:

- Hospital, surgical, medical, prescription drug and hearing aid
- Vision care
- Dental

You may choose any combination of these plans, provided you were enrolled in the coverage before the qualifying event. You are also eligible to change plans at any time after being enrolled in a plan for 12 months. Generally, if at the time of the Qualifying Event you had group medical coverage and coverage under separate plans, such as vision or dental plans, you are eligible to continue those plans too, but you are not required to do so. If some coverages stop while others continue at Company expense, you may elect, and pay for, only those coverages that are no longer Company-paid.

If you are not eligible for continued Company-paid coverage but have the option of continuing coverage under Company cash-pay rules by paying 100% of the full group rate for a certain period of time, you may choose between continuing coverage under Company cash-pay rules or under COBRA rules, **but not both**.

Expanded COBRA Coverage

Trade Adjustment Assistance Act of 2015

The Trade Adjustment Assistance Act of 2015 repealed the Trade Adjustment Assistance Extension Act of 2011 and extended certain coverage for eligible workers through June 30, 2021 under the trade Act of 1974.

Services and Benefits

Trade Adjustment Assistance (TAA) and Alternative Trade Adjustment Assistance (ATAA) help trade-affected workers who have lost their jobs as a result of increased imports or shifts in production out of the United States. Certified individuals may be eligible to receive one or more program benefits and services depending on what is needed to return them to employment. For detailed information on TAA and ATAA, visit the United States Department of Labor website at: **doleta.gov/tradeact**.

Health Coverage Tax Credit (HCTC)

Workers who are eligible to receive income support under the TAA program may be eligible to receive tax credits for 65% of the monthly health insurance premium they pay. Qualifying insurance coverage includes COBRA, state COBRA, continuing individual coverage or other state-qualified plans. For detailed information on HCTC, and a list of state-qualified health plans, visit the Internal Revenue Service website at: **irs.gov/Individuals/The-Health-Coverage-Tax-Credit-(HCTC)-Program**.

Second Qualifying Event

If you or your dependents lost Ford coverage because of your termination of employment or reduction in hours, you or your dependents may continue the coverage for 18 months. However, if you are continuing coverage for 18 months and a second Qualifying Event occurs that would cause your spouse or dependent children to lose coverage (i.e., death of the employee or retiree, divorce or legal separation, a child ceasing to be a "dependent child"), the COBRA continuation period is expanded so that they may continue coverage on their own COBRA contract for a maximum of 36 months measured from the date of the first event.

If you or anyone in your family is determined by the Social Security Administration to have been disabled under the Social Security Act before the 60th day of COBRA coverage and you notify the NESC (National Employee Services Center) at 1-800-248-4444 within 60 days of the later of (1) the Social Security Administration's determination and (2) the date on which a qualifying event occurs, and in all cases before the expiration of the 18-month COBRA continuation period, you and your family members may be eligible for COBRA coverage for a maximum of 29 months, rather than 18 months.

If you are subsequently determined by the Social Security Administration to no longer be disabled under the Social Security Act, you must notify the NESC at 1-800-248-4444 within 30 days of the Social Security Administration's determination.

Termination of COBRA Coverage

You also should be aware that health care coverage continued under COBRA will be terminated before the end of the 18- or 36-month period for any of the following reasons:

- Failure to make the required payment on time
- Obtaining coverage under any other group health care plan which does not contain any exclusion or limitation with respect to any preexisting condition of the covered beneficiary
- Eligibility for Medicare
- Voluntary cancellation of coverage
- The Company no longer provides group health care coverage to any of its employees

Once coverage under COBRA has been terminated, it will not be reinstated. By Federal law, in the event that COBRA coverage is terminated early, you will be provided notice.

Additional Information

If you have any questions about COBRA, contact the NESC at 1-800-248-4444.

Coverage Continuation Under "Cash-Pay" Rules

You may continue coverage for yourself and your dependents after Company-paid coverage ends by paying the Plan's cash-pay rate under certain circumstances.

For example, if you are laid-off, you may continue hospital, surgical, medical, prescription drug, vision and hearing aid coverages (but not dental coverage) during a layoff without a break in seniority for up to 12 months after your Company-paid coverage ends.

If you go on an approved leave of absence (other than for disability), you may continue your hospital, surgical, medical, prescription drug, vision care and hearing aid coverages for up to 12 months by paying the Plan's cash pay rate.

Certain categories of surviving spouses may pay the Plan's cash pay rate to continue hospital, surgical, medical, prescription drug and hearing aid coverage (but not dental or vision care coverage) after Company-paid coverage ends for themselves and dependents who were eligible or sponsored at the time of your death.

"Cash-pay" coverage may only be continued as long as the surviving spouse is eligible to receive survivor income benefits under the Group Life and Disability Insurance part of the program (including for this purpose, a surviving spouse whose Survivor Income Benefit (SIB) is not payable because she is receiving Mother's Insurance Benefits under Social Security). A surviving spouse who would be eligible for Bridge Survivor Income Benefits except that such spouse is age 60 or older may cash-pay to continue coverage until the end of the month in which the spouse reaches age 65.

If you are not eligible for continued Company-paid coverage but have the option of continuing coverage under Company cash-pay rules by paying 100% of the full group rate for a certain period of time, you may choose between continuing coverage under Company cash-pay rules or under COBRA rules, **but not both**.

Certificate of Creditable Coverage

If you become covered under another group health care plan, coverage under the Ford Health Care Plan may count toward satisfying any preexisting condition clause contained in the new plan. For example, if your new health care plan excludes coverage for certain pre-existing conditions for six months, and you had Ford coverage for a total of three months, you may present a Certificate of Creditable Coverage from Ford to reduce the exclusionary period to three months.

Without evidence of creditable coverage, you may be subject to a preexisting condition for up to 12 months (18 months for late enrollees) after your enrollment date in your new, non-Ford coverage, depending on that Plan's terms.

You will be provided a Certificate of Creditable Coverage, free of charge, from the Ford Health Care Plan when:

- You lose coverage under the Plan
- You become entitled to elect COBRA continuation coverage
- Your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage

The Ford Health Care Plan does not contain a pre-existing condition clause.

COVID-19 and COBRA Continuation Coverage Timeframes

During the COVID-19 Outbreak Period (as defined by Federal law and regulations), the following COBRA deadlines have been modified. You will have until the earlier of one year from the date you were first eligible for relief or (ii) the time period from March 1, 2020 until 60 days after the end of the National Emergency. Neither period will be counted in determining whether any of the below actions are timely:

- The 60-day deadline for a qualified beneficiary to elect continuation coverage.
- The deadlines for a COBRA qualified beneficiary to pay his or her required COBRA premiums.
- The deadline for you to notify the Plan of a qualifying event.

For example, if you experience a qualifying event on September 25, 2020, during the COVID-19 Outbreak Period, you have until September 24, 2021 to elect COBRA coverage, rather than the 60 days after the date of the event to elect COBRA. However, if the Outbreak Period ended on or before July 25, 2021, you would have to elect COBRA by 60 days after that date. All benefit plan payments associated with delayed enrollment or suspended payments will be due in full no later than 60 days following the end of the Outbreak Period. Failure to pay past due amounts at that time will result in retroactive cancelation of coverage to align with the date of last payment.

Life Insurance Program

UAW-Ford Life Insurance Program Summary Plan Description, November 2021
For UAW-Ford Represented:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011, who attained Skilled Trades Journeyperson status prior to November 18, 2019
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" employees who transitioned to "New Traditional" status in 2015

Life Insurance Program Overview

The Life Insurance Program provides important financial protection for you and your family if you die, are injured in an accident involving a covered dismemberment or loss of sight, or become terminally ill.

If you die or become terminally ill, you or your family has financial protection through the Life Insurance Program. Through the Program, you may be eligible for:

- **Basic Life Insurance** — paying a benefit if you die or become terminally ill
- **Accidental Death and Dismemberment Insurance (AD&D)** — paying a benefit to you if you suffer a covered dismemberment, or to your beneficiary if you die as the result of an accident
- **Survivor Income Benefits (SIB)** — providing monthly income to your eligible survivors after you die
- **Safety Belt User Benefits** — paying a $15,000 benefit if you or another covered participant dies as a result of an automobile accident while wearing a qualified passenger restraint

Naming a Beneficiary

For some benefits, you will be asked to name a beneficiary — the person you want to receive your insurance if you die. You may change any beneficiary you have named at any time.

Eligibility and Basic Coverage Details

Eligibility

You are eligible for the following benefits under the Life Insurance Program if you are represented by the UAW under the Collective Bargaining Agreement effective November 18, 2019, and are a:

- **Legacy Employee:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employee:** Hired or rehired prior to October 24, 2011, who attained Skilled Trades Journeyperson status prior to November 18, 2019
- **"New" Skilled Trades Employee:** Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employee:** Former "Entry Level" Employee who transitioned to "New Traditional" status in 2015

When Coverages Begin

Your coverages become effective as shown here:

Your Situation	Basic Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits
You are hired or rehired	Date of hire or rehire
You are reinstated	Date of your reinstatement (for any coverage in effect at the time you terminated prior Ford Employment)
You return from military service	Date of your reinstatement. If you are placed on layoff (rather than reinstated), Basic Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits coverages become effective on the date you are laid off.

If you are absent from work due to sickness or injury on the day your coverage ordinarily would start, coverage will begin on the first day you return to active work.

Determination

Your Survivor Income Benefits and Safety Belt User benefits are fixed dollar amounts, as described later in this section. Your Basic Life Insurance, Accidental Death and Dismemberment Insurance are based on your base hourly rate on the last day you worked preceding your death or disability or, if higher, the rate determined in the following section. (This is your base hourly rate before any contributions to the Tax-Efficient Savings Plan for Hourly Employees.) Your base hourly rate does not include shift differentials, overtime, cost-of-living allowance or other extras.

Certain rules, however, apply:

In this situation:	Your benefits are based on:
You are under an incentive plan	• Your average straight-time hourly earnings (not including shift differentials, overtime, cost-of-living allowance or other extras) during the four pay periods you worked immediately preceding the January 1, April 1, July 1 and October 1 **OR** • If higher, the greater of the scheduled amounts applicable to you as described in the If Your Base Hourly Rate Changes section on the last two dates on which Coverage Bracket changes took effect, immediately preceding death or disability
You are assigned a lower-rated job because of an occupational injury resulting in a reduction in pay	• Your base hourly rate at the time of injury, while you are at work and receiving weekly Workers' Compensation **OR** • If higher, the greater of the scheduled amounts applicable to you as described in the If Your Base Hourly Rate Changes section on the last two dates on which Coverage Bracket changes took effect, immediately preceding death or disability

If Your Base Hourly Rate Changes

The level of your Basic Life Insurance coverage changes if a change in your base hourly rate puts you into a new "coverage bracket."

Specifically:

If you receive a change in pay effective:	You are in a new coverage bracket on:	The change in your coverage will take effect on:
October 2 – January 1	January 1	February 1
January 2 – April 1	April 1	May 1
April 2 – July 1	July 1	August 1
July 2 – October 1	October 1	November 1

If you are absent from work due to sickness or injury on the day your change in coverage is due to take effect, the change won't take effect until the day you return to work.

Your Cost

Under the UAW-Ford Agreement, the Company pays the full cost of your Basic Life Insurance, Accidental Death and Dismemberment Insurance, Survivor Income Benefits, and Safety Belt User Benefits:

- For any months you receive pay from the Company
- For certain months when you are away from work

For certain other months when you are away from work, you may continue coverage beyond the period for which the Company pays the cost by paying a monthly contribution. The "Employment Status Changes" heading in the *Additional Information* section has more details.

Basic Life Insurance Benefits

If you die while insured, your beneficiary may receive a Basic Life Insurance benefit. If you become terminally ill, you may be eligible to receive a benefit. Any benefit amount is based on your base hourly rate.

Taxation

Federal law requires that employers report to the Internal Revenue Service (IRS) the “imputed income” of certain employer-paid benefits, including Basic Life Insurance that exceeds $50,000 and the Survivor Income Benefit. Imputed income represents the value of “in kind” compensation not actually received as wages but having value to the employee. The income is subject to Federal, Social Security and Medicare (FICA), State, and local taxes and is reportable on an employee’s or retiree’s Form W-2 in box 12C. It will also appear on the first paycheck in December for December wages.

The amount of imputed income is determined based on:

- Basic Life Insurance amount, and
- Value of Survivor Income Benefit as determined by spouse's age and age of youngest dependent.

If you die from any cause while insured, your beneficiary will receive the Basic Life Insurance amount shown here for your coverage bracket:

Insurance Code	If your base hourly rate is:[1] (Coverage Bracket)	Your Basic Life Insurance is:
1J	Up to but less than $14.30	$32,500
1I	$14.30 but less than $14.65	$33,500
1H	$14.65 but less than $15.00	$34,000
1G	$15.00 but less than $15.35	$35,000
1F	$15.35 but less than $15.70	$36,000
1E	$15.70 but less than $16.05	$36,500
1D	$16.05 but less than $16.40	$37,500
1C	$16.40 but less than $16.75	$38,000
1B	$16.75 but less than $17.10	$38,500
1A	$17.10 but less than $17.45	$39,500
A	$17.45 but less than $17.80	$40,500
B	$17.80 but less than $18.15	$41,000
C	$18.15 but less than $18.50	$42,500
D	$18.50 but less than $18.85	$43,000
E	$18.85 but less than $19.20	$44,000
F	$19.20 but less than $19.55	$44,500
G	$19.55 but less than $19.90	$45,500
H	$19.90 but less than $20.25	$46,500
I	$20.25 but less than $20.60	$47,000
J	$20.60 but less than $20.95	$47,500
K	$20.95 but less than $21.30	$48,500
L	$21.30 but less than $21.65	$49,000
M	$21.65 but less than $22.00	$50,000
N	$22.00 but less than $22.35	$50,500
O	$22.35 but less than $22.70	$51,500
P	$22.70 but less than $23.05	$52,500
Q	$23.05 but less than $23.40	$53,000
R	$23.40 but less than $23.75	$54,000
S	$23.75 but less than $24.10	$54,500
T	$24.10 but less than $24.45	$55,500
U	$24.45 but less than $24.80	$56,500
V	$24.80 but less than $25.15	$57,000
W	$25.15 but less than $25.50	$58,000
X	$25.50 but less than $25.85	$58,500
Y	$25.85 but less than $26.20	$59,500
Z	$26.20 but less than $26.55	$60,500
AA	$26.55 but less than $26.90	$61,000

Insurance Code	If your base hourly rate is:[1] (Coverage Bracket)	Your Basic Life Insurance is:
BB	$26.90 but less than $27.25	$62,000
CC	$27.25 but less than $27.60	$62,500
DD	$27.60 but less than $27.95	$63,500
EE	$27.95 but less than $28.30	$64,500
FF	$28.30 but less than $28.65	$65,000
GG	$28.65 but less than $29.00	$66,000
HH	$29.00 but less than $29.35	$67,500
II	$29.35 but less than $29.70	$68,000
JJ	$29.70 but less than $30.05	$69,000
KK	$30.05 but less than $30.40	$70,000
LL	$30.40 but less than $30.75	$70,500
MM	$30.75 but less than $31.10	$71,500
NN	$31.10 but less than $31.45	$72,000
OO	$31.45 but less than $31.80	$72,500
PP	$31.80 but less than $32.15	$73,000
QQ	$32.15 but less than $32.50	$74,000
RR	$32.50 but less than $32.85	$75,000
SS	$32.85 but less than $33.20	$75,500
TT	$33.20 but less than $33.55	$76,500
UU	$33.55 but less than $33.90	$77,000
VV	$33.90 but less than $34.25	$78,000
WW	$34.25 but less than $34.60	$79,000
XX	$34.60 but less than $34.95	$79,500
YY	$34.95 but less than $35.30	$80,500
ZZ	$35.30 but less than $35.65	$81,000
2A	$35.65 but less than $36.00	$82,500
2B	$36.00 but less than $36.35	$83,500
2C	$36.35 but less than $36.70	$84,500
2D	$36.70 but less than $37.05	$85,000
2E	$37.05 but less than $37.40	$86,000
2F	$37.40 but less than $37.75	$86,500
2G	$37.75 but less than $38.10	$87,500
2H	$38.10 but less than $38.45	$88,500
2I	$38.45 but less than $38.80	$89,000
2J	$38.80 and over	$90,000

[1]If an employee is under an incentive plan, coverage is based upon average straight time hourly earnings.

The above amounts will be reduced by any amount of insurance paid prior to your death due to terminal illness.

If you last worked before October 24, 2011, your Basic Life Insurance amount is shown in the Collective Bargaining Agreement in effect when you last worked.

Post-employment Life Insurance

The amount of your Basic Life Insurance benefit is dependent upon your employee type and hire date. This section describes the Basic Life Insurance benefits when you retire or separate from employment.

Benefit Amount After Retirement for the following employees:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011, who attained Skilled Trades Journeyperson status prior to November 18, 2019

If you retire with 10 or more years of creditable service under the Retirement Plan, your Basic Life Insurance will be continued until your death. Effective the first day of the 18th month following your retirement effective date, the amount of life insurance will be gradually reduced at the rate of 2% each month but not below a Continuing Group Life Insurance amount if you are eligible for that coverage.

Continuation Amount

If you are insured and have 10 or more years of credited service under the Retirement Plan, your Basic Life Insurance is continued by the Company until you die.

The level of your Continuing Group Life Insurance amount is determined in the following manner:

Your years of credited service under the Retirement Plan
x 1.5%
x Your Basic Life Insurance in force on the date of retirement
= Your Continuing Group Life Insurance amount

The minimum amount of Continuing Group Life Insurance is the greater of 15% of Basic Life Insurance in force at retirement (with 10 years of credited service) or $5,000.

Example:

If your base hourly rate is $28.12, your Basic Life Insurance benefit as an active employee would be $64,500.

Assume you retire with 23 years of credited service. Beginning the first day of the 18th month after retirement, your Basic Life Insurance would start reducing at the rate of 2% per month (**$1,290**) until it reaches a Continuing Group Life Insurance amount of **$22,252.50**. For this example, it will take approximately 33 months to reach the Continuing Group Life amount.

The Continuing Group Life Insurance amount is based on:

23 years of credited service
x 1.5%
x $64,500
= $22,252.50

Benefit Amount After Separation for the following employees:

- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

If you separate from the Company with 10 or more years of seniority and at least age 55 or 30 or more years of seniority at any age, you are provided post-employment Life Insurance coverage in the amount of $15,000.

How Benefits Are Paid

As soon as satisfactory proof of your death is submitted to the insurer, your Basic Life Insurance and Accidental Death benefits will be paid to your beneficiary(ies). If $5,000 ($10,000 prior to January 1, 2021) or more is payable to a beneficiary, the full amount will be deposited into an interest-bearing account established by the insurer on the beneficiary's behalf. Additional information about the interest-bearing account option will be provided to your beneficiary(ies) in the event of your death, including options to use a debit card, mobile payment app, or transfer into a bank account.

Amounts less than $5,000 ($10,000 prior to January 1, 2021) are always paid in one lump-sum check.

At your death, the insurer may deduct up to the statutory limit ($11,020 in 2019 and adjusted annually for changes in the Consumer Price Index (CPI)) from the benefit — to be paid to any person or persons who have incurred burial expenses on your behalf.

The insurer will not distribute any of the benefit if the death claim is in dispute or litigation or where the beneficiary or guardian does not agree with such distribution.

Naming a Beneficiary

You may name a beneficiary you want to receive your Basic Life Insurance. You have the right to name the beneficiary of your choice — and to change that beneficiary at any time by notifying the insurer.

Your beneficiary will be the last designation indicated on the insurer's records. When the insurer receives notice of a beneficiary change, the change takes effect on the date the notice was signed even though the insurer may receive the notice of change after your death. If the insurer makes a payment on account of your death before receiving the notice of change, however, the insurer will not be liable for another benefit payment.

If an employee names more than one primary beneficiary and a primary beneficiary predeceases the employee, the full death benefit upon the death of the employee is paid to the remaining primary beneficiaries.

If your last-named beneficiary dies before you do, or if no beneficiary designation is in effect at your death, your Basic Life Insurance will be paid, in this order, to:

- Your surviving spouse
- Your surviving children (divided equally among them)
- Your surviving mother or father (or to both equally)
- Your siblings (divided equally among them)

If there are no such survivors, your Life Insurance will be paid to the executor or administrator of your estate.

Be sure to update your beneficiary designation on file with the insurer. If you do not, your benefit could be delayed or paid to someone other than the person you want to receive the benefit.

Basic Life Insurance is not assignable, unless the assignment is made in writing and consented to by the insurer in writing.

Terminal Illness

You may elect to receive a portion of your Basic Life Insurance proceeds, up to 80% of coverage, if you become terminally ill. “Terminal illness” means an injury or sickness expected to result in death within one year without any reasonable prospect of recovery as determined by the insurer. The combined accelerated benefit amount under Basic and Optional Life Insurance may not exceed $600,000.

The amount of Basic Life Insurance remaining in force will be reduced by the amount paid. This option does not apply to individuals who have irrevocably assigned their Basic Life Insurance.

Accidental Death and Dismemberment (AD&D) Benefits

If you suffer certain dismemberments or die as the result of an accident (including presumption of accidental death due to disappearance, or death due to exposure to the elements as a result of an accident), Accidental Death and Dismemberment Insurance pays a benefit if you are insured at the time of the injury and at the time of the loss.

Benefit Amount

If you are insured for Accidental Death and Dismemberment Insurance, you are covered for two types of benefits:

- **Death benefits**. If you die while insured as the result of an accidental bodily injury within two years after the injury occurred, your beneficiary will receive an accidental death benefit. The benefit equals one half of the Basic Life Insurance amount in force. This amount is paid in addition to your Life Insurance benefit.

  If your base hourly rate is $28.12, for instance, you are eligible for a Basic Life Insurance benefit of $64,500. You are also eligible for an accidental death benefit of $32,250 if your death is accidental.

- **Dismemberment benefits**. Accidental Death and Dismemberment Insurance also pays a benefit if you suffer a covered dismemberment or loss of sight as a result of an accidental bodily injury within two years of the injury. The benefit you receive will be a percentage of your Basic Life Insurance benefit — depending on the nature of your loss:

Loss	Accidental Death and Dismemberment Benefit
Accidental death, including presumption of accidental death due to disappearance, or death due to exposure to elements as a result of an accident or accidental loss of more than one of the following*: hand, foot or sight of an eye	Equal to ½ Basic Life Insurance in force
Job-related accidental death	Equal to three times the AD&D benefit in force
Accidental loss of one of the following: hand, foot or sight of an eye	Equal to ¼ Life Insurance in force

** Loss of a hand or foot means loss by severance at or above the wrist or ankle joint; and loss of sight means permanent and uncorrectable loss of sight in the eye.*

If you file a dismemberment claim, the insurer reserves the right to examine you while a claim is pending — at its expense — as often as it may reasonably require. (In the case of an accidental death, the insurer also reserves the right to conduct an autopsy, if permitted by law.)

Maximum Benefits

Total payment for losses from a single accident cannot be more than one-half of your Basic Life Insurance benefit, unless you die as a result of a job-related accident. In that instance, the benefit paid will be three times the scheduled amount of the Accidental Death and Dismemberment Benefit. Your beneficiary will receive this benefit if your death results:

- From accidental bodily injuries caused solely by your employment with the Company

- Solely from an accident in which the cause and results are unexpected and definite as to time and place

Losses Not Covered

Accidental Death and Dismemberment Insurance does not pay benefits for any loss caused by:

- Physical illness or infirmity, unless the physical illness or infirmity merely hastened the occurrence of a loss caused by the accident;
- The diagnosis or treatment of a physical illness or infirmity unless the diagnosis or treatment of a physical illness or infirmity merely hastened the occurrence of a loss caused by the accident;
- Infection;
    - Unless an infection merely hastened the occurrence of a loss caused by the accident; or
    - Unless an infection occurring in an external accidental wound.

In addition to the exclusions above, the insurer will not pay benefits under this section for any loss caused or contributed to by:

- Medical malpractice or other medical errors;
- Mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Committing or attempting to commit a felony;
- The voluntary intake or use by any means of any drug, medication or sedative, unless it is:
    - Taken or used as prescribed by a physician; or
    - An "over-the-counter" drug, medication or sedative taken as directed;
    - Alcohol in combination with any drug, medication or sedative; or
    - Poison, gas or fumes
- War, whether declared or undeclared; or act of war, insurrection, rebellion or active participation in a riot.

Post-employment Accidental Death & Dismemberment (AD&D) Benefits

Benefit amount after retirement for the following employees:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired before October 24, 2011, who attained Skilled Trades Journeyperson status prior to November 18, 2019

If you retire with 10 or more years of creditable service under the Retirement Plan, your AD&D amount remains in effect until the first day of the 18th month following your retirement.

Benefit amount after separation for the following employees:

- **"New" Skilled Trades Employees:** Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

If you separate from the Company with 10 or more years of seniority and at least age 55 or 30 or more years of seniority at any age, you are provided post-employment AD&D coverage in the amount of $7,500 until the first day of the 18th month following your separation.

How Benefits Are Paid

As soon as satisfactory proof of your death is submitted to the insurer, your Basic Life Insurance and Accidental Death benefits will be paid to your beneficiary(ies). If $5,000 ($10,000 prior to January 1, 2021) or more is payable to a beneficiary, the full amount will be deposited into an interest-bearing account established by the insurer on the beneficiary's behalf. Additional information about the interest-bearing account option will be provided to your beneficiary(ies) in the event of your death, including options to use a debit card, mobile payment app, or transfer into a bank account. Amounts less than $5,000 ($10,000 prior to January 1, 2021) are always paid in one lump-sum check.

Accidental dismemberment benefits will be paid in a lump sum only — as soon as satisfactory proof of your loss is received by the insurer.

Beneficiary

Accidental death benefits are paid to the beneficiary of your Basic Life Insurance. Accidental dismemberment benefits are paid to you.

Survivor Income Benefits

If you have one or more survivors, they may be eligible for Survivor Income Benefits — first Transition benefits; then, in some cases, Bridge benefits.

Transition Survivor Income Benefits

If you die while covered for Survivor Income Benefits, your eligible survivor will receive a monthly Transition benefit for up to 24 months. Payments will begin on the first day of the month after you die and continue for the next 23 months as long as there is at least one eligible survivor. If on the first day of any month after your death there is no eligible survivor, no benefit will be paid for that or any subsequent month.

If you last worked on or after October 24, 2011, the monthly Transition benefit is $700. The benefit is reduced to $375 if your eligible survivor is entitled to receive one of the following Social Security benefits:

- Unreduced old-age (retirement) benefits
- Survivor benefits not reduced for age
- Disability benefits

For months in which two or more eligible survivors share a benefit, each survivor's share is computed as a fraction of the benefit that would be paid to him or her as a sole survivor, according to his or her own eligibility for Social Security benefits.

The amount of monthly Transition Survivor Income Benefit for a survivor of an employee who last worked prior to October 24, 2011, remains unchanged.

Eligible Survivors

Survivor Income Benefits are paid:

- First, to your eligible surviving widow or widower (Class A or B from table on next page)
- Next, if you do not have an eligible surviving widow or widower, to your eligible surviving children, divided equally (Class C)
- Finally, if you do not have an eligible widow, widower or child, to your eligible surviving parents, divided equally between the two (Class D)

The eligibility requirements for a survivor are:

Survivor classes	At the time of your death	At the time a benefit is payable
A. Widow, whether or not remarried	Married to you	Living
B. Widower, whether or not remarried	Married to you	Living
C. Children	• Unmarried and under age 21 • Unmarried, legally residing with you and dependent on you at the time of your death: o Either under age 25, or o Totally and permanently disabled	Living and still satisfying the eligibility requirements at the time of your death
Children include:	Natural-born children born prior to the first of the month following your death, legally adopted children, or children for whom legal adoption proceedings were undertaken or stepchildren who resided with you at your death	
D. Father or mother by blood or adopting parent	You were providing at least 50% of support during calendar year immediately preceding your death	Living

Bridge Survivor Income Benefits

If you have an eligible spouse, he or she may qualify for additional Bridge Survivor Income Benefits at the end of the Transition Survivor Income Benefits period. Your spouse is eligible if:

- He or she has not remarried, and
- He or she was eligible to receive 24 Transition Benefit payments.

If your spouse is eligible, he or she will receive a monthly Bridge benefit of $700, if you last worked on or after November 23, 2015, until the earliest of:

- Death
- Remarriage
- Reaching age 62 or
- Reaching age 62 and one month, provided your spouse is:
    - Not eligible to receive a Social Security Widow's or Widower's benefit during that additional month
    - Eligible to receive and has applied for a reduced Social Security old-age (retirement) benefit that first will be paid during the second month following his or her 62nd birthday
    - Reaching an age when full Widow's or Widower's insurance benefits are available under the Social Security Act, as amended
    - Not eligible for a survivor benefit under the Retirement Plan

Any Survivor Income Benefits paid to an employee's widow or widower will be reduced by the amount of any Minimum Required Distribution paid to the Surviving Spouse under the Retirement Plan.

No additional Survivor Income Benefits will be payable for any month a widow or widower is eligible (because of the care of a child) to receive Social Security Mother's Insurance benefits or comparable benefits for a father.

The amount of monthly Bridge Survivor Income Benefit for a survivor of an employee who last worked prior to November 23, 2015, remains unchanged.

Waiver of Benefits

When it's to your surviving spouse's **advantage** to waive Survivor Income Benefits, he or she may do so by completing the insurer's form. The waiver will take effect on the first day of the second month after the waiver is received by the insurer or, if later, at the beginning of the period covered by the waiver.

Survivor Income Benefits will not be payable for any period covered by the waiver. Any month in which a Transition benefit is not paid because of a waiver, however, still will be counted for purposes of determining the 24-month Transition Benefit payment maximum.

Your eligible surviving spouse may revoke the waiver by completing the appropriate form furnished by the insurer.

Attachment of Benefits

To the extent permitted by applicable law, monthly Survivor Income Benefits will not be subject to attachment or other encumbrance or subject to the debts or liability of any eligible survivor.

Safety Belt User Benefits

If you, your surviving spouse or an eligible dependent dies as a result of an automobile accident while wearing a qualified passenger restraint, a $15,000 benefit may be paid.

Eligibility

If you, your surviving spouse or eligible dependents have Company-paid benefits under the Hospital-Surgical-Medical-Drug-Dental-Vision (H-S-M-D-D-V) Program, you and your eligible dependents are covered participants in the Safety Belt User Benefit Program.

Benefit Amount

If you or another covered participant dies as a result of bodily injury caused solely by an automobile accident that occurs while the participant is properly using a qualified passenger restraint, the Program pays $15,000. The accident must occur in the United States or Canada, and death must occur within 365 days of the accident's date.

The Program pays only one $15,000 benefit for each eligible person who dies as a result of a covered automobile accident.

Safety Belt means any restraint device that:

- Meets published United States Government safety standards;
- Is properly installed by the car manufacturer; and
- Is not altered after the installation.

The term includes any child restraint device that meets the requirements of state law.

For purposes of the Program, **Passenger Car** means a private passenger land motor vehicle of pleasure design. Passenger Car includes vans, four-wheel drive vehicles, self-propelled motor homes and trucks with a factory-rated load capacity of 2,000 pounds or less but excludes custom-fabricated specialty vehicles. A Passenger Car does not include any vehicle used for farming, commercial business, military business, racing or any type of competitive speed event.

Deaths Not Covered

No payment will be made for any loss caused wholly or partly, directly or indirectly, by:

- Disease or bodily or mental infirmity, or medical or surgical treatment thereof;
- Any infection, except infection caused by an injury sustained in an automobile accident as provided herein;
- Intentionally self-inflicted injury;
- Suicide or attempted suicide;
- War, whether declared or undeclared; or act of war, insurrection, rebellion or active participation in a riot; or
- Committing or attempting to commit a felony.

Beneficiary

You are the beneficiary if you are living. If you die before the covered participant, the benefit will be paid, in this order, to:

- Your surviving spouse
- Your surviving children (divided equally among them)
- Your surviving mother or father (or to both equally)
- Your siblings (divided equally among them)

If there are no such survivors, the benefits will be paid to the estate of the deceased covered participant.

The Safety Belt User Benefit may not be assigned.

Claims and Appeals (On or after January 1, 2021)

Before you or your beneficiary can receive benefits, you must file a proper claim**.**

Filing a Claim

(For Basic Life, Accidental Death and Dismemberment, Safety Belt or Survivor Income Benefits)

Following the death of an insured person on or after January 1, 2021, notify the insurer by calling 1-833-552-FORD (3673). This notice should be given to the insurer as soon as reasonably possible after the death. The claim form will be sent to the beneficiary or beneficiaries of record.

The beneficiary or beneficiaries should complete the claim form and send it and proof of the death to the insurer as instructed on the claim form.

When the insurer receives the claim form and proof, the insurer will review the claim and, if the insurer approves it, the insurer will pay benefits subject to the terms and provisions of the Plan. The benefit amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time the insurer makes payment.

Claims for Accidental Death and Dismemberment Insurance Benefits

When there has been a covered loss, notify the insurer by calling 1-833-552-FORD (3673). This notice should be given to the insurer as soon as reasonably possible but in any case, within 20 days of the covered loss. The claim form will be sent to you or the beneficiary or beneficiaries of record.

The claim form should be completed and sent along with proof of the covered loss to the insurer as instructed on the claim form. If you or the beneficiary have not received a claim form within 15 days of giving notice of the claim, proof may be sent using any form sufficient to provide the insurer with the required proof.

The claimant must give the insurer proof no later than 90 days after the date of the covered loss. If notice of claim or proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice or proof is given as soon as is reasonably possible.

When the insurer receives the claim form and proof, the insurer will review the claim and, if the insurer approves it, the insurer will pay benefits subject to the terms of the Plan. The benefit amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time the insurer makes payment.

Time Limit on Legal Actions. A legal action on a claim may only be brought against the insurer during a certain period. This period begins 60 days after the date proof is filed and ends three years after the date such proof is required.

Initial Determination

After the insurer receives a claim for benefits, the insurer will review the claim and notify the claimant of its decision to approve or deny the claim. Such notification will be provided to the claimant within a reasonable period, not to exceed 90 days from the date the insurer received the claim, unless the insurer notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If the insurer denies the claim in whole or in part, the notification of the decision will state the reason why the claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because the insurer did not receive sufficient information, the notification of the decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of the claimant's right to bring a civil action if the claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied, in whole or in part, you can request a review of the claim by the insurer. This request for review should be sent in writing to Group Insurance Claims Review at the address of the insurer's office that processed the claim within 60 days after you received notice of denial of the claim. When requesting a review, you should state the reason you believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you deem appropriate. Upon your written request, the insurer will provide you, free of charge, with copies of relevant documents, records and other information.

The insurer will re-evaluate all the information, will conduct a full and fair review of the claim, and you will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date the insurer received the request for review, unless the insurer notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If the insurer denies the claim on appeal, the insurer will send you a final written decision that states the reason(s) why the appealed claim is being denied, references any specific Plan provision(s) on which the denial is based, and Voluntary Appeal procedures offered by the Plan, and a statement of your right to bring a civil action if the claim is denied after an appeal. Upon written request, the insurer will provide you, free of charge, with copies of documents, records and other information relevant to the claim.

Filing a Voluntary Appeal

This section contains a description of the procedures for seeking review of a denied claim for Basic Life Insurance, Accidental Death and Dismemberment, Safety Belt User or Survivor Income Benefits.

In the event that the insurer denies a claim for Basic Life Insurance, Accidental Death and Dismemberment, Safety Belt user or Survivor Income Benefits, a claimant may request reconsideration/appeal of your claim. You should write the insurer within 60 days of your receipt of denial.

Unless the insurer requests additional information in a timely manner, you will be notified of the insurer's decision within 60 days after your letter is received. If your request for reconsideration/appeal is denied, you may:

1. Request a review upon appeal by written application to the Ford Group Life and Disability Appeal Committee (Committee);

2. Review pertinent documents; and

3. Submit issues and comments in writing within 60 days after the claimant receives the written notification of denial of the appeal.

The UAW will appoint three members and alternate members to the Committee. Three additional members of the Committee are appointed by the Company. The members of the Committee and the alternate members receive no additional compensation for Committee services.

Address appeal requests to:

Ford Motor Company
P.O. Box 6214
Dearborn, MI 48121-6214
Attn: UAW-Ford Group Life and Disability Committee

The request for appeal should clearly indicate the reason(s) why you or your beneficiary(ies) think your claim should not have been denied. You are encouraged to submit copies of any additional documents, records, information or comments you think have a bearing on your claim.

The appeal will be considered at the Committee's next regularly scheduled meeting. If the appeal is filed within 30 days of the next meeting, a decision by the Committee will be made by the date of the second meeting after receipt of your request for review. Under special circumstances an extension of time for processing may be required, in which case a decision will be rendered by the date of the third meeting.

If an extension is required because information is incomplete, you will receive a written notice of the extension before the extension period begins. The appeal review period will be extended from the date the notice of extension was mailed to the date the complete information is received.

Written notice of a decision will be made no later than five days after the decision has been made by the Committee. The notice will include the final decision and, if the appeal is denied, will include the specific reasons for denial and references to the applicable Plan provisions on which the denial is based and a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. The notice will also advise you of your right to bring a civil action under ERISA following an adverse benefit determination of appeal. No legal action may be brought until after the claims and appeals procedures have been exhausted. No legal action may be taken later than two years after the claim accrues

Claims and Appeals Timelines and COVID-19

During the COVID-19 Outbreak Period (as defined by Federal law and regulations), the deadlines for you to file claims, appeals and external review requests with the Plan have been modified. You will have until the earlier of (i) one year from the date you were first eligible for the COVID relief or (ii) the time period from March 1, 2020 until 60 days after the end of the National Emergency. Neither period will be counted in determining whether any of the below actions are timely:

1. The 31-day period to request special enrollment in a group life plan upon experiencing certain enrollment events (e.g., upon acquisition of a new spouse or dependent by marriage, birth, or adoption).

2. The date for individuals to notify the plan of a qualifying event or determination of disability.

For example, if you received a claim denial letter dated July 10, 2020 and wish to appeal the denial, you will have until January 6, 2021 (180 days from the date of the claim denial) or the date that is 60 days following the end of the COVID-19 Outbreak Period, whichever is later, to submit your appeal.

Claims and Appeals (On or before December 31, 2020)

Before you or your beneficiary can receive benefits, you must file a proper claim**.**

Filing a Claim

(For Basic Life, Accidental Death and Dismemberment, Safety Belt User or Survivor Income Benefits)

If the death of an insured person took place on or before December 31, 2020, notify UniCare by calling **1-800-843-8184**.

To begin the process for a death claim, your family or beneficiary will need to provide copies of the death certificate certified by the governmental unit maintaining the record.

Death certificates usually are kept on file in the Department of Health of the city or county where death occurred. You may contact that office directly to obtain the number of death certificate copies you need. Usually, only certain members of the immediate family may obtain these copies.

The funeral home director might obtain the death certificate copies for your family.

To file a claim for Basic Life Insurance, Accidental Death and Dismemberment Insurance, Safety Belt User or Survivor Income Benefits, contact:

UniCare Life and Health Insurance Company
Dearborn Service Center
P.O. Box 2090
Dearborn, MI 48123-2090
1-800-843-8184

After the insurer receives a claim for benefits, the insurer will review the claim and notify you or, if applicable, your beneficiary of its decision to approve or deny the claim.

You or your beneficiary will receive the written notification within a reasonable period, not to exceed 90 days from the date the insurer received your claim. You or your beneficiary may be notified of a required extension within the original 90-day period if there are special circumstances. The additional review period is also 90 days.

If a claim for benefits is denied in whole or in part, the written notification will include:

1. The specific reason or reasons for the denial;

2. Reference to the specific Plan provision(s) on which the denial is based;

3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and

4. A description of the Plan's review* procedures and the time limits applicable to such procedures, along with a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, if your claim is denied after an appeal.

**To request a review (appeal) of a claims decision, you or your beneficiary must submit your request in writing to the insurer for Company-paid coverages. Such requests should be submitted to the address of the insurer indicated in the Summary of Administrative Information at the end of this section.*

Filing an Appeal

This section contains a description of the procedures for seeking review of a denied claim for Basic Life Insurance, Accidental Death and Dismemberment, Safety Belt User or Survivor Income Benefits.

In the event that the insurer denies a claim for Basic Life Insurance, Accidental Death or Dismemberment, Safety Belt user or Survivor Income Benefits, a claimant may request reconsideration/appeal of your claim. You should write the insurer within 60 days of your receipt of denial.

Unless the insurer requests additional information in a timely manner, you will be notified of the insurer's decision within 60 days after your letter is received. If your request for reconsideration/appeal is denied, you may:

1. Request a review upon appeal by written application to the Ford Group Life and Disability Appeal Committee (Committee);

2. Review pertinent documents; and

3. Submit issues and comments in writing within sixty (60) days after the claimant receives the written notification of denial of the appeal.

The UAW will appoint three members and alternate members to the Committee. Three additional members of the Committee are appointed by the Company. The members of the Committee and the alternate members receive no additional compensation for Committee services.

Address appeal requests to:

Ford Motor Company
P.O. Box 6214
Dearborn, MI 48121-6214
Attn: UAW-Ford Group Life and Disability Committee

The request for appeal should clearly indicate the reason(s) why you or your beneficiary(ies) think your claim should not have been denied. You are encouraged to submit copies of any additional documents, records, information or comments you think have a bearing on your claim.

Since a committee is reviewing the appeal, it will be considered at the Committee's next regularly scheduled meeting. If it is filed within thirty (30) days of the next meeting, a decision by the Committee will be made by the date of the second meeting after receipt of the claimant's request for review. Under special circumstances an extension of time for processing may be required, in which case a decision will be rendered by the date of the third meeting.

If an extension is required because information is incomplete, the review period will be adjusted from the date the notice was sent to the date the complete information is received. If an extension is needed, you will receive a written notice before the extension period begins.

Written notice of a decision will be made no later than five (5) days after the decision has been made by the Committee. Your notice will include the final decision and the specific reasons for denial and reference to pertinent Plan provisions on which the denial is based and a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. The notice will also advise you of your right to bring a civil action under ERISA following an adverse benefit determination of appeal. No legal action may be brought until after the claims and appeals procedures have been exhausted. No legal action can be taken later than two years after the claim accrues.

Additional Information

Employment Status Changes

If you stop working, are away from work or your employment status changes to an ineligible status, Life Insurance benefits coverages will be affected.

Depending on the reason you stop working, the Company may pay for certain coverages for you or may allow you to continue certain coverages under the Life Insurance Program as described in this section. Additionally, you or your dependents, upon loss of coverage or eligibility under the Life Insurance Program, may be eligible to apply to continue coverage outside of the Ford Life Insurance Program. For more information, see the following "Coverage Continuation Contributions" heading.

Conversion

If you leave the Company or no longer are eligible for coverage, you can convert Basic Life and Survivor Income Benefits within 31 days of the time coverage ends to any individual life insurance policy then customarily issued by the insurer except term insurance. This is done by making application and paying the required premium to the insurer. The maximum amount of the individual policy will be equal to the amount of your Life Insurance in force when you left the Company, including Survivor Income Benefits.

Accidental Death and Dismemberment is not convertible to an individual policy.

Employment Termination

If your employment is terminated because of a quit or discharge, your Basic Life, Accidental Death and Dismemberment, and Survivor Income Benefit coverage terminates as of the date you quit or are discharged. If, however, you are discharged and have a grievance pending to protest your loss of seniority, coverage for Basic Life Insurance will continue to the end of the month you were discharged and up to two additional months.

If your employment is terminated for failing to report or overstaying leave, your coverage terminates as of the end of the month in which seniority is broken.

If you terminate employment between ages 60 and 65, you may be eligible to continue certain Life Insurance coverages.

Basic Life Insurance and Survivor Income Benefits coverages remain in effect for 31 days following your termination of coverage. (See the *Basic Life Insurance Benefits* and *Survivor Income Benefits* sections for more details.)

Layoff

If you are laid off, all your coverages will continue for one month after the month in which you are laid off.

If you are a returning veteran and are placed on layoff instead of being reinstated, your Basic Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits will continue at no cost to you for the rest of the month in which you are placed on layoff. (A returning veteran is an employee applying for re-employment who would be entitled to reinstatement as a military service veteran under the Collective Bargaining Agreement.)

If you have one or more years of seniority, your Basic Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits may continue for a longer period of time, at no cost to you, during a layoff meeting the conditions of the Supplemental Unemployment Benefits Plan (Article l, Section 3).

You will receive these additional coverages for the greater of:

- The number of months (up to 24 months) for which you are eligible based on your years of seniority on your last day worked before layoff (or the date placed on layoff if you are a returning veteran) according to this table:

If your year(s) of seniority on the last day worked before layoff were:	Coverage will be provided for up to this number of months at no cost to you:
Less than 1	0
1 but less than 2	2
2 but less than 3	4
3 but less than 4	6
4 but less than 5	8
5 but less than 6	10
6 but less than 10	12
10 and over	24

OR

- One full calendar month of layoff (up to 24 months) for each full 4 weeks of Regular Benefits to which your Credit Units as of the last day worked prior to layoff entitle you based on your seniority and the Credit Unit Cancellation Base under the provisions of the 1987 SUB Plan.

If, after your last day worked before layoff, you are credited with Credit Units under the SUB Plan, the Credit Unit Cancellation Base as of the date you are entitled to be credited with Credit Units, will be used.

If you remain on layoff beyond the period of time for which coverage is provided at no cost, you may continue coverage for up to an additional 12 months. To do so, you will be required to make monthly contributions. The contribution amount is based on your base hourly rate and your level of coverage at the time your employment terminated.

Additionally, to continue any optional coverages during layoff, you must make your premium payments directly to the insurer.

If you become eligible for reinstated Accident and Sickness Benefits during layoff, the Company will provide Basic Life and Accidental Death and Dismemberment Insurance and Survivor Income Benefits while you are eligible to receive Extended Disability Benefits after receipt of reinstated Accident and Sickness Benefits. For additional information on Extended Disability Benefits or reinstated Accident and Sickness Benefits, see the *Disability Insurance* section in this handbook.

Medical Leave of Absence

If you cease active work because of a disability, all of your coverages will continue up to a period of time equal to your seniority when your absence began. If you remain continuously and totally disabled beyond that time, you can continue Basic Life Insurance and Accidental Death and Dismemberment Insurance coverages by making monthly contributions.

If your absence is due to pregnancy, the Company will continue all your coverages through the month following the month of delivery. If your disability continues beyond that time, your coverages also will continue as for any other disability.

Additionally, to continue any optional coverages during a leave, you must make your premium payments directly to the insurer.

Non-medical Leave of Absence

If you go on an approved non-medical leave of absence (except while serving as International Union Representative), all of your coverages for Basic Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits will continue for the first full month of your leave. You may continue coverage beyond that time up to the end of your approved leave by making monthly contributions.

If you go on an approved Union Leave of Absence while serving as an International Union Representative, you may continue your Basic Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits coverages by making monthly contributions.

Additionally, to continue any optional coverages during a leave, you must make your premium payments directly to the insurer.

Retirement

If you take early or special early retirement under the Retirement Plan, the Company will continue your full Basic Life Insurance and Accidental Death and Dismemberment Insurance coverages until the first day of the 18th month after your retirement effective date. Thereafter your Basic Life Insurance will be continued at a reduced level until you die, and your Accidental Death and Dismemberment benefit will end.

If you take disability retirement under the Retirement Plan, the Company will continue your Basic Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits until the first day of the 18th month after your retirement effective date. After this date, your Basic Life Insurance will be continued at a reduced level until you die, and your Accidental Death and Dismemberment benefit will end.

If you are uninsured and retire under the Retirement Plan before age 65, the following applies. If you did not return to work from layoff or leave of absence, you will become insured on the first day of the month following the month you broke seniority, due to that retirement, for the same coverages you otherwise would have been eligible to receive at the time of your retirement, in the amount you had in force while last working. The Company will continue those coverages for you until the first day of the 18th month after your retirement effective date, at which time your Life Insurance will be continued at a reduced level (as described in “Continuation Amount” in the *Basic Life Insurance Benefits* section), and your Accidental Death and Dismemberment benefit will end.

See the *Basic Life Insurance Benefits* section for details on coverage after you reach age 65.

Employment Termination Between Ages 60 and 65

If you terminate employment for any reason except retirement between ages 60 (or prior to that age if you still are insured at age 60) and 65 and you had at least five years of credited service under the Retirement Plan at age 60, you may continue your Basic Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits coverages under the Program until you reach age 65 by making monthly contributions. If, however, you are terminated for total and permanent disability, the Company will pay the cost for you.

Grievance Pending

The Company will continue your Basic Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits coverages if you have a grievance pending to protest your disciplinary layoff or your loss of seniority from:

- Discharge
- Failure to report, or
- Overstaying leave

Coverage will continue for the month of discharge plus up to two additional months.

To continue coverage after the period in which your loss of seniority or disciplinary layoff occurred, you will need to make monthly contributions.

If you are reinstated or if your disciplinary layoff is reduced after this period, the Company will reimburse you for the continuation payments that the Company would have made had you remained at work.

Coverage Continuation Contributions

Employees are eligible to continue Basic Life, Accidental Death and Dismemberment, and Survivor Income Benefit under Schedule I and Schedule III (identified on the following pages).

Employees are also eligible to continue Basic Life, Accidental Death and Dismemberment, and Survivor Income Benefit under Schedule II and IV (identified on the following pages).

The following charts summarize reasons why your employment may terminate and whether or not your coverage(s) may continue:

Your situation	The Company continues your coverage for:	You then can contribute according to Contribution Schedule #:
You quit or are discharged	—	—
You have a grievance pending	Month of discharge plus up to two additional months	II
You are laid off	First month (plus additional months for which you may qualify)	II
You are on a leave of absence (except medical or Union leave)	First month	I
You are on a Union leave absence (Local Union)	First month	III
You are on a Union leave of absence (International Union)	Through month in which leave is issued	IV
You are on a medical leave of absence	Length of your absence due to disability but not to exceed period equal to your seniority	II
You take early, normal or special early, retirement with 10 years of service	Entire period	—
You take disability retirement with 10 years of service	Entire period	—
You terminate between ages 60 and 65	—	II

To continue coverage beyond the period for which the Company pays for your coverage, the monthly contribution provided in the following Contribution Schedules I–IV you are required to pay depends on the coverage bracket you were in as of the last day worked and the kinds of insurance coverage that can be continued.

Contribution Schedule I & II

Insurance Code	If your base hourly rate is: (Coverage Bracket)	Basic Life, AD&D and SIB Contribution Schedule I* & II
1J	Up to but less than $14.30	$15.60
1I	$14.30 but less than $14.65	$16.08
1H	$14.65 but less than $15.00	$16.32
1G	$15.00 but less than $15.35	$16.80
1F	$15.35 but less than $15.70	$17.28
1E	$15.70 but less than $16.05	$17.52
1D	$16.05 but less than $16.40	$18.00
1C	$16.40 but less than $16.75	$18.24
1B	$16.75 but less than $17.10	$18.48
1A	$17.10 but less than $17.45	$18.96
A	$17.45 but less than $17.80	$19.44
B	$17.80 but less than $18.15	$19.68
C	$18.15 but less than $18.50	$20.40
D	$18.50 but less than $18.85	$20.64
E	$18.85 but less than $19.20	$21.12
F	$19.20 but less than $19.55	$21.36
G	$19.55 but less than $19.90	$21.84
H	$19.90 but less than $20.25	$22.32
I	$20.25 but less than $20.60	$22.56
J	$20.60 but less than $20.95	$22.80
K	$20.95 but less than $21.30	$23.28
L	$21.30 but less than $21.65	$23.52
M	$21.65 but less than $22.00	$24.00
N	$22.00 but less than $22.35	$24.24
O	$22.35 but less than $22.70	$24.72
P	$22.70 but less than $23.05	$25.20
Q	$23.05 but less than $23.40	$25.44
R	$23.40 but less than $23.75	$25.92
S	$23.75 but less than $24.10	$26.16
T	$24.10 but less than $24.45	$26.64
U	$24.45 but less than $24.80	$27.12
V	$24.80 but less than $25.15	$27.36
W	$25.15 but less than $25.50	$27.84
X	$25.50 but less than $25.85	$28.08
Y	$25.85 but less than $26.20	$28.56
Z	$26.20 but less than $26.55	$29.04
AA	$26.55 but less than $26.90	$29.28
BB	$26.90 but less than $27.25	$29.76
CC	$27.25 but less than $27.60	$30.00
DD	$27.60 but less than $27.95	$30.48
EE	$27.95 but less than $28.30	$30.96

Insurance Code	If your base hourly rate is: (Coverage Bracket)	Basic Life, AD&D and SIB Contribution Schedule I* & II
FF	$28.30 but less than $28.65	$31.20
GG	$28.65 but less than $29.00	$31.68
HH	$29.00 but less than $29.35	$32.40
II	$29.35 but less than $29.70	$32.64
JJ	$29.70 but less than $30.05	$33.12
KK	$30.05 but less than $30.40	$33.60
LL	$30.40 but less than $30.75	$33.84
MM	$30.75 but less than $31.10	$34.32
NN	$31.10 but less than $31.45	$34.56
OO	$31.45 but less than $31.80	$34.80
PP	$31.80 but less than $32.15	$35.04
QQ	$32.15 but less than $32.50	$35.52
RR	$32.50 but less than $32.85	$36.00
SS	$32.85 but less than $33.20	$36.24
TT	$33.20 but less than $33.55	$36.72
UU	$33.55 but less than $33.90	$36.96
VV	$33.90 but less than $34.25	$37.44
WW	$34.25 but less than $34.60	$37.92
XX	$34.60 but less than $34.95	$38.16
YY	$34.95 but less than $35.30	$38.64
ZZ	$35.30 but less than $35.65	$38.88
2A	$35.65 but less than $36.00	$39.60
2B	$36.00 but less than $36.35	$40.08
2C	$36.35 but less than $36.70	$40.56
2D	$36.70 but less than $37.05	$40.80
2E	$37.05 but less than $37.40	$41.28
2F	$37.40 but less than $37.75	$41.52
2G	$37.75 but less than $38.10	$42.00
2H	$38.10 but less than $38.45	$42.48
2I	$38.45 but less than $38.80	$42.72
2J	$38.80 and over	$43.20

** In order to continue coverage for Life Insurance Benefits, you must also continue your Disability Insurance benefits. Please see the Disability Insurance Program Summary Plan Description for further information regarding rates and where to send payment of your Disability Insurance contributions.*

The rates are subject to change, if necessary, by mutual agreement between the Company and the Union.

Contribution Schedule III & IV. Your contribution is 60¢ per $1,000 Life Insurance for Basic Life, Accidental Death and Dismemberment and Survivor Income Benefit coverages.

Your contributions for the coverages available to you should be mailed to:

MetLife
P.O. Box 13724
Philadelphia, PA 19101-3724
1-833-552-FORD (3673)

Payment will be due on the first day of each month for that month's coverage. Payment will be accepted anytime within that month. Late payments are not acceptable, however, and can result in permanent termination of your coverage.

If you return to work from layoff in a month for which you have made payment, you will be reimbursed by the insurer for that payment.

Making timely premium payments is your responsibility.

Coverage Continuation

For Optional Group Life Insurance, Dependent Group Life Insurance and Optional Accident Insurance

You may continue Optional Group Life Insurance, Dependent Group Life Insurance and Optional Accident Insurance coverage for certain periods when you are not at work while insured for the Basic Life Insurance benefit. Additional information can be found under the *Optional Life Insurance Program* section.

Life Insurance Coverage End

Coverage will end when you are no longer eligible for coverage under the Program. However, certain coverages may be continued.

An employee or dependent may only continue coverage under one continuation of coverage option. Coverage may not be continued simultaneously under the:

1. Cash pay schedules I, II, III or IV (found in the previous *Additional Information* section)
2. "Conversion Privilege," or
3. "Portability of Coverage Provision"

More information on the continuation of coverage options may be located in the sections referenced above. Conversion and Portability are described in this section.

Company-paid coverages will end on the earliest of:

- Safety Belt User Coverage will end when eligibility for Company-paid H-S-M-D-D-V Program coverage ends.
- The date the Program terminates;
- The end of the period for which you last made contributions for continuing coverage;
- The end of the month you are transferred within the Company to an ineligible class of employees;
- Unless specifically provided otherwise, the end of the month you stop active work (unless you continue your insurance coverage as described in "Employment Status Changes" in the *Additional Information* section); or
- The day you quit or are discharged, unless you have a grievance pending to protest your loss of seniority. See "Grievance Pending" heading in the *Additional Information* section.

Upon loss of coverage, Basic Life Insurance and Survivor Income Benefits remain payable during the 31 days following loss of coverage, during which time you are eligible to convert the loss of coverage to an individual policy.

Conversion Privilege

If you are no longer eligible for coverage, you can convert Basic Life Insurance and Survivor Income Benefit, within 31 days of the time coverage ends, to any individual Life Insurance policy then customarily issued by the insurer, except for term insurance. This is done by making application and paying the required premium to the insurer. The maximum amount of the individual policy will be equal to the amount of your Life Insurance in force when you left the Company, including Survivor Income Benefits.

Accidental Death and Dismemberment is not convertible to an individual policy.

Circumstances that Affect Benefits

This section of your handbook has summarized your Life Insurance Plan coverages. Additional circumstances, however, might affect your benefits.

Assigning Benefits

You and your beneficiary may assign the death benefit under your Basic Life Insurance, Accidental Death and Dismemberment Insurance by making your assignment in writing with the insurer. Neither you nor your survivors may assign your Survivor Income Benefits and Safety Belt User Benefits.

Certain court orders relating to domestic relations matters could require that your benefits (or a part of your benefits) be paid to someone else — your former spouse, or children, for example. This could apply to benefits paid to you as well as to any beneficiary. If the insurer or claims processor determines that the court order qualifies, payments will be made according to the order.

As soon as you are aware of any court proceedings that may affect your Life Insurance Program benefits, On or after January 1, 2021, contact MetLife at **1-833-552-FORD (3673)**. On or before December 31, 2020, contact UniCare Life and Health Insurance Company at 1-800-843-8184.

Attachment of Survivor Income Benefits

To the extent permitted by applicable law, Survivor Income Benefits are not subject to attachment or other encumbrance or subject to the debts or liability of any survivor.

Filing Claims

No benefits can be paid until you or your beneficiary files a claim. If you have questions or need to file a claim regarding an incident that occurred on or after January 1, 2021, contact MetLife at **1-833-552-FORD (3673)**.

If you have questions or need to file a claim regarding an incident that occurred on or before December 31, 2020, contact UniCare Life and Health Insurance Company at **1-800-843-8184**.

Summary of Administrative Information

Group Life insurance Program					
Name:	**Plan Number:**	**Type of Plan:**	**Cost Paid By:**	**Trustee:**	**Benefits Administered or Insured Through:**
Basic Life Insurance, Accidental Death and Dismemberment Insurance, Safety Belt User and Survivor Income Benefits	521	Welfare plan providing Life Insurance	The Company pays premiums to the insurer in amounts reflecting the number and amount of claims paid	None	Basic Life Insurance, Accidental Death and Dismemberment Insurance, Safety Belt User and Survivor Income Benefits are provided by: Group Policy 17-GCC UniCare Life and Health Insurance Company P.O. Box2090 Dearborn, MI 48123-2090 **1-800-843-8184** MetLife P.O. Box 14406 Lexington, KY 40512-4406 **1-833-552-FORD (3673)**

Optional Life & Accident Insurance Program

UAW-Ford Optional Life and Accident Insurance Program
Summary Plan Description, November 2021

For UAW-Ford Represented:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011, who attained Skilled Trades Journeyperson status prior to November 18, 2019
- **"New" Skilled Trades Employees:** Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" employees who transitioned to "New Traditional" status in 2015

Optional Life & Accident Insurance Program Overview

If there is a discrepancy between this summary and the official plan documents, including the insurer's Policy and Certificates, the terms of the official plan documents will govern.

The Group Life Insurance Program provides optional life and accident insurance coverages in which you may elect to enroll. This coverage may be purchased by you and provides additional financial protection for you and your family.

The Optional Life & Accident Insurance Program includes:

- **Optional Group Life Insurance Benefits** — pays a benefit if you have enrolled in this coverage to your beneficiary in the event of your death
- **Dependent Group Life Insurance Benefits** — pays a benefit to you if you have enrolled in this coverage and a covered dependent dies
- **Optional Accident Insurance Benefits** — pays a benefit if you have enrolled in this coverage, to you, if you or a covered dependent suffer a covered dismemberment or if a covered dependent dies as the result of an accident; to your beneficiary if you die as the result of an accident.

Naming a Beneficiary

You will be asked to name a beneficiary — the person(s) you want to receive your insurance if you die. You may change any beneficiary you have named at any time, unless you have named an irrevocable beneficiary.

Basic Coverage Details

Eligibility

You are eligible for the following benefits under the Life and Disability Insurance Program if you are represented by the UAW under the 2019 Collective Bargaining Agreement, as a Regular Full-Time employee. Coverages described herein are effective January 1, 2020.

Certain provisions described herein are effective January 1, 2021.

Determination

Optional Group Life Insurance, Dependent Group Life Insurance and Optional Accident Insurance benefits are fixed dollar amounts, as described later in this section.

Cost

Optional Group Life Insurance, Dependent Group Life Insurance and Optional Accident Insurance are voluntary. If you choose to enroll, you pay a monthly premium for coverage.

Optional Group Life Insurance

You may buy Optional Group Life Insurance coverage to supplement the Basic Life Insurance coverage paid for by the Company.

Eligibility

You are eligible for Optional Group Life Insurance on the first day of the month following the month you are employed. You may enroll within 60 days (31 days prior to January 1, 2021) following your eligibility date or within the 31-day period following marriage or acquisition of a child.

If you enroll within the 60-day period following your eligibility date, you will not have to provide evidence of your good health for coverage up to $250,000 ($200,000 prior to January 1, 2021).

Some Examples

1. On or after January 1, 2021: If you are hired June 15, 2021, you are eligible to enroll in coverage on July 1, 2021. You will have 60 days from July 1, 2021 to enroll in Optional Group Life coverage.

2. Prior to January 1, 2021: If you were hired June 15, 2020, you were eligible to enroll in coverage on July 1, 2020. You had 31 days from July 1, 2020 to enroll in Optional Group Life coverage.

When Coverage Begins

Your Optional Group Life Insurance coverage will take effect:

If you enroll:	Coverage will begin on this date:
On or before the day you are eligible for Optional Group Life Insurance	First day of the month following your hire or rehire date for coverage up to $250,000 ($200,000 prior to January 1, 2021). If applying for an amount greater than $250,000 ($200,000 prior to January 1, 2021), evidence of good health is required. If evidence of good health is approved, coverage above $250,000 ($200,000 prior to January 1, 2021) will begin on the first day of the month following the date the insurer approves such evidence.
During the 60-day period after your eligibility date (31-day period prior to January 1, 2021)	First day of the month following your enrollment for coverage up to $250,000 ($200,000 prior to January 1, 2021). If applying for an amount greater than $250,000 ($200,000 prior to January 1, 2021), evidence of good health is required. If evidence of good health is approved, coverage above $250,000 ($200,000 prior to January 1, 2021) will begin on the first day of the month following the date the insurer approves such evidence.
During the 31-day period following marriage or acquisition of a child or children by birth or adoption	Once the family change has taken place and if coverage elected is $250,000 ($200,000 prior to January 1, 2021) or less, coverage is effective the first day of the month following your request. If applying for an amount greater than $250,000 ($200,000 prior to January 1, 2021), evidence of good health is required. If evidence of good health is approved, coverage above $250,000 ($200,000 prior to January 1, 2021) will begin on the first day of the month following the date the insurer approves such evidence of good health.
After the 60th day following eligibility date (31-day period prior to January 1, 2021)	Evidence of good health is required for any coverage amount. Once you have provided your satisfactory evidence of good health, coverage is effective the first day of the month after the insurer approves that evidence.
During Open Enrollment	If you enroll during open enrollment, coverage is effective (1) for guaranteed coverage amounts (coverage amounts as specified in the open enrollment where evidence of good health Is not required), the first of the month following enrollment, or (2) for amounts requiring evidence of good health, the first of the month following the date the insurer approves coverage.

You must be actively at work for coverage to become effective; otherwise, coverage is effective on the first day worked thereafter.

COVID-19 REGULATORY UPDATE

The DOL, Internal Revenue Service, and Department of the Treasury have announced the extension of certain ERISA and Internal Revenue Code timeframes during the COVID-19 National Emergency. The following COVID relief is available to you.

The earlier of (i) one year from the date you were first eligible for the COVID relief or (ii) the time period from March 1, 2020 until 60 days after the end of the National Emergency will not be counted in determining whether any of the below actions are timely:

1. The 31-day period to request special enrollment in a group life plan upon experiencing certain enrollment events (e.g., upon acquisition of a new spouse or dependent by marriage, birth, or adoption).

2. The date for individuals to notify the plan of a qualifying event or determination of disability.

Benefit Amount

You may elect one of the following schedules of Optional Group Life Insurance:

	Amount of Optional Life Insurance
Schedule 1	$ 10,000
Schedule 2	$ 20,000
Schedule 3	$ 30,000
Schedule 4	$ 40,000
Schedule 5	$ 50,000
Schedule 6	$ 75,000
Schedule 7	$100,000
Schedule 8	$125,000
Schedule 9	$150,000
Schedule 10	$175,000
Schedule 11	$200,000
Schedule 12	$225,000
Schedule 13	$250,000
Schedule 14	$275,000
Schedule 15	$300,000
Schedule 16	$350,000*
Schedule 17	$400,000
Schedule 18	$450,000*
Schedule 19	$500,000
Schedule 20	$550,000*
Schedule 21	$600,000
*New options effective January 1, 2021	

Contributions

Optional Group Life Insurance is voluntary. The required monthly contributions for each $1,000 of Optional Group Life Insurance are based on your age. The following rates are subject to change, if necessary, by mutual agreement between the Company and the Union:

ACTIVE EMPLOYEE CONTRIBUTION RATES

Employee's age*	Monthly contribution for each $1,000 of insurance: On or after 1-1-21
Less than 30	$ .028
30–34	$ .043
35–39	$ .057
40–44	$ .075
45–49	$ .113
50–54	$ .172
55–59	$ .322
60–64	$ .494
65–69	$ .950
70–74	$1.541
75–79	$2.060
80–84	$2.060
85–89	$2.060
90–94	$2.060
95 & over	$2.060

Employee's age*	Monthly contribution for each $1,000 of insurance: Prior to 1-1-21
Less than 30	$ .028
30–34	$ .043
35–39	$ .057
40–44	$ .075
45–49	$ .113
50–54	$ .172
55–59	$ .322
60–64	$ .494
65–69	$ .950
70–74	$1.541
75–79	$2.435
80–84	$3.492
85–89	$5.028
90–94	$7.064
95 & over	$11.973

**Monthly contribution is based on your age and will take effect the first day of the calendar month following the month in which the birthday occurs.*

Premiums are payable through payroll deductions during the current month of coverage (Prior to January 1, 2021, premiums were payable in advance through payroll deductions for each month of coverage).

Some Examples

1. If you are age 39 and are purchasing $40,000 of Life Insurance coverage (See Schedule 4 under previous “Benefit Amount” heading), your monthly contribution is $2.28. That is:

$40,000 ÷ each $1,000 of insurance = 40.
40 x $0.057 (age 39 rate from previous “Active Employee Contribution Table”) =$2.28

2. If on July 12, 2022 you will be age 40, your monthly contribution for $40,000 of Life Insurance coverage will increase from $2.28 to $3.00 as of August 1. That is:

$40,000 ÷ each $1,000 of insurance = 40.
40 x $0.075 (age 40 rate from previous “Active Employee Contribution Table”) = $3.00

3. If you are age 54 and are purchasing $40,000 of Life Insurance coverage (See Schedule 4 under previous “Benefit Amount” heading), your monthly contribution is $6.88. That is:

$40,000 ÷ each $1,000 of insurance = 40.
40 x $0.172 (age 54 rate from previous “Active Employee Contribution Table”) = $6.88

4. If on July 15, 2022 you will be age 55, your monthly contribution for $40,000 of Life Insurance coverage will increase from $6.88 to $12.88 as of August 1. That is:

$40,000 ÷ each $1,000 of insurance = 40.
40 x $0.322 (age 55 rate from previous “Active Employee Contribution Table”) = $12.88

Changing Coverage Amounts

You may change your Optional Group Life Insurance amount if you choose. Your change in coverage will take effect as shown here:

If you elect to:	The change will take effect:
Change or increase your coverage amount because you have married or acquired a child or children by birth or adoption during the 31-day period preceding enrollment for increased coverage	During the 31-day period immediately prior to such enrollment, coverage up to $250,000 ($200,000 prior to January 1, 2021) is effective the 1st of the month following your request of the family change. If you apply for an amount greater than $250,000 ($200,000 prior to January 1, 2021), evidence of good health is required. If evidence of good health is approved, coverage above $250,000 ($200,000 prior to January 1, 2021) will begin on the first day of the month following the date the insurer approves such evidence. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.
Increase your coverage amount for any reason other than: 1. A family change as described above, or 2. Open enrollment	Evidence of good health is required for all coverage. Once you have provided your satisfactory evidence of good health, coverage is effective the first day of the month after the insurer approves that evidence. You must be actively at work on that date, otherwise on the first day worked thereafter.
Decrease your coverage	First day of the month after the last month for which you made required contributions for coverage at the higher amount, whether or not you are actively at work on that day.
Increase your coverage amount during Open Enrollment	If you enroll during Open Enrollment, coverage is effective (1) for guaranteed coverage amounts (coverage amounts as specified in the open enrollment where evidence of good health is not required), the 1st of the month following enrollment, or (2) for amounts requiring evidence of good health, the first of the month following the date the insurer approves coverage. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.

Coverage Continuation

If you cease active employment, payroll deductions will be discontinued and you must make your premium contributions directly to the insurer to continue coverage. If you do not make premium contributions, your coverage will terminate. **You must continue to pay for coverage of your Company-paid life insurance in order to continue coverage under the optional program. Contact MetLife at 1-833-552-FORD (3673) for payment arrangements. Prior to January 1, 2021, contact UniCare at 1-800-843-8184.**

Naming a Beneficiary

You may name a beneficiary you want to receive your Optional Group Life Insurance. You have the right to name the beneficiary of your choice — and to change that beneficiary at any time by notifying the insurer. It is important to name a beneficiary for Optional Group Life Insurance even though you want the beneficiary to be the same as the beneficiary you have named for your Company-paid Basic Life Insurance.

Your beneficiary will be the last designation indicated on the insurer's records. When the insurer receives notice of a beneficiary change, the change takes effect on the date the notice was signed even though the insurer may receive the notice of change after your death. If the insurer makes a payment on account of your death before receiving the notice of change, however, the insurer will not be liable for another benefit payment.

If your last-named beneficiary dies before you do, or if no beneficiary designation is in effect at your death, your insurance will be paid, in this order, to:

- Your surviving spouse
- Your surviving children (divided equally among them)
- Your surviving mother or father (or to both equally)
- Your siblings (divided equally among them)

If there are no such survivors, your insurance will be paid to the executor or administrator of your estate.

Be sure to update your beneficiary designation on file with the insurer. If you do not, your benefit could be delayed or paid to someone other than the person you want to receive the benefit. Remember to update your beneficiary designations on both your Company-paid and Optional Group Life Insurance.

How Benefits Are Paid

The Optional Group Life Insurance may be paid as soon as satisfactory proof of your death is submitted to the insurer. If $5,000 ($10,000 prior to January 1, 2021) or more is payable to a beneficiary, the full amount will be deposited into an interest-bearing account established by the insurer on the beneficiary's behalf, unless the beneficiary requests payment by check. Additional information about the interest-bearing account option will be provided to your beneficiary(ies) in the event of your death, including options to use a debit card, mobile payment app, or transfer into a bank account. Amounts less than $5,000 ($10,000 prior to January 1, 2021) are always paid in one lump-sum check.

Accelerated Benefits for Terminal Illness

The Accelerated Benefits provision is provided for terminally ill employees insured under the Optional Group Life Insurance Program. A terminal illness is one in which life expectancy is less than 12 months.

A terminally ill employee or his or her legal representative may request a one-time lump sum payment of up to 80% of his or her Optional Group Life Insurance amount in advance of his or her death by submitting the request for such payment to the insurer. The combined accelerated benefit amounts under Basic and Optional Group Life Insurance may not exceed $600,000. The insurer will determine if the benefit is payable.

The Accelerated Benefits provision is not available if the employee has irrevocably assigned Group Life benefits under the program, unless the insurer receives written consent from the beneficiary.

The amount of coverage that remains in force will be reduced by the amount paid out under the Accelerated Benefits provision. The amount of Optional Group Life Insurance that may be converted in accordance with the Conversion Privilege provision of the program will be reduced by the amount of accelerated benefit paid.

Assignment

Optional Group Life Insurance may be assigned if the assignment is made by you in writing and the insurer consents in writing.

Dependent Group Life Insurance

You may buy Dependent Group Life Insurance coverage, if you wish, to cover your spouse and unmarried dependent children. If your covered spouse or dependent dies from any cause, a benefit will be paid to you.

Eligibility

You are eligible for Dependent Group Life Insurance on the first day of the month following the month you:

- Are employed
- Are insured for Life Insurance under the Life and Disability Insurance Program
- Have at least one "eligible dependent," as defined by the Plan

If you enroll within the 60-day period (31-day period prior to January 1, 2021) following your eligibility date, you will not have to provide evidence of good health for your spouse's coverage up to $100,000 ($75,000 prior to January 1, 2021) or your child's coverage up to $40,000 ($30,000 prior to January 1, 2021).

Eligible Dependents

For purposes of Dependent Group Life Insurance benefits, your eligible dependents are your spouse and unmarried dependent children over 14 days of age. Dependent children include:

- Your children by birth, legal adoption or legal guardianship while they legally reside with and are dependent on you
- Your spouse's children who are:
  - In your spouse's custody
  - Dependent on your spouse
  - Residing with you
- Children as defined previously who do not reside with you but are your legal responsibility for the provision of health care
- Children who reside with and are related to you by blood or marriage — for whom you provide principal support as defined by the Internal Revenue Code and who:
  - Were reported as dependents on your most recent income tax return
  - Qualify in the current year for dependency tax status

Children are included until the end of the calendar year in which they reach age 26. Children will be covered, however, regardless of age if they are totally and permanently disabled, provided that after the end of the calendar year a child reaches age 19, that child:

- Is dependent on you according to the Internal Revenue Code
- Legally resides with you and is a member of your household
- Your child is "totally and permanently" disabled as long as the disability:
  - Is a medically determinable physical or mental condition
  - Keeps your child from engaging in substantial gainful activity
  - Is expected to result in death or to be of long-continued or indefinite duration

If your spouse is eligible for this coverage, only one of you may enroll your children as dependents.

When Coverage Begins

Your dependents' insurance coverage will take effect:

If you enroll:	Coverage will begin on this date:
On or before the day you are eligible for Dependent Group Life Insurance	First day of the month following your hire or rehire date for coverage up to $100,000/$40,000 ($75,000/$30,000 prior to January 1, 2021). If applying for an amount greater than $100,000/$40,000 ($75,000/$30,000 prior to January 1, 2021), evidence of good health is required. If evidence of good health is approved, coverage above $100,000/$40,000 ($75,000/$30,000 prior to January 1, 2021) will begin on the first day of the month following the date the insurer approves such evidence. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.
During the 60-day period (31 days prior to January 1, 2021) after your dependent eligibility date	First day of the month following your enrollment for coverage up to $100,000/$40,000 ($75,000/$30,000 prior to January 1, 2021). If applying for an amount greater than $100,000/$40,000 ($75,000/$30,000 prior to January 1, 2021), evidence of good health is required. If evidence of good health is approved, coverage above $100,000/$40,000 ($75,000/$30,000 prior to January 1, 2021) will begin on the first day of the month following the date the insurer approves such evidence. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.
After the 60th day (31 days prior to January 1, 2021) following your dependent eligibility date	Evidence of good health is required for any coverage amount. Once you have provided satisfactory evidence of your dependent's good health, coverage is effective the first day of the month after the insurer approves the evidence of good health; provided you are actively at work on that date, otherwise on the first day worked thereafter.
During Open Enrollment	First of the month following the enrollment for guaranteed coverage amounts (coverage where evidence of good health is not required) or for amounts requiring evidence of good health, the first of the month following the date the insurer approves the evidence of good health. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.
If you change or increase your coverage amount because you have married or acquired a child or children by birth or adoption during the 31-day period preceding enrollment for increased coverage	Once the family change has taken place during the 31-day period immediately prior to such enrollment, coverage up to $100,000/$40,000 ($75,000/$30,000 prior to January 1, 2021) is effective the first of the month following receipt of your request. If you apply for an amount greater than $100,000/$40,000 ($75,000/$30,000 prior to January 1, 2021), evidence of good health is required. If evidence of good health is approved, coverage above $100,000/$40,000 ($75,000/$30,000 prior to January 1, 2021) will begin on the first day of the month following the date the insurer approves such evidence. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.

Benefit Amount

As an active employee, you have fourteen levels of dependent coverage to choose from:

	Your Spouse	Each Child
Option I	$ 5,000	$ 2,000
Option II	$ 10,000	$ 4,000
Option III	$ 15,000	$ 6,000
Option IV	$ 20,000	$ 8,000
Option V	$ 25,000	$10,000
Option VI	$ 30,000	$12,000
Option VII	$ 35,000	$14,000
Option VIII	$ 40,000	$16,000
Option IX	$ 50,000	$20,000
Option X	$ 60,000	$24,000
Option XI	$ 75,000	$30,000
Option XII	$100,000	$40,000
Option XIII	$125,000	$50,000
Option XIV	$150,000	$60,000

Contributions

Dependent Group Life Insurance is voluntary. If you enroll for this coverage, you will have to pay a monthly premium. Regardless of the number of dependents you have, your premium is based on your age and the amount of coverage you select.

Premiums are payable through payroll deductions during the current month of coverage (prior to January 1, 2021, premiums were payable in advance through payroll deductions for each month of coverage).

Following are the monthly rates for Dependents of Employees and Surviving Spouses of Deceased Employees or Retirees. The rates are subject to change, if necessary, by mutual agreement between the Company and the Union:

Monthly Rates per $1,000 of Dependent Life Insurance (Effective 1-1-2020)

Employee's Age	Dependents of Employees	Dependents of Retirees and Surviving Spouse of Deceased Employee or Retiree
Less than 30	$ .051	$ .074
30–34	$ .068	$ .095
35–39	$ .077	$ .119
40–44	$ .085	$ .166
45–49	$ .128	$ .238
50–54	$ .196	$ .363
55–59	$ .366	$ .575
60–64	$ .561	$ .830
65–69	$1.080	$1.384
70–74	$1.751	$2.185*
75–79	$2.531	$3.165**
80–84	$3.480	$4.345**
85–89	$4.580	$5.724**
90–94	$5.907	$7.376**
95 & over	$7.735	$9.662**

**For dependents of retirees and surviving spouses of deceased employees and retirees, maximum coverage is 75% of scheduled insurance amount in force on last day the employee or retiree worked. No further coverage reductions will occur on and after January 1, 2021.*

***For dependents of retirees and surviving spouses of deceased employees and retirees, maximum coverage is 37.5% of scheduled insurance amount on last day the employee or retiree worked. No further coverage reductions will occur on and after January 1, 2021*

Changing Coverage Amounts

You may change your Dependent Group Life Insurance amounts if you choose. Your change in coverage will take effect as shown here:

If you elect to:	The change will take effect:
Increase your dependents' coverage amounts (later than 31 days following the dependents' eligibility date)	• Evidence of good health is required for any coverage amount. Once you have provided satisfactory evidence of your dependents' good health, coverage will begin the first day of the month after the insurer approves that evidence. You must be actively at work on that date for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.
Decrease your dependents' coverage amounts	• First day of the month after the last month for which you made required contributions for coverage at the higher amount, whether or not you are actively at work on that day.
During Open Enrollment	• First of the month following the enrollment period for guaranteed coverage amounts (coverage where evidence of good health is not required) or, for amounts requiring evidence of good health, the first of the month following the date the insurer approves the evidence of good health. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.

Coverage Continuation

If you cease active employment, payroll deductions will be discontinued, and you must make your premium contributions directly to the insurer to continue coverage. If you do not make premium contributions, your dependent coverage will terminate. It is your responsibility to make the requirement payments. Contact MetLife at 1-833-552-FORD (3673) for payment arrangements. Prior to January 1, 2021, contact UniCare at 1-800-843-8184.

Coverage may continue for a variety of reasons, including:

- A surviving spouse of an employee who, at the time of death, was enrolled for dependent coverage may continue coverage for themselves and the eligible enrolled dependents by notifying the insurer and paying the required premium within 31 days of the employee's death. The required premium will be based on the age of the surviving spouse. The amount of coverage may not exceed the amount in force at the time of the employee's death but may be decreased.
- Continuation of coverage for dependents shall terminate automatically at the earliest of the date of expiration of the period to which the last premium payment made is applicable or the date immediately preceding the date a dependent ceases to qualify as a dependent.
- If a spouse is insured as an employee under the Optional Group Life Insurance Plan and as a dependent under the Dependent Group Life Insurance Plan, the surviving employee has the option to continue coverage as either an employee or a surviving spouse, but not both.

Beneficiary

You are your covered dependents' beneficiary for purposes of Dependent Group Life Insurance.

How Benefits Are Paid

Death

The insurance will be paid to you in a lump sum as soon as satisfactory proof of your dependent's death is submitted to the insurer.

The amount of Dependent Group Life Insurance paid will be reduced by the amount of the Dependent Group Life Insurance paid out under the Accelerated Benefits provision (see "Accelerated Benefits for Terminal Illness").

Accelerated Benefits for Terminal Illness

The Accelerated Benefits provision is provided for terminally ill spouses insured under the Dependent Group Life Insurance Program. (The Accelerated Benefits provision is not available for children). A terminal illness is one in which life expectancy is less than 12 months. A terminally ill spouse or their legal representative may request a one-time lump sum payment of up to 80% of their Dependent Group Life Insurance amount in advance of their death by submitting a request for such payment to the insurer. The insurer will determine if the benefit is payable. The Accelerated Benefits provision is not an option for insured dependent children.

The Accelerated Benefits provision is not available if dependent death benefits have been irrevocably assigned under the program, unless the insurer receives written consent from the beneficiary.

The amount of coverage that remains in force will be reduced by the amount paid out under the Accelerated Benefits provision. The amount of Dependent Group Life Insurance that may be converted in accordance with the Conversion Privilege provision of the program will be reduced by the amount of accelerated benefit paid.

Optional Accident Insurance

Optional Accident Insurance Benefits (Employee-Paid coverage) are benefits you may choose to purchase for coverage that will be paid in addition to the Accident Insurance coverage that is paid for by the Company. Benefits apply if you suffer certain dismemberments or die as a result of an accident.

Eligibility

You are eligible for Optional Accident (Employee Paid) Insurance on the first day of the month following the month of employment, providing you are insured for Company-paid Life Insurance under the Group Life and Disability Insurance Program.

You may purchase this benefit for yourself (Employee Coverage), or your spouse and eligible dependents (Family Coverage).

When Coverage Begins

Your Optional Accident Insurance coverage will take effect:

If you enroll:	Coverage will begin on this date:
On or before the day you are eligible for Optional Accident Insurance	First day of the month following your eligibility date
After your eligibility date	The first day of the next month following the date of enrollment or change

For the insurance to become effective, you must be actively at work on the date the insurance would otherwise become effective, otherwise, coverage is effective on the first day worked thereafter.

Amount of Insurance

Coverage must be purchased in units of $10,000. You 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 $500,000.

Loss of Life or a Bodily Injury

If you sustain an accidental bodily injury that results in one of the following losses within 365 days of the accident, the following schedule applies:

*Loss	Amount of Accident Insurance
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 the 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 of the Principal Sum
Loss of the entire sight of one eye	One-Half of the Principal Sum
Loss of speech or hearing	One-Half of the Principal Sum
Loss of thumb and index finger (of the same hand)	One-Quarter of the Principal Sum

Loss of a hand or foot* *means loss by severance at or above the wrist or ankle joint; and* ***Loss of sight* *means permanent and uncorrectable loss of sight in the eye.* ***Loss of speech*** *means the entire and irrecoverable loss of speech following the accidental injury.* ***Loss of hearing*** *means the entire and irrecoverable loss of hearing in both ears following the accidental injury.* ***Loss of thumb and index finger of same hand*** *means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.*

If you elect Family Coverage, both you and eligible family members are insured; your spouse is covered for an amount equal to fifty percent (50%) of your coverage and each other eligible dependent is covered for ten percent (10%) of your coverage.

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

Paralysis Benefits

If you sustain an accidental bodily injury that results in permanent paralysis* within 365 days of the accident, the following schedule applies:

Quadriplegia	The Principal Sum
Paraplegia/Triplegia	Three-Quarters of the Principal Sum
Hemiplegia/Uniplegia	One-Half of the Principal Sum

***Paralysis** means loss of use of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible.*

If you elect Family Coverage, your spouse is covered for an amount equal to fifty percent (50%) of your coverage and each other eligible dependent is covered for ten percent (10%) of your coverage.

If you sustain an accidental bodily injury that results in a permanent paralysis within 365 days of the accident and less than the Principal Sum is payable by reason of such loss and you thereafter suffer a greater loss as a result of the same accidental bodily injury within such 365-day period following the accident, the excess benefit amount will be payable.

Comatose Benefit

If you sustain an accidental bodily injury that results in lapse into a comatose* state within 365 days of the accident, a benefit equal to one percent (1%) of the difference between the Principal Sum and amounts paid for any other losses in that same accident, shall be payable on the 32nd day of the coma and each month thereafter for a maximum of 100 months, or until death, if earlier, at which time any additional Optional Accident Insurance benefit for loss of life would be paid. If you regain consciousness, benefits shall cease and coverage for Optional Accident Insurance would resume only upon re-enrollment and payment of premiums.

***Comatose** means a state of deep and total unconsciousness from which the person cannot be aroused. Such state must begin within 365 days of the accidental injury and continue for 31 consecutive days.*

If you elect Family Coverage, your spouse is covered for an amount equal to fifty percent (50%) of your coverage and each other eligible dependent is covered for ten percent (10%) of your coverage.

Special Education Benefit

If you or your spouse dies as a result of a covered accident, an additional benefit in the amount of up to six percent (6%) of the Principal Sum or $7,000, whichever is less will be paid for each eligible dependent child enrolled within 365 days of your death as a full-time student in an accredited college or university.

This benefit is payable annually for a maximum of four consecutive years, provided the eligible child consecutively continues his/her education as a full-time student. The insurer may require proof of the child's continued enrollment as a full-time student during the period for which a benefit is claimed. No payment will be made for room, board, or other living, traveling, or clothing expenses.

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

Special Child Care Center Benefit

Upon the death of you or your insured spouse from a covered accident, the beneficiary will receive an additional benefit in an amount up to six percent (6%) of the Principal Sum (subject to a maximum of $7,000 per year) for up to four years for each eligible dependent child under the age of 13 enrolled (or who becomes enrolled within 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 employee's beneficiary.

Spousal Occupational Training Expense

If you die 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 he/she would not have sufficient qualification otherwise, will be reimbursed for expenses actually incurred up to 6% of the Principal Sum (subject to a maximum of $7,000 per year) for a period of up to three (3) academic years.

To be reimbursed, such expenses must be reasonable and necessary and must be incurred within three (3) years of the date of the death. No payment will be made for room, board, or other living, traveling, or clothing expenses.

Common Disaster Benefit

If you and your spouse suffer a loss of life in the same covered accident, or separate covered accidents which occur within one year (within 48 hours prior to January 1, 2021) of each other (common disaster), the amount payable by reason of your spouse's death will equal the amount payable by reason of your death. The common disaster benefit for you and your insured spouse will not exceed $1,000,000.

Repatriation Benefit

If an insured employee or, if Family Coverage is elected, a covered spouse or dependent child, sustains a loss of life as a direct result of a covered accident, both the accident and death occurring at a distance of 100 miles or more from the deceased person's principal residence, reimbursement up to a maximum benefit of $5,000 will be made for the expenses incurred for preparation of the body and its transportation to the city of his/her principal residence.

Seat Belt Benefit

If you or, if Family Coverage is elected, your covered spouse or an eligible dependent dies as a result of an automobile accident while wearing a qualified passenger restraint, up to $10,000 or 10% of the Principal sum, whichever is less, is payable for each member whose life is lost.

Seat Belt means any restraint device that:

- Meets published United States Government safety standards;
- Is properly installed by the car manufacturer; and
- Is not altered after the installation.

The term includes any child restraint device that meets the requirements of state law.

Passenger Car means a private passenger land motor vehicle of pleasure design. Passenger Car includes:

- Vans, four-wheel drive vehicles, self-propelled motor homes and trucks with a factory-rated load capacity of 2,000 pounds or less but excludes custom-fabricated specialty vehicles. A Passenger Car does not include any vehicle used for farming, commercial business, military business, racing or any type of competitive speed event

Exclusions

The policy doesn't cover loss caused or contributed by:

- Physical illness or infirmity, unless the physical illness or infirmity merely hastened the occurrence of a loss caused by the accident;
- The diagnosis or treatment of a physical illness or infirmity unless the diagnosis or treatment of a physical illness or infirmity merely hastened the occurrence of a loss caused by the accident;
- Infection;
    - Unless an infection merely hastened the occurrence of a loss caused by the accident; or
    - An infection occurring in an external accidental wound.

In addition to the exclusions above, the insurer will not pay benefits under this section for any loss caused or contributed to by:

- Medical malpractice or other medical errors;
- Mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Service on full-time active duty in the Armed Forces of any country or international authority except short periods or training or participation in public ceremonies while You are a member of an Organized Reserve Corps or National Guard Unit (any contributions made by You for coverage during such period of active duty will be returned to You);
- Any incident related to:
    - Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
    - Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
    - Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
    - Travel in an aircraft or device used:
        - For testing or experimental purposes;
        - By or for any military authority; or
        - For travel or designed for travel beyond the earth's atmosphere;
- Committing or attempting to commit a felony;
- The voluntary intake or use by any means of any drug, medication or sedative, unless it is:
    - Taken or used as prescribed by a Physician; or
    - An "over the counter" drug, medication or sedative taken as directed;
    - Alcohol in combination with any drug, medication, or sedative; or
    - Poison, gas, or fumes
- War, whether declared or undeclared; or act of war, insurrection, rebellion or active participation in a riot.

Coverage Continuation

If an employee's coverage ends due to their death, a covered spouse may continue coverage for themselves and dependent children by paying the required premium.

For enrolled survivors, coverage is provided at no cost for the first 12 months from the date of the employee's death.

The elected coverage for the surviving spouse may be continued until age 65, at which time they will be allowed to convert coverage to the Retiree Plan. Eligible dependents enrolled at the time of conversion to the Retiree Plan may also be covered, provided they continue to meet eligibility requirements and pay the applicable premium.

Coverage will terminate if the spouse remarries or for non-payment of the required premium.

Changing Coverage Amounts

You may change your Optional Accident Insurance amount if you choose. Your change in coverage will take effect as shown here:

If you elect to:	The change will take effect:
Increase your coverage amount	The first day of the month following the date of change, provided you are actively at work on that date, otherwise on the first day worked thereafter
Decrease your coverage amount	First day of the month after the last month for which you made required contributions for coverage at the higher amount whether or not you are actively at work on that day

Contributions

Optional Accident Insurance is voluntary. If you enroll for this coverage, you will have to pay a monthly premium in advance. The following rates are subject to change, if necessary, by mutual agreement between the Company and the Union:

- The required monthly contribution for each $10,000 is $0.35 for Employee Coverage and $0.59 for Family Coverage.
- Premiums are payable through payroll deductions during each month of coverage (Prior to January 1, 2021, premiums were payable in advance through payroll deductions for each month of coverage).
- If you cease active employment, payroll deductions will be discontinued and you must make your premium contributions directly to the insurer to continue coverage.

  If you do not make premium contributions, your coverage will terminate. Contact MetLife at 1-833-552-FORD (3673) for payment arrangements. Prior to January 1, 2021, contact UniCare at 1-800-843-8184.

Some Examples

1. You want $40,000 of Employee Coverage; your monthly contribution would be $1.40. That is:

   $40,000 ÷ $10,000 = 4
   4 x $0.35 = $1.40

2. You want $150,000 of Family Coverage; your monthly contribution would be $8.85. That is:

   $150,000 ÷ $10,000 = 15
   15 x $0.59 = $8.85

Eligible Dependents for Family Coverage

For purposes of Optional Accident Insurance benefits, your eligible dependents are your spouse and unmarried dependent children. Dependent children include:

- Your children by birth, legal adoption or legal guardianship — while they legally reside with and are dependent on you
- Your spouse's children who are:
  - In your spouse's or partner's custody
  - Dependent on your spouse or partner
  - Residing with you
- Children as defined above who do not reside with you but are your legal responsibility for the provision of health care
- Children who reside with and are related to you by blood or marriage — for whom you provide principal support as defined by the Internal Revenue Code and who:
  - Were reported as dependents on your most recent income tax return
  - Qualify in the current year for dependency tax status

Children are included until the end of the calendar year in which they reach age 26. Children will be covered, however, regardless of age if they are totally and permanently disabled, provided that after the end of the calendar year a child reaches age 19, that child:

- Is dependent on you according to the Internal Revenue Code
- Legally resides with you and is a member of your household

Your child is "totally and permanently disabled" as long as the disability:

- Is a medically determinable physical or mental condition
- Keeps your child from engaging in substantial gainful activity
- Is expected to result in death or to be of long-continued or indefinite duration

If your spouse is also eligible for this coverage, only one of you may enroll your children as dependents.

Beneficiary and Benefit Payment

If you die as a result of accidental death while insured for Optional Accident Insurance, the amount of the insurance in force will be paid to the person or persons you designated as beneficiary.

Your beneficiary will be the last designation indicated on the insurer's records. If the insurer makes a payment on account of your death before receiving the notice of change, however, the insurer will not be liable for another benefit payment. When the insurer receives notice of a beneficiary change, the change takes effect on the date the notice was signed even though the insurer may receive the notice of change after your death.

If your last-named beneficiary dies before you do, or if no beneficiary designation is in effect at your death, your Optional Accident insurance will be paid, in this order, to:

- Your surviving spouse
- Your surviving children (divided equally among them)
- Your surviving mother or father (or to both equally)
- Your siblings (divided equally among them)

If there are no such survivors, your insurance will be paid to the executor or administrator of your estate.

If your covered spouse or other covered dependent suffers a covered dismemberment or dies as a result of an accident while insured for Optional Accident Insurance, the amount of such insurance in force on account of the dependent shall be paid in a lump sum to you (the employee is the beneficiary for Optional Accident Insurance). Your insurance certificate shall set forth the procedure for payment of insurance in case a covered dependent dies after your death.

Claims and Appeals (On or after January 1, 2021)

Claims for Life Insurance Benefits

When there has been the death of an insured person, notify the insurer by calling 1-833-552-FORD (3673). This notice should be given to the insurer as soon as is reasonably possible after the death. The claim form will be sent to the beneficiary or beneficiaries of record.

The beneficiary or beneficiaries should complete the claim form and send it and proof of the death to the insurer as instructed on the claim form. When the insurer receives the claim form and proof, the insurer will review the claim and, if the insurer approves it, the insurer will pay benefits subject to the terms and provisions of this certificate and the group policy. The benefit amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time the insurer makes payment.

Claims for AD&D Insurance Benefits and Optional Accident Insurance Benefits

When there has been a covered loss, notify the insurer by calling 1-833-552-FORD (3673). This notice should be given to the insurer as soon as is reasonably possible, but in any case, within 20 days of the covered loss. The claim form will be sent to you or the beneficiary or beneficiaries of record.

The claim form should be completed and sent along with proof of the covered loss to the insurer as instructed on the claim form. If you or the beneficiary have not received a claim form within 15 days of giving notice of the claim, proof may be sent using any form sufficient to provide the insurer with the required proof.

You must give the insurer proof no later than 90 days after the date of the covered loss. If notice of claim or proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice or proof are given as soon as is reasonably possible.

When the insurer receives the claim form and proof, the insurer will review the claim and, if the insurer approves it, the insurer will pay benefits subject to the terms and provisions of this certificate and the Group policy. The benefit amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time the insurer makes payment.

Time Limit on Legal Actions. A legal action on a claim may only be brought against the insurer during a certain period. This period begins 60 days after the date proof is filed and ends three years after the date such proof is required.

Initial Determination

After the insurer receives a claim for Benefits, the insurer will review the claim and notify you of its decision to approve or deny the claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date the insurer received the claim, unless the insurer notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If the insurer denies the claim in whole or in part, the notification of the claims decision will state the reason why the claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because the insurer did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if the claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied, in whole or in part, you can request a review of the claim by the insurer. This request for review should be sent in writing to Group Insurance Claims Review at the address of the insurer's office that processed the claim within 60 days after you received notice of denial of the claim. When requesting a review, you should state the reason you believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you deem appropriate. Upon your written request, the insurer will provide you, free of charge, with copies of relevant documents, records and other information.

The insurer will re-evaluate all the information, will conduct a full and fair review of the claim, and you will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date the insurer received the request for review, unless the insurer notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If the insurer denies the claim on appeal, the insurer will send you a final written decision that states the reason(s) why the appealed claim is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if the claim is denied after an appeal. Upon written request, the insurer will provide you, free of charge, with copies of documents, records and other information relevant to the claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

COVID-19 REGULATORY UPDATE

The DOL, Internal Revenue Service, and Department of the Treasury have announced the extension of certain ERISA and Internal Revenue Code timeframes during the COVID-19 National Emergency. The following COVID relief is available to you.

The earlier of (i) one year from the date you were eligible for the COVID relief or (ii) the time period from March 1, 2020 until 60 days after the end of the National Emergency will not be counted in determining whether any of the below actions are timely:

1. The 31-day period to request special enrollment in a group life plan upon experiencing certain enrollment events (e.g., upon acquisition of a new spouse or dependent by marriage, birth, or adoption).

2. The date for individuals to notify the plan of a qualifying event or determination of disability.

For example, if you received a claim denial letter dated July 10, 2020 and wish to appeal the denial, you will have until January 6, 2021 (180 days from the date of the claim denial) or the date that is 60 days following the end of the COVID-19 Outbreak Period, whichever is later, to submit your appeal.

Claims and Appeals (Prior to January 1, 2021)

Before you or your beneficiary can receive benefits, you must file a proper claim.

You or your beneficiary should make a claim as soon as possible in the event of death or dismemberment.

To begin the process for a death claim, your family or beneficiary will need to provide copies of the death certificate certified by the governmental unit maintaining the record.

Death certificates usually are kept on file in the Department of Health of the city or county where death occurred. You may contact that office directly to obtain the number of death certificate copies you need. Usually, only certain members of the immediate family may obtain these copies.

The funeral home director might obtain the death certificate copies for your family.

To file a claim for Optional Group Life Insurance, Dependent Group Life Insurance or Optional Accident Insurance Benefits, follow these steps:

1. Contact the insurer:

   UniCare Life & Health Insurance Company
   Dearborn Service Center
   P.O. Box 2090
   Dearborn, MI 48123-2090
   1-800-843-8184

2. Complete the notice of claim form obtained from the insurer. Then return the form and a certified copy of the death certificate to the insurer.

You may receive a form requesting additional information from the insurer. After the insurer receives a claim for benefits, the insurer will review the claim and notify you or, if applicable, your beneficiary of its decision to approve or deny the claim.

You or your beneficiary will receive the written notification within a reasonable period, not to exceed 90 days from the date the insurer received your claim. You or your beneficiary may be notified of a required extension within the original 90-day period if there are special circumstances. The additional review period is also 90 days.

If a claim for benefits is denied in whole or in part, the written notification will include:

1. The specific reason or reasons for the denial;

2. Reference to the specific Plan provision(s) on which the denial is based;

3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and

4. A description of the Plan's review* procedures and the time limits applicable to such procedures, along with a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, if your claim is denied after an appeal.

**To request a review (appeal) of a claim decision, you or your beneficiary must submit your request in writing to the insurer within 60 days after you receive the insurer's decision. You will receive a determination within 60 days after the insurer receives your appeal. Such requests should be submitted to the address of the insurer indicated in the Summary of Administrative Information at the end of this section.*

Note: For Optional Life claims and appeals information after 2020, see "Claims and Appeals (On or after January 1, 2021)" in the Life Insurance section.

Employee Status Changes

If you stop working, are away from work or your employment status changes to an ineligible status, your Company-provided Basic Life Insurance coverage will be affected, resulting in an impact to your optional insurance coverages.

Depending on the reason you stop working, the Company may pay for certain coverages for you or may allow you to continue certain coverages under the Group Life & Disability Insurance Program. You or your dependents, upon loss of coverage, may be eligible to apply to continue coverage outside of the Ford Group Program.

Converting to an Individual Policy

If you leave the Company or no longer are eligible for coverage, you can convert Optional Group Life and Dependent Group Life within 31 days of the time coverage ends to any individual life insurance policy then customarily issued by the insurer except term insurance. This is done by making application and paying the required premium to the insurer. The maximum amount of the individual policy will be equal to the amount of your life insurance in force when you left the Company.

If you or a covered dependent dies within 31 days after your life insurance ends, proof of your death must be sent to the insurer. When the insurer receives such proof with the claim, the insurer will review the claim and if they approve it will pay the beneficiary. The amount the insurer will pay is the amount you were entitled to convert. The amount you were entitled to convert will not be paid as insurance under both a new individual conversion policy and the Group Policy.

Optional Accident Insurance is not convertible to an individual policy.

Employment Termination

If you terminate employment by quitting or being discharged, all coverage terminates as of the date you quit or are discharged. If, however, you have a grievance pending to protest your loss of seniority, you may continue all coverage up to two months following the month of discharge.

Layoff

To continue any optional coverages during layoff, you must make your premium payments directly to the insurer. You may continue optional coverages for the length of time you are eligible to receive Company-Paid Basic Life Insurance.

Your Company-Paid Basic Life Insurance will continue for one month after the month in which you are laid off. In addition, Company-Paid Basic Life Insurance is provided for a laid-off employee during a layoff meeting the conditions of Article I, Section 3 of the Supplemental Unemployment Benefits Plan. For layoffs meeting those requirements, Company-Paid Life Insurance will continue for up to 24 months, based on your years of seniority on your last day of work before layoff (or the date placed on layoff if you are a returning veteran) according to this table:

If your year(s) of seniority on the last day worked before layoff were:	Coverage will be provided for up to this number of months at no cost to you:
Less than 1	0
1 but less than 2	2
2 but less than 3	4
3 but less than 4	6
4 but less than 5	8
5 but less than 6	**10**
6 but less than 10	12
10 and over	24

If you remain on layoff beyond the period of time for which Company-Paid Basic Life Insurance coverage is provided at no cost, you may continue coverage for up to an additional 12 months. To do so, you will be required to make monthly contributions to the insurer. The contribution amount is based on your base hourly rate and your level of coverage at the time your employment terminated. You may also continue your optional coverages during that 12-month period.

Medical Leave of Absence

If you cease active work because of a disability, you may continue any optional coverages for as long as you are eligible for Company-Paid Basic Life Insurance. You must make your premium payments directly to the insurer.

Non-medical Leave of Absence

If you go on an approved non-medical leave of absence (except while serving as International Union Representative), your Company-Paid Basic Life Insurance will continue for the first full month of your leave. You may continue coverage beyond that time up to the end of your approved leave by making monthly contributions. To continue any optional coverages during a leave, you must make your premium payments directly to the insurer.

If you go on an approved Union Leave of Absence while serving as an International Union Representative, you may continue your Company-Paid Basic Life Insurance by making monthly contributions. To continue any optional coverages during a leave, you must make your premium payments directly to the insurer.

Contributions for Coverage

Monthly contributions are due on the first day of each month for that month's coverage. Payment will be accepted anytime within that month. Late payments are not acceptable and can result in permanent termination of your coverage. If your premiums are not collected through payroll deduction, you must make payments directly to the insurer:

Effective January 1, 2021:

MetLife
P.O. BOX 13724
Philadelphia, PA 19101-3724
1-833-552-FORD (3673)

Prior to January 1, 2021:

UniCare Life & Health Insurance Company
Dearborn Service Center
P.O. Box 2090
Dearborn, MI 48123
1-800-843-8184

Making timely premium payments is your responsibility. Contact MetLife at 1-833-552-FORD (3673) for payment arrangements. Prior to January 1, 2021, contact UniCare at 1-800-843-8184.

When Coverage Ends

Coverage will end when you or your dependents are no longer eligible for coverage under the Program. However, certain coverages may be continued.

An employee or dependent may only continue coverage under one continuation of coverage option. Coverage may not be continued simultaneously under the:

1. Dependent Group Life Insurance "Provision of Continuation of Coverage for Survivors of Deceased Employees,"
2. "Conversion Privilege," or
3. "Portability of Coverage Provision"

More information on the continuation of coverage options may be located in the sections referenced above. Conversion and Portability are described in this section. Additionally, continuation of Optional Accident coverage for a surviving spouse is previously referenced in the Optional Accident Insurance section.

Company-paid coverages and employee-paid coverages, including the optional programs under the Group Life and Disability Insurance Program, automatically will end on the earliest of:

- The date the Program terminates;
- The end of the period for which you last made contributions for continuing coverage;
- The end of the month you are transferred within the Company to an ineligible class of employees;
- Unless specifically provided otherwise, the end of the month you stop active work (unless you continue your insurance coverage as described in the *Employment Status Changes* section); or
- The day you quit or are discharged, unless you have a grievance pending to protest your loss of seniority. See the previous *Employment Status Changes* section for more information.

Dependent Group Life ends the date on which the employee dies unless the eligible surviving spouse pays for continuation of coverage as a survivor of a deceased employee or eligible surviving spouse or child elects and pays for coverage under the Portability of Coverage Provision or the Conversion Privilege (see those headings below for more information) Coverage may not be continued simultaneously under these options. (Additionally, the previous Dependent Group Life Insurance section contains information on coverage continuation.)

In the event of your death, Dependent Group Life and Optional Accident Insurance may be continued. Coverage will end automatically on the earliest of the following:

- On the date your dependent ceases to be an "eligible dependent"
- For Optional Accident insurance, on the date your surviving spouse remarries
- On the date of discontinuance of Insurance under the Group Life and Disability Program
- For Optional Accident, after twelve (12) months following the date of your death

Conversion Privilege

If you or your dependents are no longer eligible for coverage, you can convert Optional Group Life and Dependent Group Life within 31 days of the time coverage ends, to any individual Life Insurance policy then customarily issued by the insurer, except for term insurance. This is done by making application and paying the required premium to the insurer. The maximum amount of the individual policy will be equal to the amount of Insurance in force when you left the Company.

Optional Accident is not convertible to an individual policy.

Portability of Coverage Provision

An employee, spouse or child who loses coverage under the Optional Group Life or Dependent Group Life Insurance program may elect Life Insurance under the Insurance Portability Provision without providing Evidence of Insurability. To be eligible for portability coverage, a written application must be submitted to the insurer and payment of the first premium made within 31 days after their insurance under the Optional Group Life or Dependent Group Life Insurance program ends.

Benefits for a child insured under Portability provision may be provided by only one parent, not both.

At the time of porting, you may increase the amount of your portability eligible life insurance for you or a covered dependent. This may be done in increments of $25,000, up to a maximum ported amount of $2,000,000. To be eligible for this increased amount, you must provide evidence of your insurability satisfactory to the insurer, at your expense. If the insurer approves the increase, it will take effect on the date the insurer states the approval in writing (prior to January 1, 2021, the amount of insurance ported under this provision could not exceed the amount of coverage in effect when coverage under the Optional Group Life or Dependent Group Life Insurance program ended; however, coverage could have been for a lesser amount. The amount of insurance under this provision, once elected, could not be increased).

Premium rates for portability are age-banded and will increase with age. Rates are set by the insurer. Insurance under the Portability provision will end on the earliest of:

1. Employee, Surviving Spouse reaches the age limit as specified in the insurance policy
2. Failure to pay an applicable premium when due
3. Insured receives reinstated coverage under the Ford Optional Group Life or Dependent Group Life Insurance Program
4. Child no longer meets the definition of dependent
5. Prior to January 1, 2021, insured enters the Armed Forces, National Guard, or Reserves of any state or country on active duty (except for temporary active duty of two weeks or less) if the insurance policy includes this provision

Optional Accident Insurance is not portable.

Assigning Benefits

You and your beneficiary may assign the death benefit under your Optional Group Life and Accident Insurance by making your assignment in writing with the insurer. Neither you nor your survivors may assign other Optional Accident Insurance benefits.

Certain court orders relating to domestic relations matters could require that your benefits (or a part of your benefits) be paid to someone else — your former spouse or children, for example. This could apply to benefits paid to you as well as to any beneficiary. If the insurer or claims processor determines that the court order qualifies, payments will be made according to the order.

Filing Claims

No benefits can be paid until you or your beneficiary files a claim. If you have questions, contact the insurer, MetLife, at 1-833-552-FORD (3673). For claims prior to January 1, 2021, contact UniCare Life & Health Insurance Company, at 1-800-843-8184.

Incompetence

If a Beneficiary or a payee is a minor or incompetent to receive payment, the insurer will pay that person's guardian.

Any payment made in good faith will discharge the insurer’s liability to the extent of such payment.

Summary of Administrative Information

Optional Life & Accident Insurance Programs under the Group Life and Disability Insurance Program

Name:	Plan Number:	Type of Plan:	Cost Paid By:	Trustee:	Benefits Administered or Insured Through:
Optional Life & Accident Insurance Program	521	Optional Welfare plan offering: • Life Insurance • Dependent Life Insurance • Accident Insurance	Participating Employees	None	Effective January 1, 2021: MetLife P.O. Box 14406 Lexington, KY 40512-4406 **1-833-552-FORD (3673)** Prior to January 1, 2021: UniCare Life & Health Insurance Company P.O. Box 2090 Dearborn, MI 48123-2090 **1-800-843-8184**

Disability Insurance Plan

UAW-Ford Disability Insurance Plan Summary Plan Description, November 2021
For UAW-Ford Represented:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Disability Insurance Plan Overview

The Disability Insurance Plan provides important financial protection for you and your family if you become disabled.

If you become disabled, you have financial protection through the Disability Plan. You may be eligible for:

- **Accident and Sickness (A&S) Benefits** — providing a weekly benefit for up to 52 weeks if you are injured or sick and unable to work
- **Extended Disability Benefits (EDB)** — providing a monthly benefit after A&S Benefits end, if you are totally disabled and unable to work for longer periods of disability

Eligibility and Basic Coverage Details

Eligibility

You are eligible for benefits under the Disability Insurance Plan if you are a full-time employee represented by the UAW under the Collective Bargaining Agreement and in the following classifications:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees:** Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

When Coverage Begins

Your coverages become effective as shown here:

Your Situation	Accident and Sickness (A&S) Benefits and Extended Disability Benefits (EDB)
You are hired or rehired	First day of the sixth month following the date you are employed
You are reinstated	Date of your reinstatement (for any coverage in effect at the time you terminated prior Ford employment)
You are on layoff	If you are on a qualifying layoff, receiving Supplemental Unemployment Benefits (SUB), are eligible for basic life insurance and become disabled, you are automatically eligible for reinstated A&S Benefits
You return from military service	Date of your reinstatement

If you are absent from work due to sickness or injury on the day your coverage ordinarily would start, coverage will begin on the first day you return to active work.

Determination

Your A&S Benefits* and EDB* are based on your base hourly rate on the last day you worked preceding your disability or, if higher, the rate determined in the following section. (This is your base hourly rate before any contributions to the Tax-Efficient Savings Plan for Hourly Employees.) Your base hourly rate does not include shift differentials, overtime, cost-of-living allowance or other extras.

** For A&S Benefits and EDB, if you become disabled again for an old accident or illness without having returned to work for three (3) consecutive months, the benefits will be the amount you would have received under a continuation of your prior claim.*

Certain rules, however, apply:

In this situation:	Your benefits are based on:
You are under an incentive plan	• Your average straight-time hourly earnings (not including shift differentials, overtime, cost-of-living allowance or other extras) during the four pay periods you worked immediately preceding January 1, April 1, July 1 and October 1 **OR** • If higher, the greater of the scheduled amounts applicable to you as described in the "If Your Base Hourly Rate Changes" section on the last two dates on which Coverage Bracket changes took effect, immediately preceding death or disability
You are assigned a lower-rated job because of an occupational injury resulting in a reduction in pay	• Your base hourly rate at the time of injury, while you are at work and receiving weekly Workers' Compensation **OR** • If higher, the greater of the scheduled amounts applicable to you as described in the "If Your Base Hourly Rate Changes" section on the last two dates on which Coverage Bracket changes took effect, immediately preceding death or disability

If Your Base Hourly Rate Changes

The level of your disability benefits coverage changes if a change in your base hourly rate puts you into a new “coverage bracket.”

Specifically:

If you receive a change in pay effective:	You are in a new coverage bracket on:	The change in your coverage will take effect on:
October 2-January 1	January 1	February 1
January 2-April 1	April 1	May 1
April 2-July 1	July 1	August 1
July 2-October 1	October 1	November 1

If you are absent from work due to sickness or injury on the day your change in coverage is due to take effect, the change won’t take effect until the day you return to work.

Your Cost

Under the UAW-Ford Agreement, the Company pays the full cost of your A&S Benefits and EDB coverages for any months you receive pay from the Company.

For certain other months when you are away from work, you may continue coverage beyond the period for which the Company pays the cost by paying a monthly contribution. Refer to the *Additional Information* section for more details.

Accident and Sickness (A&S) Benefits

A&S Benefits can replace a portion of your pay for up to 52 weeks of illness, injury or pregnancy-related disability.

Eligibility

You are eligible for A&S Benefits if:

- You are wholly and continuously disabled by an accidental bodily injury, sickness or pregnancy while covered for A&S Benefits
- You cannot perform all duties of your job
- The claims processor is provided notice and satisfactory proof of your disability on a timely basis
- You are under a physician's care. This requirement will be deemed to have been met if you received treatment from an accredited nurse practitioner (working within applicable State licensing requirements) who provides treatment during your first 14 days of disability. You must seek treatment with a legally licensed physician after the 14th day of disability
- Your disability is medically substantiated by your physician(s). For more information, please refer to "Medical Substantiation (Objective Medical Findings)", later in this section
- You are confined for treatment in an alcohol or substance use disorder facility, as long as the facility is an inpatient residential, day treatment or outpatient substance use disorder and/or mental health treatment facility approved for benefits under the H-S-M-D-D-V Program and medical oversight is compliant, as described below:
    - o The physician-director of the facility, or a physician-consultant selected by the facility, certifies your disability based on information and recommendation furnished by, and upon the recommendation of, a therapy provider who is licensed and accredited to treat substance use disorders
    - o You are receiving treatment by a provider who is licensed and accredited to treat substance use disorders, who is supervising your therapy. For more information, please refer to the "Mental Health and/or Substance Use Disorder Claims" section
    - o You are not engaged in any employment or occupation for remuneration or pay that is the same or similar to your job classification duties and inconsistent with your disability and/or restrictions

Claims Processor

UniCare Life and Health Insurance Company is presently the disability claims processor under an administrative services agreement with the Company.

Benefit Amount

Your weekly A&S Benefits are determined according to your base hourly rate:

Insurance Code	If your base hourly rate is: [1] (Coverage Bracket)	Weekly Accident and Sickness Benefits are:
1J	Up to but less than $14.30	$340
1I	$14.30 but less than $14.65	$345
1H	$14.65 but less than $15.00	$355
1G	$15.00 but less than $15.35	$365
1F	$15.35 but less than $15.70	$375
1E	$15.70 but less than $16.05	$380
1D	$16.05 but less than $16.40	$390
1C	$16.40 but less than $16.75	$400
1B	$16.75 but less than $17.10	$405
1A	$17.10 but less than $17.45	$415
A	$17.45 but less than $17.80	$425
B	$17.80 but less than $18.15	$430
C	$18.15 but less than $18.50	$440
D	$18.50 but less than $18.85	$450
E	$18.85 but less than $19.20	$455
F	$19.20 but less than $19.55	$465
G	$19.55 but less than $19.90	$475
H	$19.90 but less than $20.25	$480
I	$20.25 but less than $20.60	$490
J	$20.60 but less than $20.95	$500
K	$20.95 but less than $21.30	$505
L	$21.30 but less than $21.65	$515
M	$21.65 but less than $22.00	$525
N	$22.00 but less than $22.35	$530
O	$22.35 but less than $22.70	$540
P	$22.70 but less than $23.05	$550
Q	$23.05 but less than $23.40	$555
R	$23.40 but less than $23.75	$565
S	$23.75 but less than $24.10	$575
T	$24.10 but less than $24.45	$585
U	$24.45 but less than $24.80	$590
V	$24.80 but less than $25.15	$600
W	$25.15 but less than $25.50	$610
X	$25.50 but less than $25.85	$615
Y	$25.85 but less than $26.20	$625
Z	$26.20 but less than $26.55	$635
AA	$26.55 but less than $26.90	$640
BB	$26.90 but less than $27.25	$650
CC	$27.25 but less than $27.60	$660

Insurance Code	If your base hourly rate is: [1] (Coverage Bracket)	Weekly Accident and Sickness Benefits are:
DD	$27.60 but less than $27.95	$665
EE	$27.95 but less than $28.30	$675
FF	$28.30 but less than $28.65	$685
GG	$28.65 but less than $29.00	$690
HH	$29.00 but less than $29.35	$700
II	$29.35 but less than $29.70	$710
JJ	$29.70 but less than $30.05	$715
KK	$30.05 but less than $30.40	$725
LL	$30.40 but less than $30.75	$735
MM	$30.75 but less than $31.10	$740
NN	$31.10 but less than $31.45	$750
OO	$31.45 but less than $31.80	$760
PP	$31.80 but less than $32.15	$765
QQ	$32.15 but less than $32.50	$775
RR	$32.50 but less than $32.85	$785
SS	$32.85 but less than $33.20	$795
TT	$33.20 but less than $33.55	$800
UU	$33.55 but less than $33.90	$810
VV	$33.90 but less than $34.25	$820
WW	$34.25 but less than $34.60	$825
XX	$34.60 but less than $34.95	$835
YY	$34.95 but less than $35.30	$845
ZZ	$35.30 but less than $35.65	$850
2A	$35.65 but less than $36.00	$860
2B	$36.00 but less than $36.35	$870
2C	$36.35 but less than $36.70	$875
2D	$36.70 but less than $37.05	$885
2E	$37.05 but less than $37.40	$895
2F	$37.40 but less than $37.75	$900
2G	$37.75 but less than $38.10	$910
2H	$38.10 but less than $38.45	$920
2I	$38.45 but less than $38.80	$925
2J	$38.80 and over	$935

[1] If an employee is under an incentive plan, coverage is based upon average straight time hourly earnings.

If you last worked before November 18, 2019, A&S Benefits are shown in the Collective Bargaining Agreement in effect when you last worked.

If you are absent from work, your A&S Benefits are based on one-fifth of the weekly benefit for each regular workday of disability (where State laws permit).

Special provisions apply to employees at operations utilizing three crew or alternate production schedules. In those instances, the benefit for each regular workday of disability will be an amount calculated in accordance with the agreement with the union for operation of an alternative work schedule at the plant at which the employee works.

If you have less than one year of seniority as a regular full-time employee, your A&S Benefits will be 75% of the weekly benefit amount for periods of disability occurring prior to the date one year of seniority is attained, subject to reduction for other benefits (as described in the *Other Sources of Benefits* section).

When Benefits Begin

If you have an accident, your A&S Benefits begin the first day of disability.

If you are absent from work due to sickness, pregnancy or an accident that occurred more than one year prior to the present disability, benefits begin on the eighth day you are disabled, or on the first day:

- That you are hospitalized at least 18 consecutive hours, whether for observation care, emergency room, inpatient or otherwise, or
- The hospital charges you for room and board, or
- Of treatment for alcohol or substance abuse in a residential facility approved for such treatment, or
- After the day you have an outpatient surgical procedure for which you are entitled to at least $25 in benefits under the H-S-M-D-D-V Program.

Any day you work less than four hours due to your accident or sickness is considered a day of disability.

When Benefits End

For one continuous period of disability, A&S Benefits end when you are able to return to work or after the lesser of:

- 52 weeks
- A period equal in duration to your service (on the date the disability began) since your most recent date of hire or rehire

Regardless of your length of service, your A&S Benefits can continue for up to 52 weeks, if:

- You still are hospitalized for the same disability at the end of this period
- You are receiving lost-time benefits under Workers' Compensation or other laws providing benefits for job-related accidents or sickness — because of your employment. (These do not include benefits for dismemberment.)

Successive Periods of Disability

You may be absent due to the same or related disabilities for several periods of time. Successive periods of absence due to the same or related disabilities are considered one continuous disability unless:

You are employed in:	And, before another absence:
California or New Jersey	You are back to work for 2 or more consecutive weeks
All Other Locations	You are back to work for 3 consecutive months or more

You will be considered to have returned to work if you work four or more hours on each working day (where State laws permit).

If a new illness or accident disables you after you have returned to work, you can make a new claim for benefits. You can also make a new claim for benefits if an old accident or illness disables you again after your return to work, as described above.

If you become disabled again for an old accident or illness without having returned to work for three consecutive months or more, the benefits will be the amount you would have received under a continuation of the prior claim.

Other Sources of Benefits

Your A&S Benefits may be affected by other benefits you receive:

If You Are Receiving:	Effect on Your Accident and Sickness (A&S) Benefits:
Unemployment Compensation	You are not entitled to A&S Benefits while: • You are eligible for unemployment benefits under any unemployment compensation law • You are entitled to unemployment benefits, but rejected or waived your right to receive them
Workers' Compensation	Your A&S Benefits are reduced by the amount of any lost-time Workers' Compensation benefits to which you are entitled. A&S Benefits are not payable for an occupational disability if you have waived your rights to Workers' Compensation benefits. Your A&S Benefits will not be reduced if you are receiving Workers' Compensation for: • A dismemberment • The 100% loss of use of a body member • A work-related, permanent partial disability unrelated to the disability for which you are applying for benefits
Social Security	A&S Benefits will be reduced by the weekly equivalent (one monthly benefit equals 4.33 weekly benefits) of any disability benefit or old-age (retirement) benefit (except for Social Security old-age benefits reduced because of age) and payable for the same period of disability. Any benefits paid to you prior to a Social Security determination, which are later determined not to be payable because of Social Security award, are an overpayment which must be repaid. If not repaid within 30 days, future A&S Benefits (and EDB if necessary) will be suspended until the overpayment is recovered.
California State Disability Compensation	A&S Benefits will be reduced by State Unemployment Compensation Disability Benefits for which you are eligible — whether or not you have rejected or waived your rights to those benefits.
New York and New Jersey State Disability Benefits	A&S Benefits are at least equal to the benefits required by State Law.
Holiday pay or other pay received from the Company	A&S Benefits are not payable for any day you are entitled to holiday pay or receive pay for at least a regular work day (defined as 8 hours or the hours you are scheduled to work under an alternate work schedule). If you receive pay for less than a regular work day (as defined above), the total of the pay you receive and the disability benefits payable cannot exceed the number of hours you work in a regular day (as defined above) multiplied by your base hourly rate.

Subrogation

If your disability is the result of an event that creates a legal liability in another person or entity and you seek to recover economic or compensatory damages through legal or other action against that person or entity, the Company may initiate or join the action to recover the cost of the benefits paid to you by the Plan. If you recover monies, economic or compensatory through personal injury action, and it creates an overpayment of benefits from the plan that is not reimbursed to the Company or UniCare, normal overpayment recovery procedures will apply, including the recovery from future disability benefits. This does not include amounts recovered due to punitive damages, or sums allocated to compensate for pain and suffering. You must notify the Company or UniCare in the event you initiate legal action to enforce your right to recovery from another party.

When recovery is made by the Company or UniCare, a share of the expense of recovery, including attorney fees, will be paid by the Plan. Expenses will be paid as ordered by the court, or in the absence of a court order, in the same proportion as the amount recovered by the Plan, in proportion to the total recovered as a result of the personal injury action.

Filing a Claim

To report your Medical Leave of Absence (MLA) and file a disability claim you must call UniCare at this toll free number: 1-877-HRLY-MLA (1-877-475-9652) or you can file online at UniCare.com/Ford

Your MLA must be reported no later than five (5) days from your last day of work. Your call to 1-877-HRLY-MLA will initiate both your disability claim at UniCare and a conditional MLA with your work location.

At the time of your call, be prepared to supply UniCare with the following information:

- Your last date of work
- The name, address and phone number of your treating physician(s)

UniCare will verify your last day of work with the Company along with your rate of pay and tax withholding information. If you know in advance that you will be absent due to medical reasons (for example, if you have a scheduled surgery), you can call UniCare with this information ahead of time.

Once you have called 1-877-HRLY-MLA, your disability claim will be established and an MLA will be issued on a conditional basis for 14 days from your last date of work. UniCare will mail you a package with all the information (e.g., forms) you need to certify your claim with UniCare. UniCare will review the information submitted and make a claim determination and provide authorization for your MLA to your plant.

MLA Process Exceptions

You will need to provide medical information directly to your plant medical location (e.g., form 5166) if you do not qualify for disability benefits and are absent for medical reasons, and in the following situations:

- You are receiving Workers' Compensation benefits
- You have not met the coverage requirement to receive disability benefits based on seniority
- You have exhausted your disability benefit entitlement, but continue to have seniority rights
- You have properly responded to a Notice to Report letter sent in accordance with Article VIII, Section 5 of Volume I of the November 18, 2019 Collective Bargaining Agreement

Once your claim is established, you may call UniCare toll free at 1-800-572-1581 if you have any questions.

Medical Leave of Absence Certification

The MLA process is integrated with the disability claims process. This means the claim determination reached by UniCare will serve as the basis of approval or denial of your MLA.

You will not need to provide medical evidence in support of your MLA to your work location, unless you are receiving workers' compensation benefits, have not yet met the coverage requirement to receive disability benefits based on seniority, or you have exhausted your disability benefit entitlement, but continue to have seniority rights.

Conditional MLA

The conditional status of your MLA will change once the required medical information is received from your treating physician(s) and a signed notice of claim is received from you.

Timing Requirements

Your MLA is issued on a conditional basis for 14 days from your last date of work. Satisfactory medical evidence to support your disability claim and MLA must be supplied to UniCare within this timeframe. Additionally, you must supply UniCare with a signed notice of claim within 14 days of your last date of work.

MLA Extensions

If your MLA is continuing, updated medical information certifying your ongoing disability must be supplied to UniCare prior to the expiration of the last approved period. You and your physician will be responsible for ensuring that UniCare is provided with the medical information necessary to determine eligibility on an ongoing basis.

If you fail to meet these timing requirements, you will be subject to loss of seniority through the 10-day quit process.

Requirements for Notice and Proof of Claim

As indicated in the previous section, notice of your medical leave request is required by the Company within five (5) days of your last date of work. For purposes of claim filing, you must notify UniCare within 20 days after you become disabled. You must provide proof of why you did not contact UniCare within 20 days after you became disabled as soon as reasonably possible and, in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Mental Health and/or Substance Use Disorder Claims

If you are diagnosed with a mental health and/or substance use disorder, you must obtain treatment from a legally licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is a specialist in psychiatry for any disability extending beyond ninety (90) days. If you fail to obtain treatment from a psychiatrist before expiration of the 90-day period, your A&S Benefits (and EDB) will be terminated.

Treatment from a provider who is licensed and accredited to treat substance use disorders during the first 90 days of your disability will qualify for purposes of benefit eligibility. The 90-day period is calculated from your first date of disability as determined by your provider or from the date your mental health and/or substance use disorder is first diagnosed.

If your claim is reopened due to a recurrence of a mental health and/or substance use disorder, you must obtain treatment from an M.D. or D.O. who specializes in psychiatry within 30 days of your most recent last date of work. You must be back to work for three or more consecutive months in order to qualify for a new claim if you are disabled for the same or related condition.

If you are disabled for a non-mental health and/or substance use disorder and you subsequently develop a mental health and/or substance use disorder, you must seek treatment with an M.D. or D.O. who specializes in psychiatry within 90 days of the diagnosis.

If you have previously sought treatment and disability certification for a mental health and/or substance use disorder and recover, but have not actually returned to work due to a secondary condition, you must seek treatment with an M.D. or D.O. who specializes in psychiatry within 30 days of recurrence of your mental health and/or substance use disorder.

Compliance with the treatment plan prescribed by your healthcare provider is required in order to maintain eligibility for A&S Benefits (or EDB).

If you do not seek treatment with a legally licensed M.D. or D.O. who specializes in psychiatry within the timeframes described above, you will not be eligible for A&S Benefits (or EDB).

Medical Substantiation (Objective Medical Findings)

Objective medical findings are medical findings that can be measured or observed by your physician (i.e. “medical substantiation”). Examples include, but are not limited to, blood pressure readings, blood sugar levels, X-ray, Magnetic Resonance Imaging (MRI) or Electromyogram (EMG) results. Before your disability claim may be approved, the objective medical evidence identified by your physician to determine you were unable to work (disabled) must be provided to UniCare for review. In the absence of disabling objective medical findings, your claim for benefits will not be approved.

A statement of disability from your physician is not sufficient to approve your disability claim if objective medical findings are not also presented in support of disability. Objective medical findings differ from subjective medical findings in that subjective medical findings cannot be measured or observed. Examples of subjective medical findings include, but are not limited to, pain, numbness, weakness or fatigue. Although subjective medical findings are important for your physician to be aware of, disability benefits may not be authorized on subjective findings alone.

Example of a Disability Claim — Medically Substantiated

Your disability begins: Your claim begins after you injure your knee and require surgery. UniCare contacts your physician’s office and confirms the surgical procedure was completed, and that you will be disabled from June 3 through July 28. You are expected to return to work on July 29. You will attend physical therapy while off work to rebuild strength and to walk without pain. For the period of June 3 to July 28, objective medical information has been provided, and disability benefits are paid. Your medical leave of absence is also approved.

Your disability continues: On July 30 UniCare is notified you did not return to work on July 29. UniCare contacts your physician’s office and is told your disability was extended until August 12. At the time of your last appointment on July 28, your physician prescribed additional physical therapy in order to improve your knee strength.

In this case, ongoing disability (July 29 through August 12) **is** medically substantiated. The medical information submitted by your physician to UniCare medically substantiates the additional time off work. Your medical leave of absence is also approved.

Example of a Disability Claim — Not Medically Substantiated

Your disability begins: Your claim begins after you injure your knee and require surgery. UniCare contacts your physician's office and confirm the surgical procedure was completed, and that you will be disabled from June 3 through July 28. You are expected to return to work on July 29. You will attend physical therapy while off work to rebuild strength and to walk without pain. For the period of June 3 to July 28, objective medical information has been provided, and disability benefits are paid. Your medical leave of absence is also approved.

Your disability continues: On July 30, UniCare is notified you did not return to work on July 29. UniCare contacts your physician's office and is told your disability was extended until August 12. At the time of your last appointment on July 28, you reported continued pain and weakness in your knee, but strength testing performed during the appointment was normal. Also, there was no additional physical therapy or other testing performed that provided evidence that you were not able to return to work.

In this case, ongoing disability (July 29 through August 12) is ***not*** medically substantiated. The medical information submitted by your physician to UniCare does not contain objective medical evidence in support of ongoing disability, and therefore, is not approved by UniCare. Your medical leave of absence is not approved for this time period and you will be expected to return to work. Absent medical substantiation, your claim for benefits under the plan will be denied.

Physical Examination

UniCare has the right to have you examined by an impartial medical examiner, at its expense, while your A&S Benefits claim is pending or being paid. Failure to report for an examination without good cause will result in denial of your claim and termination of A&S Benefits.

The results of the examination by an appropriate medical specialist are final and binding. A&S Benefits will be terminated if you are found able to work or able to work with restrictions by the examiner. You must report to your work location for assessment following such determination.

If the medical examiner determines that you are able to work and you do not report to your work location to return to work following the examination, Hospital-Surgical-Medical-Drug-Dental-Vision (H-S-M-D-D-V) coverage will be discontinued the first day of the second month following the examination date. H-S-M-D-D-V coverage will not be reinstated until you return to work.

Mileage Reimbursement for Independent Medical Examination (IME)

If an IME is scheduled for you at a location farther than 30 miles one-way (or the distance you drive to work, if greater) from your residence, you can request reimbursement from UniCare based on the Internal Revenue Service (IRS) mileage rate for actual miles driven from your residence to the IME physician's office and back using the most direct route available. You should request mileage reimbursement before your appointment. Mileage reimbursement will be made after you have kept your appointment with the IME examiner.

Social Security Disability Benefits Application

A&S Benefits and EDB are reduced by the weekly equivalent of any Social Security Disability Insurance Benefits (SSDIB) you are entitled to receive. You are expected to comply with the Social Security Disability Benefit assessment, application and advocacy process as described below.

Social Security Disability Insurance Benefits Assessment

If you have a serious or prolonged disability:

You will receive a form from the claims processor, UniCare, during your 24th week of absence to be completed by your physician.

The completed physician form must be returned to UniCare before expiration of the 28th week of your absence.

If your physician indicates on the form that you will not be disabled for longer than 12 months, no additional follow up will be required at that time.

If your physician indicates on the form that you will be disabled for more than 12 months, or the completed physician statement is not received by UniCare by the 30th week of your absence, your claim will be referred to a Social Security advocate.

Social Security Advocacy Process

Claims expected to last 12 or more months or otherwise determined to be suitable for the Social Security process will be assessed by a Social Security advocate. If the Social Security advocate determines that an application for SSDIB is appropriate, you will be required to comply with any directions provided by the Social Security advocate.

You will receive notification from UniCare regarding your responsibilities under this process and detailing the services that will be provided to you free of charge from the Social Security advocate.

The initial SSDIB application process must be completed within 45 days of the notification to avoid a presumed SSDIB offset. Your A&S Benefits and EDB will be reduced by a presumed SSDIB amount if you do not complete the process within the timeline provided.

If at any time you are asked to supply UniCare or the Social Security advocate with an authorization for the release of Social Security information and fail to do so within 30 days of the request, a presumed offset of SSDIB will be applied effective as of the first of the month following the 30-day period.

If at any time you are not compliant with the Social Security advocate, it will be presumed that your SSDIB should have commenced at the time of your SSDIB application. For example, your A&S Benefits and EDB will be reduced by a presumed SSDIB amount if you do not sign and return the reimbursement agreement to the Social Security advocate.

Non-compliance includes, but is not limited to:

- Failure to sign and submit the reimbursement agreement (account sweep) for purposes of collection of a retroactive award of SSDIB
- Failure to complete and return forms or supply required medical information
- Failure to cooperate with the Social Security advocate or follow instructions
- Failure to complete the initial application appeal, reconsideration process, etc.

Additional Information

You must apply, as instructed by the Social Security advocate, for reconsideration or appeal if you have been denied SSDIB upon your initial application. You may also be required by the Social Security advocate to submit a second application for SSDIB and exhaust all levels of appeal with the Social Security Administration, up to and including review by an Administrative Law Judge. If you fail to cooperate with any additional steps recommended by the Social Security advocate, your A&S Benefits and EDB will be reduced by a presumed SSDIB amount effective as of the date of the original SSDIB application.

Please be aware that your claim for A&S Benefits or EDB can be referred to the Social Security advocate at any time benefits are pending.

Application

The Social Security advocacy process is provided at no cost to you. If you choose to pursue application for SSDIB on your own you must notify the claims processor, UniCare, of this action. Proof of application for SSDIB must be provided to UniCare within 30 days of your application. You are required to supply UniCare with the SSDIB award/denial information within 30 days of the determination by the Social Security Administration. Failure to provide SSDIB award or denial information to UniCare will result in a presumed offset and your A&S Benefits and/or EDB will be reduced.

Waiver of Benefits

If you have one or more years of seniority, you may waive irrevocably any right to A&S Benefits for any period of disability by completing a waiver form furnished by the claims processor. A&S Benefits will not be payable for any period of disability covered by such a waiver.

Reinstatement of A&S Benefits During Layoff

Your A&S Benefits will be reinstated if you:

- Become wholly and continuously disabled while on a qualifying layoff as defined in the 2019 Ford-UAW Supplemental Unemployment Benefit Plan (SUB Plan), are found to be medically disabled by the plant physician upon recall from a qualifying layoff, or are certified by your physician to be unable to return to work because of disability, and
- Are insured for Basic Life Insurance, and
- Are eligible for a Regular Benefit under the SUB Plan or have been employed by another employer immediately before becoming disabled.

If you wish to receive benefits, you must submit notice and proof of your claim to UniCare within the time limits described above.

With respect to each week for which a benefit is claimed, you also must be:

- Unable to perform all duties of your job,
- Under the care of a physician (as defined in the *A&S Benefits* section), and
- Otherwise eligible to receive a benefit under the SUB Plan or, if the 1987 SUB Plan is reinstated, have to your credit at least a Credit Unit under the 1987 SUB Plan.

If you were receiving Regular Benefits under the SUB Plan immediately before you became disabled, A&S Benefits will begin on the first day following the last day a Regular Benefit was payable to you. If you were not receiving Regular Benefits, A&S Benefits will begin on the first day of qualifying disability.

Benefits will not continue after you cease to satisfy the disability requirements. If, however, you remain on qualifying layoff under the SUB Plan, benefits are payable for remaining days in the same week (as defined in the SUB Plan) for which you do not receive a Regular Benefit.

Reinstated A&S Benefits will not be paid for any week in which:

- You receive A&S Benefits (see the *A&S Benefits* section for more details) or an EDB, or
- If the 1987 SUB Plan is reinstated, the Credit Unit Cancellation Base under the SUB Plan is below the applicable dollar amount at which a SUB benefit is payable according to your seniority.

Your Reinstated A&S Benefits will be reduced by the amount of any disability benefit you receive for the same week under a plan paid in whole or in part by another employer.

Reinstated A&S Benefits are governed by the applicable A&S Benefits provisions described earlier.

Extended Disability Benefits

If your disability continues beyond the period you are entitled to receive Accident and Sickness (A&S) Benefits, Extended Disability Benefits (EDB) may provide monthly payments for an extended period of time.

Eligibility

You are eligible for EDB if:

- You are covered for A&S Benefits
- Your disability continues beyond the period that you were eligible for A&S Benefits, and
- You are totally disabled, which means:
  - You are not engaged in any regular occupation or employment for remuneration or profit, and
  - You are prevented by bodily injury or disease from engaging in any regular occupation or employment with the Company at the plant or plants where you have seniority.

Claims Processor

UniCare Life and Health Insurance Company is presently the claims processor under an administrative services agreement with the Company.

UniCare Phone Number: 1-800-572-1581

Benefit Amount

Your maximum EDB are determined according to:

- Your base hourly rate on your last day of work, and
- Your number of years of credited service under the Retirement Plan, or
- Your number of years of participation under the Disability Insurance Plan.

If you have less than 10 years of credited service under the Retirement Plan and less than 10 years of participation in the Disability Insurance Plan, your monthly benefit is shown in Column I (see the following table). If you have 10 or more years of credited service or 10 or more years of participation in the Disability Insurance Plan, your monthly benefit is shown in Column II.

The EDB shown in the table below will be reduced by the amount of benefits from other sources for which you are eligible:

Benefit Amount:		Your Monthly EDB is:	
Insurance Code	**If your base hourly rate is: [1] (Coverage Bracket)**	**(I) Less than 10 years**	**(II) 10 or more years**
1J	Up to but less than $14.30	$1250	$1370
1I	$14.30 but less than $14.65	$1280	$1405
1H	$14.65 but less than $15.00	$1310	$1440
1G	$15.00 but less than $15.35	$1340	$1475
1F	$15.35 but less than $15.70	$1370	$1505
1E	$15.70 but less than $16.05	$1405	$1540
1D	$16.05 but less than $16.40	$1435	$1575
1C	$16.40 but less than $16.75	$1465	$1610
1B	$16.75 but less than $17.10	$1495	$1640
1A	$17.10 but less than $17.45	$1525	$1675
A	$17.45 but less than $17.80	$1560	$1710
B	$17.80 but less than $18.15	$1590	$1745
C	$18.15 but less than $18.50	$1620	$1780
D	$18.50 but less than $18.85	$1650	$1810
E	$18.85 but less than $19.20	$1680	$1845
F	$19.20 but less than $19.55	$1710	$1880
G	$19.55 but less than $19.90	$1745	$1915
H	$19.90 but less than $20.25	$1775	$1950
I	$20.25 but less than $20.60	$1805	$1980
J	$20.60 but less than $20.95	$1835	$2015
K	$20.95 but less than $21.30	$1865	$2050
L	$21.30 but less than $21.65	$1900	$2085
M	$21.65 but less than $22.00	$1930	$2120
N	$22.00 but less than $22.35	$1960	$2150
O	$22.35 but less than $22.70	$1990	$2185
P	$22.70 but less than $23.05	$2020	$2220
Q	$23.05 but less than $23.40	$2055	$2255
R	$23.40 but less than $23.75	$2085	$2290
S	$23.75 but less than $24.10	$2115	$2320
T	$24.10 but less than $24.45	$2145	$2355
U	$24.45 but less than $24.80	$2175	$2390
V	$24.80 but less than $25.15	$2205	$2425
W	$25.15 but less than $25.50	$2240	$2460
X	$25.50 but less than $25.85	$2270	$2490
Y	$25.85 but less than $26.20	$2300	$2525
Z	$26.20 but less than $26.55	$2330	$2560
AA	$26.55 but less than $26.90	$2360	$2595
BB	$26.90 but less than $27.25	$2395	$2630
CC	$27.25 but less than $27.60	$2425	$2660

Benefit Amount:		Your Monthly EDB is:	
Insurance Code	**If your base hourly rate is: [1] (Coverage Bracket)**	**(I) Less than 10 years**	**(II) 10 or more years**
DD	$27.60 but less than $27.95	$2455	$2695
EE	$27.95 but less than $28.30	$2485	$2730
FF	$28.30 but less than $28.65	$2515	$2765
GG	$28.65 but less than $29.00	$2550	$2795
HH	$29.00 but less than $29.35	$2580	$2830
II	$29.35 but less than $29.70	$2610	$2865
JJ	$29.70 but less than $30.05	$2640	$2900
KK	$30.05 but less than $30.40	$2670	$2935
LL	$30.40 but less than $30.75	$2700	$2965
MM	$30.75 but less than $31.10	$2735	$3000
NN	$31.10 but less than $31.45	$2765	$3035
OO	$31.45 but less than $31.80	$2795	$3070
PP	$31.80 but less than $32.15	$2825	$3105
QQ	$32.15 but less than $32.50	$2855	$3135
RR	$32.50 but less than $32.85	$2890	$3170
SS	$32.85 but less than $33.20	$2920	$3205
TT	$33.20 but less than $33.55	$2950	$3240
UU	$33.55 but less than $33.90	$2980	$3275
VV	$33.90 but less than $34.25	$3010	$3305
WW	$34.25 but less than $34.60	$3045	$3340
XX	$34.60 but less than $34.95	$3075	$3375
YY	$34.95 but less than $35.30	$3105	$3410
ZZ	$35.30 but less than $35.65	$3135	$3445
2A	$35.65 but less than $36.00	$3165	$3475
2B	$36.00 but less than $36.35	$3195	$3510
2C	$36.35 but less than $36.70	$3230	$3545
2D	$36.70 but less than $37.05	$3260	$3580
2E	$37.05 but less than $37.40	$3290	$3615
2F	$37.40 but less than $37.75	$3320	$3645
2G	$37.75 but less than $38.10	$3350	$3680
2H	$38.10 but less than $38.45	$3385	$3715
2I	$38.45 but less than $38.80	$3415	$3750
2J	$38.80 and over	$3445	$3785
[1]If an employee is under an incentive plan, coverage is based upon average straight time hourly earnings.			

If you last worked before November 18, 2019, your EDB are shown in the Collective Bargaining Agreement in effect when you last worked.

Medical Substantiation (Objective Medical Findings)

Objective medical findings are medical findings that can be measured or observed by your physician. Examples include, but are not limited to, blood pressure readings, blood sugar levels, X-ray, Magnetic Resonance Imaging (MRI) or Electromyogram (EMG) results. Before your disability claim may be approved, the objective medical evidence identified by your physician to determine you were unable to work (disabled) must be provided to UniCare for review. In the absence of disabling objective medical findings, your claim for benefits will not be approved.

A statement of disability from your physician is not sufficient to approve your disability claim if objective medical findings are not also presented in support of disability. Objective medical findings differ from subjective medical findings in that subjective medical findings cannot be measured or observed. Examples of subjective medical findings include, but are not limited to, pain, numbness, weakness, or fatigue. Although subjective medical findings are important for your physician to be aware of, disability benefits may not be authorized on subjective findings alone.

Example of a Disability Claim — Medically Substantiated

Your disability begins: You had back surgery and have been disabled for more than a year due to another complicating medical condition (diabetes). The diabetes slowed your ability to heal from surgery.

You exhausted your A&S Benefits entitlement and are now receiving EDB. Your medical leave of absence has been continuous during this time. The last information UniCare received from your physician indicated you were expected to return to work on October 3. Your physician also confirmed your medical status, testing results, including blood sugar readings, and physical therapy notes.

Your disability continues: On October 6, UniCare is notified you did not return to work on October 3. UniCare contacts your physician's office and is told your disability was extended until December 3. At the time of your last appointment, October 2, you had continued pain in your back, so your physician scheduled a Magnetic Resonance Imaging (MRI) for your back, and your blood sugar was still not under control.

In this case, ongoing disability (October 3 through December 3) **is** medically substantiated. The medical information submitted by your physician to UniCare medically substantiates the additional time off work. Your medical leave of absence is also approved.

Example of a Disability Claim — Not Medically Substantiated

Your disability begins: You had back surgery and have been disabled for more than a year due to another complicating medical condition (diabetes). The diabetes slowed your ability to heal from surgery.

You exhausted your A&S Benefits entitlement and are now receiving EDB. Your medical leave of absence has been continuous during this time. The last information UniCare received from your physician indicated you were expected to return to work on October 3. Your physician also confirmed your medical status, testing results, including blood sugar readings, and physical therapy notes.

Your disability continues: On October 6, UniCare is notified you did not return to work on October 3. UniCare contacts your physician's office and is told your disability was extended until December 3. At the time of your last appointment on October 2, you complained of continued pain, but you were able to touch your toes, turn to each side without any problems, and had completed your physical therapy successfully. Additionally, your blood sugar was under control. Your physician did not order any additional physical therapy or other testing that provided evidence that you were not able to return to work.

In this case, ongoing disability (October 3 through December 3) **is not** medically substantiated. The medical information submitted by your physician to UniCare does not contain objective medical evidence in support of ongoing disability, and therefore, is not approved by UniCare. Your medical leave of absence is not approved for this time period and you will be expected to return to work.

Absent medical substantiation, your claim for benefits under the plan will be denied.

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

If you become disabled again for an old accident or illness without having returned to work for three consecutive months or more, the benefits will be the amount you would have received under a continuation of the prior claim.

Other Sources of Benefits

Other sources of benefits are:

- Benefits under any retirement plan for Company employees
- Lost-time benefits under Workers' Compensation laws or other laws providing benefits for occupational injury or disease, including lump-sum settlements (excluding specific allowances for loss, 100% loss of use of a body member, or permanent partial disability payments for a work-related disability unrelated to the disability for which EDB are payable)
- Disability or old-age (retirement) primary Social Security benefits to which you are entitled (except for retirement benefits reduced because of your age at the time you receive them); this includes any similar benefits arising from future legislation, and
- Benefits under any State or Federal law providing benefits for lost time because of disability, except benefits for total disability due to pneumoconiosis

EDB are reduced by the amounts you receive from other sources. To determine the amounts paid from other sources, those benefits paid on a weekly or lump-sum basis are converted to monthly amounts (by multiplying the weekly amount by 4.33).

Subrogation

If your disability is the result of an event that creates a legal liability in another person or entity and you seek to recover economic or compensatory damages through legal or other action against that person or entity, the Company may initiate or join the action to recover the cost of the benefits paid to you by the plan. If you recover monies, economic or compensatory through personal injury action, and it creates an overpayment of benefits from the plan that is not reimbursed to the Company or UniCare, normal overpayment recovery procedures will apply, including the recovery from future disability benefits. This does not include amounts recovered due to punitive damages, or sums allocated to compensate for pain and suffering. You must notify the Company or UniCare in the event you initiate legal action to enforce your right to recovery from another party.

When recovery is made by the Company or UniCare, a share of the expense of recovery, including attorney fees, will be paid by the Plan. Expenses will be paid as ordered by the court, or in the absence of a court order, in the same proportion as the amount recovered by the plan, in proportion to the total recovered as a result of the personal injury action.

Social Security Disability Benefits Insurance Offset

Your EDB are reduced by any Social Security Disability Insurance Benefits you are entitled to receive. Please refer to the *Social Security Disability Insurance Benefits Application* section for more information on the Social Security advocacy process, and your role and responsibilities.

Retirement Plan Benefits Offset

After you have received EDB for 24 months, your EDB will be reduced by the amount of retirement benefit for which you are presumed to be eligible if you have not previously applied for benefits under the Ford-UAW Retirement Plan, or if you applied for retirement benefits but have not yet received a determination on your application. This provision does not apply to you if you applied for retirement benefits and received a determination on your application prior to the 24th month. The amount deducted from your EDB based on presumed eligibility for retirement benefits will be paid to you if you provide evidence that your application for retirement benefits was denied, unless the reason for the denial was your refusal to accept vocational rehabilitation services. If you apply for Retirement Plan benefits after the twenty-fourth month of your eligibility for EDB and your application is approved, the amounts deducted prior to the scheduled effective date of the retirement will not be paid to you.

After EDB begin, any increases in the amount of other benefits mentioned above will not affect the amounts payable from EDB — unless the increase represents an adjustment in the benefit originally determined.

You may be required to verify the amounts of your income from other sources while you are eligible for EDB.

Duration of Benefits

The duration of benefits is based on your years of seniority and your last day worked before disability began:

Extended Disability Benefits (EDB) will continue:

If:	Until:
You have 10 or more years of seniority on the date disability began	Your recovery or attainment of age 65, whichever is sooner
You have less than 10 years of seniority on the date disability began	The sooner of your recovery, attainment of age 65, or minus the number of full months of seniority at the onset of disability, minus the number of weeks for which you are entitled to receive A&S Benefits

For purposes of determining the maximum period of monthly EDB, a month in which benefits are partially or wholly offset by benefits from other sources is counted as a full month. A month during which you engage in some gainful occupation or employment for which you are not reasonably qualified by education, training or experience also is counted as a full month.

For those employees who have less than 10 years of seniority when the disability commenced, the total number of months during any previous period of eligibility for EDB, regardless of whether the disability was for the same or a related condition, will reduce the maximum number of monthly benefit payments which you are eligible to receive.

If you become disabled at or after the age of 60, and are otherwise eligible for EDB, benefits will continue for the length of your disability, not to exceed five years.

Benefits May Be Suspended

EDB will be suspended for the period of your return to work if:

- Your return to work is not effective to qualify you for a new period of A&S Benefits, or
- You engage in some gainful occupation or employment for which you are reasonably qualified by education, training or experience.

Work determined to be primarily for training under a recognized program of vocational rehabilitation will not disqualify you for EDB.

UniCare may require you to provide proof that you have no other employment. If this information is not provided, benefits will be suspended until such information is provided and it is determined that you did not engage in gainful occupation or employment.

If your EDB are discontinued because you no longer satisfy the disability requirement, and within two weeks of the date of such discontinuance and before you return to work with the Company, you again become disabled so as to satisfy the disability requirements, monthly EDB will be resumed.

Special Medicare Benefit

If you are an EDB recipient enrolled in voluntary Medicare coverage (Part B), you will receive the following special benefit:

Starting this date:	Your Monthly Special Benefit is the lesser of the generally applicable Medicare Part B Premium or this amount:
January 1, 1999	$45.50
January 1, 2000	$61.50
January 1, 2004	$76.20

Special Medicare benefit payments will begin on the first day of the month after the month you notify the claims processor that you have enrolled for Part B coverage. If you already are receiving a special benefit for your Part B payments through the Retirement Plan or Health Care Plan, however, you will not receive duplicate payments.

Special Medicare payments are paid along with EDB. If you do not receive an EDB payment because other benefit sources exceed the monthly EDB amount, you still will receive this special payment.

Physical Examination

UniCare has the right to have you examined by an impartial medical examiner, at its expense, while your EDB claim is pending or being paid. Failure to report for an examination without good cause will result in denial of your claim and termination of EDB.

The results of the examination by an appropriate medical specialist are final and binding. EDB will be terminated if you are found able to work/able to work with restrictions by the examiner. You must report to your work location for assessment following such determination.

If the medical examiner determines that you are able to work and you do not report to your work location to return to work following the examination, H-S-M-D-D-V coverage will be discontinued the first day of the second month following the examination date. H-S-M-D-D-V coverage will not be reinstated until you return to work.

Mileage Reimbursement for Independent Medical Examination (IME)

If an IME is scheduled for you at a location farther than 30 miles one-way (or the distance you drive to work, if greater) from your residence, you can request reimbursement from UniCare based on the Internal Revenue Service (IRS) mileage rate for actual miles driven from your residence to the IME physician’s office and back using the most direct route available. You should request mileage reimbursement before your appointment. Mileage reimbursement will be made after you have kept your appointment with the IME examiner.

Waiver of Benefits

You may waive irrevocably your right to receive EDB for any period of disability by completing a waiver form furnished by the claims processor. No EDB will be payable for any period of disability covered by such waiver.

Filing a Claim

To file a claim for A&S Benefits or EDB, follow these steps:

1. Your claim should be reported directly to:

   UniCare Life and Health Insurance Company
   Dearborn Service Center
   P.O. Box 4479
   Dearborn, MI 48126
   1-877-HRLY-MLA (1-877-475-9652) or UniCare.com/Ford

2. If you are employed in California and become disabled, you must apply for State Unemployment Compensation Disability Benefits.

Taxation

Taxes will be withheld from all disability payments just as they are from your paychecks.

Withholding will be based on your current exemption status on record with the Company. When your exemption status is not available, the withholding amounts will be determined as if you were single and claiming zero exemptions until the claims processor is provided with a valid Form W-4.

If you wish to change your exemption status while you are receiving disability benefits, you may contact the claims processor regarding the submission of updated Form W-4. Changes submitted to the claims processor will take effect as soon as possible for future benefits only. Your exemption status will be obtained from the Company payroll records each time you file a claim. For that reason, you must submit Form W-4 changes for each claim if you desire a different level of tax withholding than appears on Company payroll records. Any Form W-4 changes that are submitted to the claims processor will not affect your Company payroll records.

Your disability benefits also will be reduced by the amount of any applicable court order directing the Company to withhold from your wages or benefits. Court orders for dependent support, bankruptcy, tax levies, garnishment, etc. which are on file with Payroll Services or served directly upon UniCare will apply to your disability benefits. The amount withheld will be sent by UniCare to the court involved. An explanation of withholding will be included on your disability benefit draft.

Claim Denial

If a claim for benefits is denied in whole or in part, you should receive written notification within forty-five (45) days of the date that the claim is received. If the Plan Administrator requires more time to review your claim, determination may be delayed up to an additional two (2) thirty- (30-) day extensions. You will receive notice of the delay, which will include the reasons for delay and the date a final decision can be expected. In all cases, a final decision will be reached, and you will be notified within one hundred and five (105) days after the Plan Administrator receives your claim for benefits.

Your first level of appeal is a review of the denied claim by the Plan Administrator.

Review of Denial by the Plan Administrator

If a claim is denied, you will receive a written notice. The notice will explain the reason for the denial, refer to the specific Plan provision or provisions on which the denial is based, describe what additional information, if any, is necessary to consider a further appeal, and describe how to appeal your claim.

In the event of a denial, you may request a first level appeal review by the Plan Administrator by submitting an appeal in writing. Your request for review must be submitted within one hundred eighty (180) days after you receive the written notification of denial of the claim. Within forty-five (45) days following receipt of your appeal letter, the Plan Administrator will notify you of their decision. Special circumstances may require an extension of an additional forty-five (45) days for processing. If your claim has been denied, the notice will describe the specific reasons for the denial.

In all cases, a final decision will be reached, and you will be notified in writing after your written request for a review is received by the Plan Administrator.

First level appeals should be addressed to:

UniCare Life and Health Insurance Company
Dearborn Service Center
P.O. Box 4479
Dearborn, MI 48126

Claims and Appeals Timelines and COVID-19

During the COVID-19 Outbreak Period (as defined by Federal law and regulations), the deadlines for you to file claims, appeals and external review requests with the Plan have been modified. You will have until the earlier of (i) one year from the date you were eligible for the COVID relief or (ii) the time period from March 1, 2020 until 60 days after the end of the National Emergency. Neither period will be counted in determining whether the date for individuals to notify the plan of a qualifying event or determination of disability is timely.

For example, if you received a claim denial letter dated July 10, 2020 and wish to appeal the denial, you will have until January 6, 2021 (180 days from the date of the claim denial) or the date that is 60 days following the end of the COVID-19 Outbreak Period, whichever is later, to submit your appeal.

Review of Denial of the Appeal by the Committee

In the event that the Plan Administrator denies the appeal of a claim, you may request further review of your claim by submitting your request for appeal in writing to the UAW-Ford Group Life and Disability Appeal Committee (the Committee). The procedures and time limits for reviewing the appeal are the same as the appeal to the Plan Administrator as listed on the previous page.

The UAW will appoint three members and alternate members to the Committee. Three additional members of the Committee are appointed by the Company. The members of the Committee and the alternate members receive no additional compensation for Committee services.

Address appeal requests to:

Ford Motor Company
P.O. Box 6214
Dearborn, MI 48121-6214
Attn: UAW-Ford Group Life and Disability Committee

The request for appeal should clearly indicate the reason(s) why you think your claim should not have been denied by the Plan Administrator. You are encouraged to submit copies of any additional documents, records, information or comments you think have a bearing on your claim.

You will be notified of the outcome of your appeal in writing, within forty-five (45) days from the date the written notice is received, unless special circumstances require an extension of additional forty-five (45) days for processing. Your notice will include the final decision and the specific reasons to support the decision. No legal action may be brought until after the claims and appeals procedures have been exhausted. No legal action can be taken later than two years after the claim accrues.

Special Note

If your claim has been denied because your claim was not medically substantiated and the Committee cannot reach a determination on your appeal, you may be referred for an Independent Medical Examination (IME) by the Committee or peer-to-peer review. The IME is separate from other medical reviews that may have been completed and will only be utilized in the event you have not returned to work. The Committee will agree to the disability determination of the examiner. In the event an IME is required, you will receive notice to attend the appointment from the Committee, and your appeal will be placed in a tolling status, pending completion of the IME. The Committee will utilize a peer-to-peer medical review if they cannot reach a decision on an appeal involving an employee who has already returned to work or may be appealing a closed period of disability. In the case of a peer-to-peer review, you will not be required to attend an exam.

Additional Information

Employment Status Changes

If you stop working, are away from work or your employment status changes to an ineligible status, disability benefits coverages will be affected.

Depending on the reason you stop working, the Company may pay for certain coverages for you or may allow you to continue certain coverages under the Disability Insurance Plan, as described in this section. Additionally, upon loss of coverage or eligibility under the Disability Insurance Plan, you may be eligible to apply to continue coverage outside of the Disability Insurance Plan. For more information, see the following "Coverage Continuation Contributions" heading.

Employment Termination

If your employment is terminated because of a quit or discharge, your coverage terminates as of the date you quit or are discharged.

If your employment is terminated for failing to report or overstaying leave, your coverage terminates as of the end of the month in which seniority is broken.

Layoff

If you become eligible for reinstated A&S benefits during layoff, you may become eligible for other Company-paid benefits while you are eligible to receive EDB after receipt of reinstated A&S Benefits.

Medical Leave of Absence

If you cease active work because of a disability, all of your coverages will continue up to a period of time equal to your seniority when your absence began. If you remain continuously and totally disabled beyond that time, you may be able to continue coverages for other benefits. Please review the appropriate summary plan description, in this handbook, or contact the NESC (1-800-248-4444) for more information.

Non-Medical Leave of Absence

If you go on an approved non-medical leave of absence, your disability coverage will cease as of the start of the leave. You may continue disability coverage beyond that time up to the end of your approved leave by making monthly contributions.

Additionally, to continue any disability coverage during a leave, you must make your premium payments directly to the insurer.

Coverage Continuation Contributions

Employees are eligible to continue Disability under Schedule I (below).

The following chart summarizes reasons why your employment may terminate and whether or not your coverage(s) may continue:

Your situation:	The Company continues your coverage for:	You then can contribute according to Contribution Schedule #:
You quit or are discharged	—	—
You are on a leave of absence (except medical or Union leave)	First month	I
You take early, normal or special early retirement with 10 years of service	Entire period	—
You take disability retirement with 10 years of service	Entire period	—

To continue coverage beyond the period for which the Company pays for your coverage, the monthly contribution you are required to pay (provided in the following Contribution Schedule) depends on the coverage bracket you were in as of the last day worked and the kinds of insurance coverage that can be continued.

In order to continue coverage for Disability Benefits, you must also continue your life insurance benefits. Please see the Life Insurance Summary Plan Description for further information regarding rates and where to send payment of your life insurance contributions.

Contribution Schedule I

Insurance Code	If your base hourly rate is: (Coverage Bracket)	Disability Contribution Schedule I*
1J	Up to but less than $14.30	$10.61
1I	$14.30 but less than $14.65	$10.97
1H	$14.65 but less than $15.00	$10.90
1G	$15.00 but less than $15.35	$11.26
1F	$15.35 but less than $15.70	$11.62
1E	$15.70 but less than $16.05	$11.80
1D	$16.05 but less than $16.40	$12.16
1C	$16.40 but less than $16.75	$12.34
1B	$16.75 but less than $17.10	$12.52
1A	$17.10 but less than $17.45	$12.88
A	$17.45 but less than $17.80	$13.24
B	$17.80 but less than $18.15	$13.42
C	$18.15 but less than $18.50	$13.96
D	$18.50 but less than $18.85	$14.14
E	$18.85 but less than $19.20	$14.50
F	$19.20 but less than $19.55	$14.68
G	$19.55 but less than $19.90	$15.04
H	$19.90 but less than $20.25	$15.40
I	$20.25 but less than $20.60	$15.58
J	$20.60 but less than $20.95	$15.76
K	$20.95 but less than $21.30	$16.12
L	$21.30 but less than $21.65	$16.30
M	$21.65 but less than $22.00	$16.66
N	$22.00 but less than $22.35	$16.84
O	$22.35 but less than $22.70	$17.20
P	$22.70 but less than $23.05	$17.56
Q	$23.05 but less than $23.40	$17.74
R	$23.40 but less than $23.75	$18.10
S	$23.75 but less than $24.10	$18.28
T	$24.10 but less than $24.45	$18.64
U	$24.45 but less than $24.80	$19.00
V	$24.80 but less than $25.15	$19.18
W	$25.15 but less than $25.50	$19.54
X	$25.50 but less than $25.85	$19.72
Y	$25.85 but less than $26.20	$20.08
Z	$26.20 but less than $26.55	$20.44
AA	$26.55 but less than $26.90	$20.62
BB	$26.90 but less than $27.25	$20.98
CC	$27.25 but less than $27.60	$21.16
DD	$27.60 but less than $27.95	$21.52
EE	$27.95 but less than $28.30	$21.88

Insurance Code	If your base hourly rate is: (Coverage Bracket)	Disability Contribution Schedule I*
FF	$28.30 but less than $28.65	$22.06
GG	$28.65 but less than $29.00	$22.42
HH	$29.00 but less than $29.35	$22.96
II	$29.35 but less than $29.70	$23.14
JJ	$29.70 but less than $30.05	$23.50
KK	$30.05 but less than $30.40	$23.86
LL	$30.40 but less than $30.75	$24.04
MM	$30.75 but less than $31.10	$24.40
NN	$31.10 but less than $31.45	$24.58
OO	$31.45 but less than $31.80	$24.76
PP	$31.80 but less than $32.15	$24.94
QQ	$32.15 but less than $32.50	$25.30
RR	$32.50 but less than $32.85	$25.66
SS	$32.85 but less than $33.20	$25.84
TT	$33.20 but less than $33.55	$26.20
UU	$33.55 but less than $33.90	$26.38
VV	$33.90 but less than $34.25	$26.74
WW	$34.25 but less than $34.60	$27.10
XX	$34.60 but less than $34.95	$27.28
YY	$34.95 but less than $35.30	$27.64
ZZ	$35.30 but less than $35.65	$27.82
2A	$35.65 but less than $36.00	$28.36
2B	$36.00 but less than $36.35	$28.72
2C	$36.35 but less than $36.70	$29.08
2D	$36.70 but less than $37.05	$29.26
2E	$37.05 but less than $37.40	$29.62
2F	$37.40 but less than $37.75	$29.80
2G	$37.75 but less than $38.10	$30.75
2H	$38.10 but less than $38.45	$31.72
2I	$38.45 but less than $38.80	$32.97
2J	$38.80 and over	$34.00

** In order to continue your Disability coverage, you must also continue your Life Insurance through MetLife. See the Life Insurance SPD for additional details.*

The rates are subject to change, if necessary, by mutual agreement between the Company and the Union.

Your contributions for the coverages available to you should be mailed to:

UniCare Life and Health Insurance Company
Dearborn Service Center
P.O. Box 2090
Dearborn, MI 48123
1-313-336-5550 or
1-800-843-8184

Payment will be due on the first day of each month for that month's coverage. Payment will be accepted anytime within that month. Late payments are not acceptable and will result in permanent termination of your coverage.

If you return to work from layoff in a month for which you have made payment, you will be reimbursed by UniCare for that payment.

Making timely premium payments is your responsibility.

Coverage Continuation

This section of your handbook has summarized your Disability Insurance Plan coverages. Additional circumstances, however, might affect your benefits.

Circumstances that Affect Benefits

Assigning Benefits

Neither you nor your survivors may assign your A&S Benefits or EDB.

Disability Benefits Overpayment

If a disability benefit is overpaid for any reason, you will receive a written notice that you should repay that amount directly to the claims processor.

If you do not pay that amount promptly, the claims processor has the right to deduct the overpaid amount from future benefit payments. At the claims processor's request, the Company may deduct the overpaid amount from your future paychecks. However, repayment of overpayments caused solely by Company or insurer error is only required if notice is given within one year from the date an overpayment is established.

Incompetency

If you are incompetent or otherwise incapable of giving a valid release, the disability claims processor may withhold payment until a guardian is appointed. In the case of weekly or monthly benefits, payment may be made to any relative by blood or marriage or to any other individual or institution appearing to the insurer or claims processor to have assumed custody of the person. The liability of the insurer or claims processor will be fully discharged to the extent of such payment.

Summary of Administrative Information

Group Life and Disability Insurance Plan					
Name:	**Plan Number:**	**Type of Plan:**	**Cost Paid By:**	**Trustee:**	**Benefits Administered or Insured Through:**
Accident and Sickness (A&S) Benefits and Extended Disability Benefits (EDB)	521	Welfare plan providing disability benefits	Benefits are paid by the Company	None	Accident and Sickness (A&S) (except New York and New Jersey) and Extended Disability Benefits are paid by Ford Motor Company. Claims are processed by: UniCare Life &Health Insurance Company P.O. Box 4479 Dearborn, MI 48126 1-800-572-1581 Accident and Sickness (A&S) Benefits for employees in New York and New Jersey, are insured by UniCare Life & Health Insurance Company (Group Policy 17-GCC)

Optional Long-Term Disability (OLTD) Insurance Program

OLTD Insurance Program Summary Plan Description, November 2021

OLTD benefits are for employees who are not eligible for Company-paid Extended Disability Benefits (EDB) to age 65 based on age and seniority, which include employees in the following classifications:

- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Optional Long-Term Disability (OLTD) Insurance Program Overview

See your certificate of insurance and/or the plan document for any terms not defined in this Summary Plan Description. For any additional questions or information regarding any provisions below, refer to your certificate of insurance (available from the insurer at* unicare.com/ford *or 1-800-843-8184

The UAW-Ford group life and disability insurance program offers eligible employees the opportunity to purchase voluntary OLTD insurance. If you become disabled, OLTD provides additional financial protection for you and your family by paying a monthly benefit that begins after you have exhausted the maximum benefits payable under the Accident and Sickness (A&S) Benefits and Extended Disability Benefits (EDB) programs.

Eligibility

You are eligible to elect OLTD insurance if you are represented by the UAW under the Collective Bargaining Agreement, and are not eligible for Company-paid Extended Disability Benefits (EDB) to age 65 based on age and seniority, in the following classifications:

- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees:** Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

See the following section titled *Enrollment* to learn more about when insurance becomes effective.

Note: OLTD insurance is voluntary. If you choose to enroll, you will pay a monthly premium for insurance.

Here's when you become eligible for OLTD insurance:

Your situation	You become eligible after you complete the eligibility waiting period
You are hired or rehired	The day after you acquire one year and one month of seniority
You are reinstated	Date of your reinstatement (for any insurance in effect at the time you terminated prior Ford employment)*
You return from military service	Date of your reinstatement (for any insurance in effect at the time you left Ford employment)*

***You must contact UniCare at unicare.com/ford or 1-800-843-8184 to re-enroll in OLTD insurance within 31 days of your reinstatement.**

Enrollment

Once you are hired, you can enroll for insurance at any time within 31 days of becoming eligible without having to show proof of insurability. (You also may enroll in OLTD before you become eligible for Extended Disability Benefits (EDB) without having to show proof of insurability.) Your insurance effective date will be the day after you become eligible or the day you enroll, whichever is later. Your payroll deductions will begin the month after your insurance effective date.

- ***Example:*** You were hired July 1 as a New Traditional or New Skilled Trades (hired after October 24, 2011) employee; you are eligible for EDB beginning August 1 of the following year. You may elect to enroll for OLTD through August 31 of the year following your date of hire without having to show proof of insurability. Your premium will be paid through payroll deductions.

If you enroll after the 31-day period following your eligibility date, you will be required to provide proof of your insurability to be enrolled for insurance.

- ***Example:*** You were hired July 1 as a New Traditional or New Skilled Trades (hired after October 24, 2011) employee; you are eligible for EDB beginning August 1 of the following year. If you elect to enroll in November the year following your date of hire, then you must show proof of insurability. Once proof of insurability is approved, your payroll deductions will begin the first pay period of the following month.

If you did not enroll when you first became eligible, or when the OLTD program began, an open enrollment may be held in the future, if mutually agreed upon.

When Coverage Begins

Your insurance becomes effective on the latest of the following dates:

If you enroll…	Insurance will begin on…
Before the end of your eligibility waiting period	The day after you complete your eligibility waiting period
Within 31 days after satisfying your eligibility waiting period	The date you enroll
Later than 31 days after satisfying your eligibility waiting period, with proof of insurability	The date on which the insurer has, in writing, approved your proof of insurability

If you are absent from work due to illness or injury on the day your insurance ordinarily would start, insurance will begin on the first day you return to active work.

If your OLTD is scheduled to become effective while you are on a layoff, your OLTD will become effective on the date you return to active full-time work.

- ***Example****:* You are placed on a layoff beginning July 1, and your OLTD would have become effective August 1. You would not be eligible for OLTD until you return to full-time work.*

***Contact UniCare at unicare.com/ford or 1-800-843-8184 to re-enroll for OLTD insurance and to get answers to any questions you have.**

If you are placed on a temporary layoff after your OLTD becomes effective, you may continue to be eligible for OLTD until the end of the month following the month of layoff.

- ***Example****:* You are placed on a temporary layoff beginning July 1. You may continue to be eligible for OLTD until August 31.

If you are placed on an indefinite layoff after your OLTD becomes effective, you must re-enroll for insurance after returning to full-time work. If you re-enroll within 31 days of returning to full-time work, you will not be required to provide proof of insurability.

- ***Example:*** You are placed on an indefinite layoff beginning July 1, and you were insured for OLTD benefits as of June 1. **You must contact UniCare within 31 days of returning to full-time work to re-enroll without being required to provide proof of insurability.**

If you become disabled, you must exhaust your A&S Benefits and EDB before OLTD benefits will begin.

Refer to your Disability Insurance Program Summary Plan Description to determine how long you are eligible to receive A&S Benefits and EDB.

Optional Long-Term Disability (OLTD) Benefits

The UAW-Ford OLTD plan pays 40% of your base monthly income, tax-free, up to a maximum of $2,800 per month.

Your OLTD benefits are based on your base hourly rate on the last day you worked preceding your disability. (This is your base hourly rate before any contributions to the Tax-Efficient Savings Plan for Hourly Employees.) Your base hourly rate does not include shift premiums, overtime, cost-of-living allowance or other extras.

Cost

You are responsible for 100% of the cost of this benefit because it is an optional plan. Premiums will be deducted beginning the first pay period of the month after your benefits become effective. This table shows the monthly premium rates, which are based on age and pay rate, effective January 1, 2020.

Note: This table does not include all possible base hourly pay rates. If your pay rate does not appear in the table, call the insurer at 1-800-843-8184.

Age	UniCare Rate per $100	Base Hourly Pay Rate	UniCare Monthly Premium	Base Hourly Pay Rate	UniCare Monthly Premium	Base Hourly Pay Rate	UniCare Monthly Premium	Base Hourly Pay Rate	UniCare Monthly Premium
<25	$0.144	$18.96	$4.73	$24.72	$6.17	$25.40	$6.34	$25.75	$6.43
25-29	$0.237	$18.96	$7.79	$24.72	$10.15	$25.40	$10.43	$25.75	$10.58
30-34	$0.372	$18.96	$12.23	$24.72	$15.94	$25.40	$16.38	$25.75	$16.60
35-39	$0.517	$18.96	$16.99	$24.72	$22.15	$25.40	$22.76	$25.75	$23.08
40-44	$0.723	$18.96	$23.76	$24.72	$30.98	$25.40	$31.83	$25.75	$32.27
45-49	$0.95	$18.96	$31.22	$24.72	$40.71	$25.40	$41.83	$25.75	$42.40
50-54	$1.023	$18.96	$33.62	$24.72	$43.83	$25.40	$45.04	$25.75	$45.66
55-59	$1.075	$18.96	$35.33	$24.72	$46.06	$25.40	$47.33	$25.75	$47.98
60-64	$1.126	$18.96	$37.00	$24.72	$48.25	$25.40	$49.57	$25.75	$50.26
Monthly Benefit		**$1,314.56**		**$1,713.92**		**$1,761.07**		**$1,785.33**	

Determining your monthly premium

1. First, calculate your base monthly pay:
    - Take your base hourly rate and multiply by 40 to find your weekly base pay;
    - Multiply that result by 52 weeks
    - Divide that result by 12 months
2. Divide your base monthly pay by 100
3. Find your age and the corresponding premium rate in the chart above
4. Multiply the premium rate per $100 by the results you obtained in calculation 2 above

Example:

Doug, an assembly line worker, is 32 years old and earns $24.72 per hour. If he purchases UAW-Ford OLTD insurance, he will pay $13.39 each month for a $1,326.07 tax-free monthly benefit if he gets sick or hurt and can't work. Here's how it works.

Establish his base monthly pay:

Doug's pay rate is $24.72 per hour
$24.72 x 40 hours per week = $988.80
$988.80 x 52 work weeks per year = $51,417.60
$51,417.60 ÷ 12 months = $4,284.80

Then, determine his monthly payment for insurance:

$4,284.80 (Doug's base monthly pay) ÷ 100 = $42.85 per $100 of base monthly covered pay
$42.85 x $0.372 (rate for Doug at age 32) = $15.94

To calculate his tax-free monthly OLTD benefit, which is 40% of base monthly pay:

$3,315.17 (Doug's base monthly pay) x 40% = $1,326.07

Note: Doug's monthly benefit may be reduced by other sources of income, such as Social Security benefits. For more information, see the *Deductible Sources of Income* section.

For a complete description of how OLTD benefits are calculated, refer to your certificate of insurance (available from the insurer at **unicare.com/ford**).

Minimum Benefit

At no time will your monthly benefit payment be less than $100 per month or 10% of the gross monthly benefit amount, whichever is greater, unless your monthly benefit payment is reduced to recover an overpayment. "Gross monthly benefit" means your gross OLTD benefit before any reduction for deductible sources of income.

Maximum Benefit Period

OLTD benefits are payable to age 65, unless your disability results from (1) mental illness, alcoholism or drug addiction, or (2) special conditions as described below, in which case the maximum benefit period is 24 months during your lifetime combined, for all conditions in items (1) or (2).

Special conditions include but are not limited to:

- Chronic fatigue syndrome
- Environmental allergic illness
- Headaches
- Fibromyalgia
- Fibrositis
- Stress-related pain
- Over-use syndrome

- A condition recognized by your physician that is not verifiable using tests, procedures or clinical examinations standardly accepted in medicine
- Musculoskeletal and connective tissue disorders of the neck and back, including any disease or disorder of the cervical, thoracic and lumbosacral back and its surrounding soft tissue, including sprains and strains of joints and adjacent muscles, except for:
  - Arthritis
  - Ruptured intervertebral discs
  - Scoliosis
  - Spinal fractures
  - Osteopathies
  - Spinal tumors, malignancy or vascular malformations
  - Radiculopathies, documented by electromyogram
  - Spondylolisthesis, grade II or higher
  - Myelopathies and myelitis
  - Demyelinating diseases
  - Traumatic spinal cord necrosis

Additional special conditions can be found in your certificate of insurance (available from the insurer at **unicare.com/ford**).

Key Definitions

Disability and Disabled: You meet the definitions of disability and disabled if, due to an injury or illness, all the following statements are true **while you are receiving EDB benefits and the next 24 months of monthly benefit payments under OLTD:**

- You are unable to do the duties of your job on a full-time basis
- You are receiving regular care from a physician for that injury or illness
- Your disability work earnings, if any, are equal to or less than 80% of your indexed monthly earnings
- You are insured under the terms of the policy

You meet the definitions of disability and disabled if, due to your injury or illness, all the following statements are true **after the first 24 months of monthly benefit payments:**

- You are unable to perform the duties of any gainful occupation for which you are or may become reasonably qualified by education, training or experience.
- You are receiving regular care from a physician for that injury or illness.
- Your disability work earnings, if any, are equal to or less than 60% of your indexed monthly earnings.
- You are insured under the terms of the policy.

Disability Work Earnings: Monthly earnings that you receive while you are disabled and working.

Elimination Period: The period of time you were paid EDB. As soon as satisfactory proof is submitted to the insurer, your OLTD benefit payments will begin provided you have satisfied the elimination period.

Gainful Occupation: An occupation that provides you, or can be expected to provide you, with an income that exceeds 60% of your indexed monthly earnings within 12 months of your return to work.

Indexed Earnings: An annual adjustment of the monthly earnings you received immediately prior to your disability. Monthly earnings are adjusted on each anniversary of monthly benefit payments by the lesser of 7% or the current annual percentage increase of the Consumer Price Index. Your indexed monthly earnings amount may increase or remain the same but will never decrease.

Indexing: Used to determine your percentage of lost earnings while you are disabled and working, and in the determination of a gainful occupation.

When Benefits Begin

Your disability must begin while you are insured under the OLTD policy, and your loss of earnings must be a direct result of your injury or illness. You will not be considered disabled from an occupation solely due to loss of earnings as a result of economic factors such as a layoff or recession. For a complete list of situations in which you would *not* be considered disabled, refer to your certificate of insurance (available from the insurer at **unicare.com/ford**).

How Benefits are Paid

The insurer will send you a monthly payment as long as you are eligible for OLTD benefits under the policy. The insurer will explain how your net monthly benefit is calculated. The monthly benefit will be adjusted for disability work earnings (if applicable), and reduced by any deductible sources of income, as summarized in the section below. You are required to apply for all available deductible sources of income.

Recurrent Disability Provision

If you become disabled again after your prior disability ends and you return to work for less than three consecutive months, the insurer will consider your subsequent disability to be part of your initial claim, so you will not have to complete another elimination period. Your monthly benefit payment will be based on your monthly earnings as of the date of your initial claim and will be subject to the same terms and conditions as your initial claim.

Your subsequent disability will be treated as a new claim if:

- It is unrelated to your initial disability; or
- After your initial disability ended, you returned to work for three or more consecutive months.

The subsequent claim will require you to satisfy a new elimination period. For additional information and detail, see your certificate of insurance (available from the insurer at **unicare.com/ford**).

Premium Waiver

Premiums do not need to be paid during the period you are receiving monthly OLTD payments. However, premium payments are required during the elimination period, and after your monthly benefit payments end, if you continue to be insured under the policy.

Deductible Sources of Income

Deductible sources of income are certain benefits you're entitled to as a result of your disability. The insurer will require you to apply for these deductible sources of income and will reduce your OLTD monthly benefit payment by these amounts. If you do not apply for all available deductible sources of income, the insurer will estimate these adjustment amounts and reduce your OLTD monthly benefit payment accordingly.

Examples of deductible sources of income include benefits you receive, or are eligible to receive, from:

- Workers' Compensation
- Automobile liability insurance policy
- Social Security

The insurer will also withhold amounts subject to court orders for dependent support, bankruptcy, tax levies and/or garnishments.

Your benefits **may** also be reduced if you receive benefits under the Ford-UAW Retirement Plan.

For the complete list of deductible sources of income and other important details, see your certificate of insurance (available from the insurer at **unicare.com/ford**).

Non-deductible Sources of Income

The insurer will **not** reduce your OLTD monthly benefit payment any income you receive from the following:

- 401(k) plans
- Profit sharing plans
- Thrift plans
- Tax sheltered annuities
- Stock ownership plans
- Credit disability insurance
- Non-qualified plans of deferred compensation
- Military pension and disability income plans
- Individual disability plans paid by you
- Retirement plans from another plan sponsor, and
- Individual retirement accounts

Recovery of Overpayment

The insurer has the right to recover any amount that is determined to be an overpayment.

Exclusions

The policy does **not** cover any disabilities or loss caused by, resulting from or related to any of the following:

- War or an act of war, declared or undeclared, whether civil or international
- Service in any armed forces, active or reserve
- Self-inflicted injury while sane or insane
- Active participation in a riot or civil commotion
- Any involvement in a felony, unlawful or illegal act
- Any accident or injury that occurs while under the influence of any legal or illegal drug or narcotic, or if your blood alcohol concentration is in excess of the legal limit in the state in which the accident or injury occurred
- Loss of professional license or certification
- Any pre-existing condition

In addition, the policy will **not** pay a benefit under the following circumstances, whichever occurs first:

- You no longer meet the definition of disabled under the terms of the policy
- You are no longer receiving or accepting care from your physician for the reason you are disabled
- You have applied for benefits under fraudulent circumstances resulting in a conviction of fraud
- The maximum benefit period ends
- Beyond the day before your death
- You fail to submit to an independent medical exam or provide documentation requested by the insurer

- You work, unless you are working as part of a vocational rehabilitation program approved by the insurer
- Your disability work earnings exceed the amount allowable under the policy
- You cease to reside in the United States or Canada for six or more months during 12 consecutive months of benefit payments
- You decline to participate in a vocational rehabilitation program that is considered appropriate for you based on your education, training, work experience, skills, interests and disability
- You would be able to work in your own occupation on a part-time basis earning more than 20% of your monthly earnings, but choose not to do so
- You would be able to increase your current earnings to more than 80% by increasing the number of hours worked or duties performed in your own occupation, but choose not to do so
- You refuse to make a good faith effort to adhere to necessary wellness programs that your physician has recommended and that are generally acknowledged to improve or reduce the disabling effect of the illness or injury for which you are claiming benefits
- You are confined to a penal or correctional institution
- Your disability results from cosmetic or reconstructive surgery, except for complications arising from such surgery
- You or your physician fail to provide any medical or psychiatric records that the insurer requests
- With respect to a mental disorder, or alcohol and drug addiction, any period during which you are not under the continuing regular care of a psychiatrist or appropriate alcohol/drug treatment program, or
- Any other provision of the policy is not met. See your certificate of insurance for more detail.

If it is determined that you have applied for benefits under fraudulent circumstances, your benefit payments will cease and the insurer will take the appropriate fraud defense and overpayment recovery action.

Adjustment for Underpayment

The insurer will pay you in one lump sum if the insurer determines you have been paid less than you are due.

Proration

Any OLTD benefit payable for less than one month will be prorated based on a 30-day period.

Awards of Damages and Right of Reimbursement

You are required to reimburse the insurer for any payments you receive from another third-party source relating to the disability for which OLTD benefits have been paid.

See your certificate of insurance (available from the insurer at **unicare.com/ford**) for more details on your responsibilities to reimburse the insurer.

Additional Benefit for Vocational Rehabilitation and Work Incentive

If you are disabled and receiving monthly benefit payments, you may be eligible for services through a vocational rehabilitation program.

Pre-existing Condition Exclusion

A pre-existing condition is any injury or illness that occurred within three months before the date on which you became insured under the policy, whether or not that condition is diagnosed or misdiagnosed during that time.

If the insurer determines that you visited or consulted a physician, hospital, or medical facility, or took clinical tests or received treatment for a condition during the three months before the date you became insured, that condition will be excluded from coverage under the plan.

The exclusion will not apply if the elimination period for the disability begins after the date on which you have been insured under the policy for at least 12 months.

Claims

To file a claim in the event of sickness or injury, you must provide written proof of disability. You are required to notify the insurer within 30 days after a covered loss begins. (If you are unable to provide notice within 30 days due to incapacity, you are required to do so as soon as reasonably practicable.)

To notify the insurer and obtain a claim form, provide your name and the group policy #146363 by calling or writing:

UniCare Life & Health Insurance Company
Disability Claims Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
1-800-232-0113

Note: You must notify the insurer immediately if you return to work in any capacity.

Proof of Disability

You must provide written proof of disability to the insurer within 90 days after your disability begins or as soon as reasonably possible, but in no event more than two years and 90 days after such event. The claim form contains instructions on how to complete and submit it to the insurer.

TIP: *Be sure to provide all the information required in your portion of the form, because unanswered questions or missing information may delay the processing of your claim.*

Proof of disability will include information from your physician about your condition. You must authorize your physician to release your medical information to the insurer and provide the insurer with any additional information and items required to evaluate your claim. The insurer reserves the right to determine if your proof of disability is satisfactory in accordance with the policy and any applicable act or law.

After receiving your claim for benefits, the insurer will review the claim and notify you of its decision to approve or deny the claim. Generally, the insurer will provide you with written notification within 45 days after receiving proof of your disability. If the insurer requests additional information, you will have 45 days to respond to the request. The insurer will send written notice of its claim decision within 30 days after receiving your response.

If there are special circumstances that require additional time to make a determination, the insurer will send you a written notice within 45 days to notify you that an additional 30 days is required. If more time is needed thereafter, the insurer will send written notice during the extension stating that another 30 days will be required. You will have 45 days to respond to each request for information. The insurer will send written notice of a claim decision within 30 days after receiving your response.

From time to time, at reasonable intervals, the insurer will ask you to provide satisfactory proof, at your expense, that you are still disabled. You must provide the requested proof within 30 days, or as soon as reasonably practicable thereafter. Your OLTD benefit payments will stop if you do not provide the insurer with satisfactory proof that you are still disabled.

Release of Information

You agree that the insurer may request, and anyone may give to the insurer, any information, (including copies of records) about an illness, injury or condition for which benefits are claimed, and that the insurer may give similar information, if requested, to anyone providing similar benefits to you.

Medical Examinations

The insurer may require that you undergo an independent medical exam at reasonable intervals. No benefits will be paid beyond any date that:

- You do not provide proof that you remain disabled on or before the date by which such proof is requested by the insurer; or
- You do not allow a physician to examine you on or before the date by which such examination is required by the insurer.

If you die, the insurer may require an autopsy unless it is prohibited by law. Such exam or autopsy as required by this section will be at the insurer's expense.

Appeals

If your claim is wholly or partly denied, you'll receive a notice that will include:

- Reason for denial;
- Reference to specific policy and/or plan provisions, rules or guidelines on which the denial was based;
- A description of the additional information needed to support your claim;
- Information concerning your right to request your denial be reviewed; and
- A description of review procedures, time limits, and notice of your right to bring a civil action under Section 502 of ERISA.

Filing an appeal

You may request a review of part or all of a denied claim. The request must be in writing and must be received by the insurer no later than 180 days after you receive the denial. As part of this review, you may:

- Submit written comments;
- Review any documents or information relevant to your claim; and
- Provide the insurer with other information or proof in support of your claim.

The insurer will review your appeal promptly after receiving your request. Generally, you will be advised of the results within 45 days after the insurer receives your request, or within 90 days if there are special circumstances. The insurer will advise you in writing within the initial 45-day period if an extension is needed (not to exceed an additional 45 days). If the insurer requires additional information, you will have 45 days to respond to the request.

The insurer will notify you in writing of the appeal decision within 30 days after your response is received.

Time Limits for Taking Legal Action

There are time limits as to when you can take legal action to obtain policy benefits, as follows:

- You must wait at least 60 days after you submit written proof of disability to the insurer before taking any legal action.
- You may take legal action no more than three years after the insurer requested written proof of disability.
- For a claim that is denied, in whole or in part, you may take legal action after you have filed an appeal and obtained the insurer's written appeal decision, as explained in the section above titled *Filing an appeal*.

When Insurance Ends

Your OLTD insurance will end as of the earliest date that any of the following events occur (if not currently disabled):

- The period for which you last made contributions for continuing insurance ends
- You request, in writing, that your insurance be terminated
- You cease to be eligible
- Your employment terminates because you quit or are discharged. See the Employment Status Changes section below for more information
- The policy is canceled

When OLTD Benefit Payments Continue

If you are currently disabled, your monthly benefit payments *will not* be affected by:

- Termination or cancellation of the policy; or
- Termination of your insurance; or
- Termination of your employment; or
- Any amendment to the policy that becomes effective after the date you become disabled.

Employment Status Changes

Generally, your OLTD insurance will terminate on the last day of the month in which your employment ends. However, Ford may allow you to continue insurance during certain leaves of absence and layoffs, and while you're receiving EDB benefits.

Leave of Absence: continuing insurance during a leave of absence.

- Your leave must be authorized in writing by Ford.
- Unless otherwise specifically stated under the terms of the policy, you're required to pay all premiums required by the policy.
- If you do not return to work at the end of a leave of absence, your OLTD insurance coverage will terminate at the end of the month in which your seniority is broken.

Re-enrolling for Insurance

If your insurance terminates because you stop making premium contributions, or because you request that your insurance be terminated, you will be required to provide the insurer with proof of your insurability if you want to re-enroll. Insurance will be reinstated only if the insurer approves your proof of insurability.

Claims and Appeals Timelines and COVID-19

During the COVID-19 Outbreak Period (as defined by Federal law and regulations), the deadlines for you to file claims, appeals and external review requests with the Plan have been modified. You will have until the earlier of (i) one year from the date you were eligible for the COVID relief or (ii) the time period from March 1, 2020 until 60 days after the end of the National Emergency. Neither period will be counted in determining whether any of the below actions are timely:

1. The 31-day period to request special enrollment in OLTD insurance coverage upon experiencing certain enrollment events (e.g., upon acquisition of a new spouse or dependent by marriage, birth, or adoption).

2. The date for individuals to notify the plan of a qualifying event or determination of disability.

For example, if you received a claim denial letter dated July 10, 2020 and wish to appeal the denial, you will have until January 6, 2021 (180 days from the date of the claim denial) or the date that is 60 days following the end of the COVID-19 Outbreak Period, whichever is later, to submit your appeal.

Your Rights Under ERISA

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants are entitled to:

1. *Receive information about your plan and benefits.* You may:

    - Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
    - Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

2. *Prudent actions by plan fiduciaries.* In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

3. *Enforce your rights.* If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

    - Under ERISA, there are steps you can take to enforce your rights. For example, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
    - If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court.
    - If you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.
    - If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

    The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

- If you have any questions about your plan, contact the Plan Administrator.
- If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.
- You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Summary of Administrative Information

Plan Administrator/sponsor:
Ford Motor Company

Service of process can also be made upon the Plan Administrator

Plan sponsor's EIN: 38-0549190

Insurer: UniCare Life & Health Insurance Company
Disability Claims Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
1-800-232-0113

Group policy number: 146363

End of plan year: December 31

Optional Long-Term Disability (OLTD) Insurance Program					
Name:	**Plan number:**	**Type of plan:**	**Cost paid by:**	**Trustee:**	**Benefits insured through:**
Optional Long-Term Disability Program	554	Welfare plan providing disability benefits	Employees	None	UniCare Life & Health Insurance Company Administration services performed and claims reviewed and approved by: UniCare Life & Health Insurance Company Disability Claims Service Center P.O. Box 105426 Atlanta, GA 30348-5426 1-800-232-0113 Group policy #146363

This document is intended to be a summary of the OLTD insurance plan. If you have additional questions, refer to your certificate of insurance (available from the insurer at **unicare.com/ford**), or the plan document (available from Ford).

Retirement Plan Benefits

Ford-UAW Retirement Plan Summary Plan Description, November 2021

For UAW-Ford Represented:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011

For UAW-Ford Retirees:

About this Summary

This Summary Plan Description is meant to provide a brief overview of how the Ford-UAW Retirement Plan (Plan) works. The detailed provisions of the Plan, not this summary, govern the actual rights and benefits to which you may be entitled. If there is a conflict between this summary and the Plan document, the Plan document will control.

Retirement Plan Overview

The Ford-UAW Retirement Plan (Plan) provides you with monthly income during your retirement years.

The Plan pays monthly benefits as long as you have at least five years of credited service or Employee Retirement Income Security Act (ERISA) Service.

Active Employees

Here is a brief summary of how the Plan works:

- **Retirement Types:** There are four types of retirement under the Plan:
  - Normal Retirement
  - Regular Early Retirement
  - Special Early Retirement
  - Disability Retirement
- There are different eligibility requirements for each type of retirement.
- The Plan also includes provisions under which you may be paid a:
  - Temporary Benefit
  - Supplemental Allowance
- **Survivor Benefits:** In addition to benefits provided for your retirement years, benefits may be payable to your spouse if you die, as long as you have completed five years of Plan service or ERISA Service (10 years if you don't accrue service after 1988).
- **Deferred Vested Benefits:** If you leave the Company before you are eligible to retire and you have completed at least five years of Plan service or ERISA Service (10 years if you do not accrue service after 1988), you are eligible for Deferred Vested Benefits.
- **Applying for Benefits:** You must apply for benefits before any payments from the Plan can begin. To apply, you can contact the NESC at 1-800-248-4444 (TDD: 711) to obtain a Benefit Commencement Package 30 to 180 days before you want benefits to begin. All required forms must be completed and returned before payment will begin. If you need any information about the Plan, you can call the NESC or your Union Benefits Representative.
- **Receipt of Social Security Disability Award:** If you receive an Early Retirement Supplement and you become eligible for a Social Security Disability benefit or any other unreduced Social Security benefit, you must notify the Retirement Board of the award.

Retirees

Benefits are a valuable part of compensation earned while you or your spouse was a Ford employee represented by the UAW.

This document contains a description of the benefits available to eligible hourly UAW-represented retirees (and their eligible beneficiaries) of Ford Motor Company under the Collective Bargaining Agreement effective November 18, 2019. You can review a copy of the Collective Bargaining Agreement at your former work location.

Regardless of your type of retirement (Normal, Regular Early, Special Early, or Disability), your benefit is based on your credited service, Plan provisions in effect at the time of your retirement (or termination of employment if Deferred Vested) and any subsequent amendments applicable to you as a retiree.

The Plan provides:

- Life Income Benefit
- Temporary Benefit
- Supplemental Allowance

The Life Income Benefit is a “lifetime” benefit. If you met the requirements for this benefit, you will receive payments for as long as you live.

If you qualified for a Special Early or Disability Retirement, you may be receiving a Temporary Benefit. If you elected a Regular Early Retirement, you may be receiving a Supplemental Allowance.

The Temporary Benefit and Supplemental Allowance are intended to supplement your retirement income until the earlier of:

- Age 62 and one month*
- The date you become eligible for a Social Security Disability benefit or other Social Security benefit that is not reduced because of your age.

** Or until you are eligible for 80% of your full Social Security benefit if you were born between 1/1/1944 and 9/14/1949.*

If you have questions about your retirement benefits, write or call:

Ford-UAW Retirement Board of Administration
P.O. Box 6050
Dearborn, MI 48121
1-800-829-8833

It is important that you keep your current home address on file with the Retirement Board so you will receive your taxable income statement (Form 1099-R) and other important information about your retirement benefits. Payments and Plan information or announcements could be delayed if you move and do not provide your new address.

If your address does change, complete and submit the address change form included with your retirement check (or advise the Retirement Board).

You may also update your address online at **myfordbenefits.com** or by notifying the National Employee Services Center (NESC) at 1-800-248-4444 (TDD: 711).

Plan Participation

Eligibility — Active Employees

You are automatically a Plan participant if you are represented by the UAW under the Collective Bargaining Agreement that became effective November 18, 2019 and:

- Are an hourly Ford employee covered by the Ford-UAW Agreement hired or rehired before November 19, 2007, or
- Were hired or rehired on or after November 19, 2007, but before October 24, 2011 in a specific skilled job classification described in Appendix F of the Skilled Trades Book of the Collective Bargaining Agreement.

Your participation began on your hire date. The Company pays the full cost of Plan benefits.

You do not have any rights to receive Plan benefits until you are eligible to retire or you are entitled to receive Deferred Vested Benefits. Deferred means your benefits are payable at a later date — in this case, on or after age 55. Vested means you have earned a right to receive benefits from the Plan.

If you transferred from the ZF Batavia UAW Retirement Plan to the Ford-UAW Retirement Plan and begin your benefit after December 31, 2008, your service earned under the ZF Batavia UAW Retirement benefit is used to determine your eligibility and to calculate your monthly retirement benefit under this Plan. You will not be paid a benefit from the ZF Batavia UAW Retirement Plan.

Credited Service

Service credits are used to determine your eligibility and benefit amount. Once the hours for which you received pay in a calendar year are counted, you then are given a full or partial year of credited service under the Plan, based in the table shown below:

Hours in a Calendar Year	Credited Service Earned
1,615 or more	1.0 year
1,445 but less than 1,615	0.9 year
1,275 but less than 1,445	0.8 year
1,105 but less than 1,275	0.7 year
935 but less than 1,105	0.6 year
765 but less than 935	0.5 year
595 but less than 765	0.4 year
425 but less than 595	0.3 year
255 but less than 425	0.2 year
85 but less than 255	0.1 year
Less than 85	None

You earn credited service after March 1, 1950, based on hours for which you receive pay from the Company. An hour for which a premium is paid is counted as only one hour. If you have Company service for employment before March 1, 1950, and were actively employed after that date, you may receive credit for this prior service. If you are affected, the NESC can provide more information for you. For the period of your service before 1966, your credited service will not be less than your seniority as of December 31, 1965, excluding seniority for military service before Company employment.

You cannot accrue credited service after you have a break in seniority (as described in the *Break in Seniority* section), unless you later re-establish seniority.

You also earned credited service during layoff between January 1, 1951 and January 1, 1968, as well as layoff between January 1, 1974 and January 1, 1990, depending on your seniority on specific dates, if you apply for credited service before your retirement, as shown on the following table:

If you were absent because of layoff in the following calendar years	And you had at least five years seniority as of
1951-1955	11/19/1973
1956-1962	1/1/1971
1963-1967	10/1/1979
1974-1976	10/1/1993
1976-1979	10/1/2003
1979-1983	10/1/1984 or 10/1/1999
1984-1985	10/1/1996
1986-1989	10/1/2003

You can receive credit for 40 hours for each complete calendar week of layoff multiplied by the applicable percentage shown below:

Seniority on the Above Dates	Percent
20 years or more	100%
15 years but less than 20 years	75%
10 years but less than 15 years	50%
5 years but less than 10 years	25%

If you retire October 1, 2007, or later, your credited service for the period before January 1, 1996, will not be less than your seniority as of December 31, 1995.

Service Credits During Certain Periods When Not Receiving Company Pay

You can earn credited service during certain periods when you are not receiving pay from the Company if a break in seniority has not occurred, including:

- You can earn credited service for layoff or Company approved sick leave if:
  - o You received pay for at least 170 hours during the year your absence occurred (for years after 1967), OR
  - o You received pay for at least 170 hours during the year prior to when your absence occurred.
- Layoff or Company-approved sick leave in a second calendar year if your absence continues into a second year and you received pay for at least 170 hours during the year in which your absence began (for years after 1969):
  - o You may receive credit for 40 hours of service per week up to a maximum of 1,530 hours during any single, continuous absence due to layoff or Company-approved sick leave
  - o In addition, you may receive credit during your continuing absence due to layoff (but not Company-approved sick leave) beginning on or after March 1, 1982, up to a maximum of 1,700 hours if you:
    - Are at work on or after March 1, 1982
    - Have 10 or more years of seniority at the time of layoff and
    - Have received service credit of 1,530 hours due to your absence

- Approved Union, credit union or military leave
- Approved pregnancy sick leave between March 1, 1950, and January 1, 1968 (up to a maximum of 0.3 year of credited service during each period of absence), if you apply for it before your retirement
- Approved sick leave while receiving Workers' Compensation (if Workers' Compensation benefits are terminated because of a state law that automatically terminates benefits after a certain length of time, or because an employee reaches a maximum medical improvement level, credited service can continue as long as the compensable disability continues)
- Approved leave for up to eight years to occupy public office at the State or Federal level. Public offices include:
    - State: Governor, Lt. Governor, Attorney General, Auditor, Treasurer, Secretary of State or Legislator
    - Federal: President, Vice President or Member of Congress

Other Conditions When You May Receive Service Credits

Special credited service rules apply if you:

- Have prior service outside the Contract Unit
- Were employed by a foreign subsidiary of the Company
- Were employed on certain job classifications at a Company grey iron foundry
- Were employed in certain departments within the Coke Ovens Operations or Ingot Mold Foundry

If any of these conditions apply to you, you may contact the NESC for information on how your service is counted.

ERISA Service

You are eligible to be credited with ERISA Service when you have completed one year of service and are at least age 21 (age 25 before January 1985).

You earn a year of ERISA Service for all years you have worked at least 750 regular time hours for the Company except:

- Years of ERISA Service before age 18 (age 22 if you have no credited service under the Plan after December 31, 1984)
- Years of ERISA Service before January 1, 1971, unless you have at least three years of credited service under the Plan after December 31, 1970
- Years before January 1, 1976, that would be lost under the Plan's break in seniority rules in effect on December 31, 1975
- Years of ERISA Service before a one-year break in ERISA Service until you complete one year of service after the break; a one-year break in ERISA Service is a calendar year in which you do not complete 376 ERISA Hours of Service; an ERISA Hour of Service means each regular time hour for which you are paid for the performance of duties
- Years of ERISA Service before consecutive one-year breaks in ERISA Service that equal the greater of five or your aggregate years of ERISA Service before the break. (This provision applies to employees at work on or after January 1, 1985; before January 1, 1985, ERISA Service before a break that was equal to or greater than your ERISA Service was not counted.)

In determining whether you have an ERISA break, the following will be counted as ERISA Hours of Service even though you are away from work (on or after January 1, 1985) due to:

- Your pregnancy
- The birth of your child
- Placement of a child with you for adoption
- Caring for your child immediately following birth or placement
- Any reason that qualifies you for a leave under the Family and Medical Leave Act of 1993, for absences beginning on or after September 17, 1993

Up to 376 hours for such absences will be counted to prevent a break in ERISA Service in the year in which your absence begins. If you do not need any hours that year to reach 376, the hours will be credited to you the following year to prevent a break if your absence continues into that year.

Break in Seniority

If you terminate employment in a way that constitutes a break in seniority under the 2019 Collective Bargaining Agreement, you will stop accumulating service even though you might have been accruing it until then and your benefit rate will freeze.

If you have a break in seniority on or after March 1, 1950, and return to work for the Company and regain seniority, all the credited service you had earned before you left the Company will be restored.

If you had a break in seniority before March 1, 1950, the NESC can help you determine whether you may receive service credit for the period before your break.

You may not earn more than 1.0 year of credited service for any calendar year.

Determining Retirement Benefits

Your monthly Retirement benefit amount is based on the Benefit Class Code of your job classification, the type of retirement, your retirement date and your credited service.

Your Benefit Class Code is determined by the base hourly rate of the classification you have held for the longest period during the 24 months immediately before your last day worked.

There are four Benefit Class Codes. Each job classification is assigned a Benefit Class Code determined by the base hourly rate of the classification, as shown below.

If your job is covered under an incentive job classification, your incentive earnings are included in determining your Benefit Class Code.

Benefit Class Codes for Job Classifications as of 09/14/2020 with a Maximum Base Hourly Rate	
Benefit Class Code	**Base Hourly Rate**
A	$30.765 or less
B	$30.77 – $31.08
C	$31.085 – $32.38
D	$32.385 or more

Benefit Class Codes for Job Classifications as of 09/19/2022 with a Maximum Base Hourly Rate of:	
Benefit Class Code	**Base Hourly Rate**
A	$31.69 or less
B	$31.695 – $32.01
C	$32.015 – $33.35
D	$33.355 or more

Please refer to the CBA for Benefit Class Code tables in effect prior to 2020.

Your Benefit Class Code may change because of:

- A promotion
- A transfer
- An increase in the maximum base hourly rate of your job classification

The retirement benefit you receive is determined by the provisions of the Plan in effect when you retire or terminate employment. The amount of your benefit at retirement may change as a result of certain intervening events such as Plan amendments, redetermination at age 62 and one month or your subsequent eligibility for Social Security Disability benefits.

Life Income Benefits

Your Life Income Benefit is calculated as follows:

Your Life Income Benefit rate

multiplied by

Your years of credited service

Your Life Income Benefit rate is a key factor in determining your retirement benefit amount from the Plan, regardless of the type of your retirement.

Once you have determined your Benefit Class Code and the date of your retirement, you can find your Life Income Benefit rate in the table below. The table shows the Life Income Benefit rate initially payable at retirement.

Life Income Benefit Rates Effective 10/1/2010 and After		
If Your Retirement Date Is 10/1/2010 or Later	**And Your Benefit Class Code Is:**	**Your Life Income Benefit Rate Is:**
	A	$53.55
	B	$53.80
	C	$54.05
	D	$54.30

Please refer to the CBA for Life Income Benefit Rates in effect prior to 2010.

Example: *Life Income Benefit Calculation*

Suppose you are retiring as of January 1, 2021, are age 65 and not married, with 30 years of credited service. Assume also that the base hourly rate of your job classification at this time is $30.77 and that your Benefit Class Code is B.

You then must determine your Life Income Benefit rate. According to the table, your Life Income Benefit rate is $53.80 as of January 1, 2021.

Your Life Income Benefit	
1/1/2021	$53.80 x 30 years = $1,614.00

Retirement Benefit Types

There are four types of retirement under the Plan generally applicable to employees who have not broken seniority: Normal Retirement, Regular Early Retirement, Special Early Retirement and Disability Retirement.

Here is a short summary of the eligibility requirements for each type of retirement. The following pages describe each type of retirement in more detail:

Retirement Benefit Type	Eligibility Requirements
Normal Retirement	• Age 65 or older with at least one year of credited service
Regular Early Retirement	• Age 55 but less than age 65 with at least 10 years credited service • Any age with at least 30 years credited service
Special Early Retirement	• Age 55 but less than age 65 with at least 10 years credited service and retire under mutually satisfactory conditions • Age 50 with at least 10 years credited service and laid off due to certain plant closings. (The date of the layoff and the plant closing both must occur after 10/1/1984.)
Disability Retirement	• Younger than age 65 • At least 10 years of credited service and • Totally and permanently disabled for at least five months

Generally, although you may otherwise be eligible to retire, your retirement will be deferred if you receive:

- A separation payment under the Voluntary Termination of Employment Program after the end of the allocation period
- A separation payment under the Supplemental Unemployment Benefit Plan

Please consult the specific Plans described in other sections of this handbook or the 2019 Collective Bargaining Agreement for the periods during which retirement must be deferred. If you are not eligible for retirement, you may be eligible for Deferred Vested Benefits. Deferred Vested Benefits are described later.

Normal Retirement

Eligibility

You are eligible for Normal Retirement at age 65 if you have seniority and at least one year of credited service.

Your Normal Retirement date will be the first day of the month after you reach age 65 and apply for retirement.

If you do not retire when you reach age 65, you may retire on the first day of any month thereafter by applying for Normal Retirement.

If you do not apply for Normal Retirement upon reaching age 65, you will be sent a notice advising that the Plan has suspended your Normal Retirement benefits as a result of your continued employment. This notice is a U.S. Department of Labor requirement under 29 Code of Federal Regulations Section 2530.203-3. You need not take action nor reply to this communication. Your benefits will continue to be administered under Plan terms as explained in this summary. If you reach age 72 in 2020 or later, you will have your distribution deferred until retirement.

Deferral of your age 72 distribution will result in an actuarial adjustment when your benefit is paid.

Benefit Amount

Your benefit at Normal Retirement may be made up of a Life Income Benefit.

Survivor benefits and the related payment methods are described in the *Survivor Benefits* section.

Your Life Income Benefit amount is determined using the formula shown in the *Life Income Benefits* section.

***Example:** Normal Retirement Benefit*

Your monthly retirement benefit would be calculated as follows if:

- You are married and retire on April 1, 2021, at age 65 with 30 years of credited service
- Your Benefit Class Code is B and
- Your spouse is three years younger than you.

Benefit Type	At Retirement
Your Life Income Benefit[1]	$1,533.30
Survivor Benefit[2]	$996.65

[1] *$53.80 (Life Income Benefit rate) x 30 (years of credited service) x 95% (Survivorship coverage adjustment). The benefit amount would be $1,614.00 ($53.80 x 30) without the Survivorship coverage*.

[2] *Equals 65% of the Life Income Benefit amount after the Survivorship coverage adjustment.*

If You Return to Work

If you return to work for the Company after you retire, you will continue to receive your Life Income Benefit. You will not, however, earn additional service credits during your reemployment.

Regular Early Retirement

If you meet the eligibility requirements, you can retire before age 65 and receive a Regular Early Retirement benefit under the Plan.

Eligibility

You are eligible for Regular Early Retirement if you:

- Retire between age 55 and 65 and have at least 10 years of credited service
- Retire at any age and have 30 or more years of credited service
- Have seniority when you first meet the age and service requirements

Benefit Amount

Your benefits at Regular Early Retirement may be made up of a Life Income Benefit and a Supplemental Allowance.

Survivorship coverage and related payment methods are described in the *Survivor Benefits* section.

A Life Income Benefit is determined using the formula shown in the *Life Income Benefits* section. If, however, you are younger than age 62 when you retire, your benefit will be reduced based on your age when your benefit begins.

Early Retirement Benefit Reduction			
Age When Benefit Begins	**Percentage of Life Income Benefit Payable**	**Age When Benefit Begins**	**Percentage of Life Income Benefit Payable**
62 or older	100.0%	51	41.5%
61	93.3%	50	38.3%
60	86.7%	49	35.4%
59	80.8%	48	32.8%
58	75.2%	47	30.4%
57	69.4%	46	28.2%
56	63.5%	45	26.1%
55	57.9%	44	24.3%
54	53.2%	43	22.6%
53	48.9%	42	21.0%
52	45.0%		

If you retire between the ages shown, the percentage of the Life Income Benefit payable will be prorated based on whole months.

To illustrate, if you are not married and are younger than age 62 when you retire, your Life Income Benefit is calculated as follows:

Your Life Income Benefit rate

multiplied by

Years of credited service

multiplied by

The percentage of your Life Income Benefit payable

Restoring a Reduced Life Income Benefit

If you are not married and retire before age 62, your full Life Income Benefit will be payable beginning at age 62 and one month if at retirement:

- You have at least 30 years of credited service
- Your age and years of credited service added together total at least 85

Supplemental Allowance

You also may receive a Supplemental Allowance until age 62 and one month* if you apply for retirement benefits within five years of the last day you worked for the Company.

There are two types of Supplemental Allowance payable under the Plan — the Early Retirement Supplement at 30 years of service (better known as "30-and-out") and the interim supplement. Each supplement type has its own set of eligibility requirements in addition to the general requirements described.

In any case, if you retire and then are reemployed by the Company, your Supplemental Allowance stops during your reemployment.

Early Retirement Supplement at 30 Years Credited Service

If you have at least 30 years of credited service, you are eligible to receive an Early Retirement Supplement. Your Early Retirement Supplement is the amount that, when added to your Life Income Benefit (unreduced for survivorship) and Temporary Benefit (if applicable), will bring your total benefit payable under the Plan up to the amount listed in the table that follows.

If Your Retirement Date Is:	Your Total Monthly Benefit Payable Until Age 62 and One Month* Is:
10/1/2010 and after	$3,170

Your Early Retirement Supplement begins when you retire and continues through the month following your 62nd birthday.*

***Example:** Regular Early Retirement Benefits with 30 or More Years Credited Service*

Here is an example of how monthly Regular Early Retirement benefits payable before age 62 with 30 or more years of credited service would be determined based on the following:

- You retire at age 60 on April 1, 2021, with 30 years of credited service
- Your Benefit Class Code is B and
- Your spouse is three years younger than you.

**Or until you are eligible for 80% of your full Social Security retirement benefit if you were born between 1/1/1944 and 9/14/1949.*

	At Retirement	At Age 62 and One Month and Older
Life Income Benefit	$1,318.64[1]	$1,533.30[2]
Early Retirement Supplement	$1,770.66[3]	$0.00
Your Total Benefit	$3,089.30	$1,533.30
Survivor Benefit	$996.65[4]	$996.65[4]

[1] $53.80 (Life Income Benefit rate) x 30 (years of credited service) x 86.7% (early retirement factor) minus $80.70 ($53.80 x 30 x 5%) (Survivorship coverage amount adjustment based on the unreduced benefit that would be payable if then age 62). The benefit amount would be $1,399.34 ($53.80 x 30 x 86.7%) without the Survivorship coverage.

[2] $53.80 (Life Income Benefit rate) x 30 (years of credited service) x 95% (Survivorship coverage adjustment). The benefit amount would be $1,614.00 ($53.80 x 30) without the Survivorship coverage.

[3] $3,170.00 (scheduled total benefit amount before age 62) minus $1,399.34 (Life Income Benefit before Survivorship coverage adjustment) = $1,770.66 Early Retirement Supplement.

[4] Equals 65% of the Life Income Benefit amount after the Survivorship coverage adjustment that was or would have been payable at age 62 or death.

Important: If you are receiving the Early Retirement Supplement and you become eligible to receive a Social Security Disability benefit or any other unreduced Social Security benefit, you must contact the Retirement Board at 1-800-829-8833 and advise them of the award. The Social Security award reduces your Early Retirement Supplement by the Temporary Benefit amount that would have been payable to you if you had retired as a disability retiree under the Plan.

Interim Supplement

If you have less than 30 years of credited service, you are eligible to receive an interim supplement.

Your interim supplement amount is:

Your years of credited service

multiplied by

Your interim supplement rate

Your interim supplement rate depends on your age when you retire:

Monthly Interim Supplement Rate	
If You Retire at Age	**Effective 10/1/2010 and After**
55	$22.60
56	$26.70
57	$32.25
58	$37.80
59	$42.20
60–61	$48.85

If you retire between the ages shown in the table, your interim supplement rate will be prorated based on whole months.

Your interim supplement begins at retirement and continues through the month following your 62nd birthday (or until you are eligible for 80% of your full Social Security retirement benefit if you were born between 1/1/1944 and 9/14/1949). If you become eligible to receive a Social Security Disability benefit or other Social Security benefit not reduced because of your age, you must notify the Retirement Board to stop the interim supplement.

Example: *Regular Early Retirement with Under 30 Years Credited Service*

Here is an example of how monthly Regular Early Retirement benefits payable before age 62 with less than 30 years of credited service would be calculated based on the following:

- You retire at age 60 on April 1, 2021, with 24 years of credited service
- Your Benefit Class Code is B and
- Your spouse is three years younger than you.

	At Retirement	At Age 62 and One Month and Older
Life Income Benefit	$1,063.50[1]	$1,063.50[1]
Interim Supplement	$1,172.40[2]	$0.00
Your Total Benefit	$2,235.90	$1,063.50
Survivor Benefit	$691.27[3]	$691.27[3]

[1] $53.80 (Life Income Benefit rate) x 24 (years of credited service) x 86.7% (early retirement factor) x 95% (Survivorship coverage adjustment). The benefit amount would be $1,119.47 ($53.80 x 24 x 86.7%) without the Survivorship coverage.

[2] $48.85 (interim supplement rate for retirement at age 60) x 24 (years of credited service).

[3] Equals 65% of the Life Income Benefit amount after applying the early retirement factor and the Survivorship coverage adjustment.

It is important to remember that, even though you may become disabled after you have retired and received payments from the Plan, you cannot switch from Regular Early Retirement to Disability Retirement.

Discharged Employees

A discharged employee younger than age 62 at the time of discharge is not eligible to receive a Supplemental Allowance.

Maximum Monthly Benefit

If you retire before you reach age 62 and one month, your total monthly benefit (your Life Income Benefit and any Supplemental Allowance) may not exceed 80% of your monthly base earnings. If your total benefit otherwise would exceed the 80% ceiling, your Supplemental Allowance (but not your Life Income Benefit) will be reduced by an amount necessary to provide you with a total monthly benefit equal to 80% of your monthly base earnings.

Your monthly base earnings equal 173⅓ times your highest straight-time hourly rate in effect for you during the 90 calendar days immediately preceding your last day worked, plus the cost-of-living allowance in effect on your last day worked.

If You Return to Work

If you return to work for the Company after you retire, you will continue to receive your Life Income Benefit. You will not, however, receive a Supplemental Allowance or earn additional service credits during your reemployment.

Special Early Retirement

Special Early Retirement benefits are paid if you retire under certain circumstances with 10 years of credited service.

Eligibility

You are eligible to receive Special Early Retirement benefits if you:

- Retire when you are between age 55 and 65 and have at least 10 years of credited service
- Retire under mutually satisfactory conditions
- Have seniority immediately before retirement
- Have been laid off due to a plant closing or discontinuance of operations

Beginning October 1, 1984, you also are eligible for Special Early Retirement if you:

- Retire when you are at least age 50 and have at least 10 years of credited service
- Have been laid off because of a plant closing and no other plants are in the same labor market as defined under preferential placement, or beginning October 1, 1987, as defined by the State Employment Security Commission in the State where the plant is located. (Under this provision, the date of the layoff and plant closing both must occur on or after October 1, 1984.)

Benefit Amount

Your benefits at Special Early Retirement may be made up of a Life Income Benefit, a Temporary Benefit and a Supplemental Allowance.

Survivorship coverage and related payment methods are described in the *Survivor Benefits* section.

Your Life Income Benefit is determined using the formula shown in the *Life Income Benefits* section. There is no reduction in benefits because of age.

Temporary Benefit

A Temporary Benefit also is payable at Special Early Retirement. This benefit begins when you retire and continues through the month following your 62nd birthday. However, if you become eligible to receive a Social Security Disability benefit or other Social Security benefit not reduced because of your age, you must notify the Retirement Board to stop the Temporary Benefit.

Your Temporary Benefit is based on the following formula:

Your Temporary Benefit rate

multiplied by

Your years of credited service (up to 30 years)

Your monthly Temporary Benefit rate is based on the date you retire, as shown below.

If Your Retirement Date Is:	Your Temporary Benefit Rate Is:	Your Maximum Monthly Temporary Benefit Is:
10/1/2010 and later	$51.40	$1,542.00

Supplemental Allowance

You also may receive an Early Retirement Supplement if you have at least 30 years of credited service and if your unreduced Life Income Benefit combined with your Temporary Benefit does not exceed the applicable 30-and-out benefit.

Maximum Monthly Benefit

If you retire before you reach age 62 and one month, your total monthly benefit (Life Income Benefit and any Temporary Benefit, whether or not payable, and Supplemental Allowance) may not exceed 80% of your monthly base earnings. If your total benefit otherwise would exceed this ceiling, only your Supplemental Allowance (but not your Life Income Benefit or your Temporary Benefit) will be reduced by an amount necessary to provide you with a total monthly benefit equal to the maximum percentage of your monthly base earnings as described above.

Your monthly base earnings equal 173⅓ times your highest straight-time hourly rate in effect for you during the 90 calendar days immediately preceding your last day worked plus the cost-of-living allowance in effect on your last day worked.

Example: *Monthly Special Early Retirement Benefits Payable Before Age 62 with Less than 30 Years Credited Service*

Your monthly retirement benefit would be calculated as follows if:

- You retire at age 60 on April 1, 2021, with 25 years of credited service
- Your Benefit Class Code is B and
- Your spouse is three years younger than you.

	At Retirement	At Age 62 and One Month and Older
Life Income Benefit	$1,277.75[1]	$1,277.75[1]
Temporary Benefit	$1,285.00[2]	$0.00
Your Total Benefit	$2,622.75	$1,277.75
Survivor Benefit	$830.54[3]	$830.54[3]

[1] $53.80 (Life Income Benefit rate) x 25 (years of credited service) x 95% (Survivorship coverage adjustment). The benefit amount would be $1,345.00 ($53.80 x 25) without the Survivorship coverage.

[2] $51.40 (Temporary Benefit rate) x 25 (years of credited service). The Temporary Benefit is payable until you become eligible for a Social Security Disability benefit (or other Social Security benefit not reduced because of your age) or until one month after you reach age 62, whichever is earlier.

[3] Equals 65% of the Life Income Benefit amount after the Survivorship coverage adjustment.

If You Return to Work

If you return to work for the Company after you retire, you will continue to receive your Life Income Benefit and a Temporary Benefit. You will not, however, receive a Supplemental Allowance or earn additional service credits during your reemployment.

Disability Retirement

A Disability Retirement is a benefit that you may be eligible for if you have 10 years of credited service and become totally and permanently disabled.

Eligibility

As an active employee, you are eligible to receive Disability Retirement benefits if you have seniority when you meet the following requirements:

- Are younger than age 65
- Have at least 10 years of credited service
- Have been totally and permanently disabled for at least five months

Under special circumstances, your surviving spouse may be eligible for the survivor's benefit if you have applied for Disability Retirement but do not live for the five months normally required for Disability Retirement. (See the *Survivor Benefits* section.)

If you retired from the Company on a Disability Retirement, benefits end when you no longer meet the requirements for total and permanent disability. At that time, you may retire on Normal, Regular Early, or Special Early Retirement, if you meet the eligibility requirements, or, if approved by the Retirement Board, you may return to work for the Company.

If you remain disabled until you reach age 65, your Life Income Benefit will continue and your retirement will be converted to a Normal Retirement.

If you become disabled after you retire, you do not qualify for Disability Retirement under the Plan.

Definition of Disability

You are considered totally and permanently disabled under the Plan if the Retirement Board determines that:

- You have an injury or disease that prevents you from engaging in any regular occupation or employment with the Company at the plant or plants where you have or had seniority
- You are not engaged in any regular occupation or employment for pay or profit excluding occupation or employment determined by the Retirement Board to be either for rehabilitation purposes or necessary for you to avoid a reduction or termination of Workers' Compensation benefits under the applicable state law
- Your disability is considered to be permanent and continuous for your lifetime

You will be required to have a medical exam to prove your initial disability. Other medical exams may be required from time to time to prove your continuing disability.

Incapacity resulting from service in the armed forces of any country is not covered by the Plan unless you accumulate at least five years of seniority after separation from military service and before incapacity occurs.

You will not receive a Disability Retirement benefit in any month you are receiving weekly Accident and Sickness benefits for the entire month under any plan to which the Company has contributed. If you are receiving Accident and Sickness benefits for part of the month, you will be paid a proportionate amount of your Disability Retirement benefit.

Benefit Amount

Your benefits at Disability Retirement may be made up of a Life Income Benefit, a Temporary Benefit and a Supplemental Allowance.

Survivorship coverage options and related payment methods are described in the *Survivor Benefits* section.

Your Life Income Benefit is determined using the formula shown in the *Life Income Benefits* section. There is no reduction in benefits because of age.

Temporary Benefit

A Temporary Benefit is payable at Disability Retirement only if you provide evidence that you have applied for Social Security Disability benefits and your application was denied.

This benefit begins when you retire and continues through the month following your 62nd birthday (or until you are eligible for 80% of your full Social Security retirement benefit if you were born between January 1, 1944, and September 14, 1949). If you become eligible to receive a Social Security Disability benefit or other Social Security benefit not reduced because of your age, your Temporary Benefit stops.

Your Temporary Benefit is based on this formula:

Your Temporary Benefit rate

multiplied by

Your years of credited service (up to 30 years)

Your monthly Temporary Benefit rate is based on the date you retire, as shown in this table.

If Your Retirement Date Is:	Your Temporary Benefit Rate Is:	Your Maximum Monthly Temporary Benefit Is:
10/1/2010 and later	$51.40	$1,542.00

Supplemental Allowance

You also may receive an Early Retirement Supplement if you have at least 30 years of credited service and if your unreduced Life Income Benefit combined with your Temporary Benefit does not equal the applicable 30-and-out benefit. The Plan assumes you receive a Temporary Benefit even if no Temporary Benefit is payable because you are eligible for Social Security Disability benefits.

Supplemental Allowances and/or Temporary Benefits are benefits generally provided until you are eligible for Social Security benefits. You must notify the Retirement Board if you become eligible for a Social Security Disability benefit or other unreduced Social Security benefit after retirement.

IMPORTANT NOTICE

It is important that you notify the Retirement Board immediately if you are approved for Social Security Disability benefits.

Please be aware that receipt of a lump-sum retroactive Social Security Disability benefit may cause a significant overpayment of your retirement benefits under the Plan.

Any overpayment that is not repaid could severely affect future retirement benefit payments under the Plan until the overpayment is fully recovered.

Note: Any Supplemental Allowance or Temporary Benefit you receive after you become eligible for a Social Security Disability benefit or other Social Security benefit not reduced because of your age will be recovered from your future Life Income Benefit. If you notify the Retirement Board within 15 days after your receipt of a retroactive Social Security disability award, the overpayment amount of any Temporary Benefit or Supplement for the earlier period will be reduced by the attorney fees awarded by Social Security for a successful appeal not exceeding 25% of the award. However, you will need to pay the Plan within 30 days of written notice of the award of the net overpayment.

Maximum Monthly Benefit

If you retire before you reach age 62 and one month, your total monthly benefit (Life Income Benefit and any Temporary Benefit, whether or not payable, and Supplemental Allowance) may not exceed 80% of your monthly base earnings.

If your total benefit otherwise would exceed this ceiling, only your Supplemental Allowance (but not your Life Income Benefit or your Temporary Benefit) will be reduced by an amount necessary to provide you with a total monthly benefit equal to 80% of your monthly base earnings.

Your monthly base earnings equal 173⅓ times your highest straight-time hourly rate in effect for you during the 90 calendar days immediately preceding your last day worked plus the cost-of-living allowance in effect on your last day worked.

Payment Continuation Length

Disability Retirement benefits end when you no longer meet the requirements for total and permanent disability or when you reach age 65, whichever is earlier. After age 65, you will receive Normal Retirement benefits. This will be done automatically. You will not be notified of this change.

Example: Disability Retirement Benefits Payable at or after Age 55 with Less than 30 Years Credited Service

Here is an example of how your monthly Disability Retirement benefit would be calculated based on the following:

- You retire at age 60 on April 1, 2021, with 25 years of credited service
- Your Benefit Class Code is B and
- Your spouse is three years younger than you.

	At Retirement	At Age 62 and One Month and Older
Life Income Benefit	$1,277.75[1]	$1,277.75[1]
Temporary Benefit	$1,285.00[2]	$0.00
Your Total Benefit	$2,562.75	$1,277.75
Survivor Benefit	$830.54[3]	$830.54[3]

[1] $53.80 (Life Income Benefit rate) x 25 (years of credited service) x 95% (Survivorship coverage adjustment). The benefit amount would be $1,345.00 ($53.80 x 25) without the Survivorship coverage.

[2] $51.40 (Temporary Benefit rate) x 25 (years of credited service). The Temporary Benefit is payable until you become eligible for a Social Security Disability benefit (or other Social Security benefit not reduced because of your age) or until one month after you reach age 62, whichever is earlier.

[3] Equals 65% of the Life Income Benefit amount after the Survivorship coverage adjustment.

Example: *Disability Retirement Benefits Payable Before Age 55 with Less than 30 Years Credited Service*

Here is how your monthly Disability Retirement benefit would be calculated based on the following:

- You retired at age 50 on April 1, 2021, with 25 years of credited service
- Your Benefit Class Code is B, and
- Your spouse is the same age as you.

	At Retirement	At Age 55	At Age 62 and One Month and Older
Life Income Benefit	$1,178.22[1]	$1,277.75[2]	$1,277.75[2]
Temporary Benefit	$1,285.00[3]	$1,285.00[3]	$0.00
Your Total Benefit	$2,433.98	$2,547.75	$1,277.75
Survivor Benefit	$589.11[4]	$830.54[5]	$830.54[5]

[1] $53.80 (Life Income Benefit rate) x 25 (years of credited service) x 87.6% (Special Disability Survivorship coverage adjustment). The benefit amount would be $1,345.00 ($53.80 x 25) without the Special Disability Survivorship coverage.

[2] $53.80 (Life Income Benefit rate) x 25 (years of credited service) x 95% (Survivorship coverage adjustment). The benefit amount would be $1,345.00 ($53.80 x 25) without the Survivorship coverage.

[3] $51.40 (Temporary Benefit rate) x 25 (years of credited service). The Temporary Benefit is payable until you become eligible for a Social Security Disability benefit (or other Social Security benefit not reduced because of your age) or until one month after you reach age 62, whichever is earlier.

[4] Equals 50% of the Life Income Benefit amount after the Special Disability Survivorship coverage adjustment; payable to the surviving spouse after the retired employee would have reached age 55 (assuming the retiree died before reaching age 55).

[5] Equals 65% of the Life Income Benefit amount after the Survivorship coverage adjustment.

If You Return to Work

The Ford-UAW Retirement Plan Board of Administration determines if a disability retiree may return to work for the Company. If your disability ends before age 65 and you are approved to return to work, your retirement benefit will stop. You will receive service credits earned both before and after your Disability Retirement, but not during the period of your retirement. Your Disability Benefit will also stop if you are found to be in gainful employment outside the Company.

Deferred Vested Benefit

If you leave the Company for reasons other than retirement, you may be eligible for a Deferred Vested Benefit.

Eligibility

You are eligible to receive a Deferred Vested Benefit if you have a break in seniority and you:

- Have at least five years of credited service under the Plan, five years of ERISA Service (described in another section) or 10 such years if you do not accrue service after 1988, and
- Are not eligible for any other retirement benefit under the Plan

Benefit Amount

Your Deferred Vested Benefit is calculated as follows:

The Life Income Benefit rate for a Deferred Vested Benefit based on the date of your break in seniority

Multiplied by

Years of credited service

Keep in mind that years of ERISA Service may be used to determine your eligibility for a benefit, but to determine your Life Income Benefit amount, years of credited service as defined by the Plan are used.

The Life Income Benefit rates for Deferred Vested Benefits are:

If the Date You Break Seniority Is:	And Your Benefit Class Code Is:	The Life Income Benefit Rate for Your Deferred Vested Benefit Is:
10/1/2010 or later	A	$53.55
	B	$53.80
	C	$54.05
	D	$54.30

A reduced benefit can begin as early as age 55 as long as you apply at least 180 days before you want payments to start.

Receiving Deferred Benefits Early

If you choose to begin payments before age 65, your Life Income Benefit will be reduced. The reduction amount depends on the years and months you receive payments before age 65 as shown in the table:

Age When Deferred Vested Benefit Begins:	Percentage of Life Income Benefit Payable:
64	93.3%
63	86.7%
62	80.0%
61	73.3%
60	66.7%
59	60.7%
58	55.4%
57	50.6%
56	46.4%
55	42.5%

If you retire between the exact ages shown in the table, the percentage of the Life Income Benefit payable will be prorated based on whole months.

If you had a break in seniority after June 1, 1955, but before October 1, 2010, your eligibility for Deferred Vested Benefits and the benefit amount will be based on the Plan provisions in effect at the time of your break.

ERISA Service

If you leave the Company before you have earned five years of credited service under the Plan (10 years of such service if you do not accrue service after 1988), you will be eligible to receive a Deferred Vested Benefit if you have five years of ERISA Service (10 years of service if you do not accrue service after 1988). Your benefit amount, however, will be based on your years of credited service under the Plan.

Survivor Benefits

If you are married for at least one year when you begin receiving Deferred Vested Benefits, the Plan automatically provides the Survivorship coverage.

You can reject the automatic Survivorship coverage and choose to have a monthly benefit during your lifetime with payments stopping at your death, or you may elect one of the optional forms of Survivorship coverage. Your spouse must agree to this decision, however, by giving written consent witnessed by a Plan representative or notary public.

A special Pre-retirement Survivorship coverage protects your spouse before you begin receiving Deferred Vested Benefits.

The Pre-retirement Survivorship coverage is in effect automatically for vested employees. If you left the Company and the Pre-retirement Survivorship coverage was in effect at the time you left, it continues in effect (regardless of age) until your Plan benefit begins.

If you are not legally married, the automatic Survivorship coverage does not apply to you, but you may elect one of the optional forms for someone other than a spouse.

Coverage Options

There are three automatic and two optional forms of Survivorship coverage under the Plan.

The Plan recognizes any legally married spouse for benefit purposes, regardless of the law of the State or foreign jurisdiction of residence.

If you are not legally married, Survivorship coverage does not apply to you. Otherwise, the Plan offers three automatic payment options — the Survivorship Coverage, the Special Disability Survivorship Coverage and the Pre-retirement Survivorship Coverage.

The Payment Option in Effect for You Is the:	If You Are Married for at Least One Year and Are:
Survivorship Coverage	• Receiving retirement benefits (including Deferred Vested Benefits) or eligible for Regular Early or Normal Retirement or between age 50 and age 55 and eligible for immediate Special Early Retirement • At least age 55 on Disability Retirement or have 30 or more years credited service at Disability Retirement
Special Disability Survivorship Coverage	• On Disability Retirement • Younger than age 55 and have less than 30 years credited service
Pre-retirement Survivorship Coverage	• An employee with five years credited service or ERISA Service (10 years of such service if you do not accrue service after 1988) • A former employee with five years credited service or ERISA Service (10 years of such service if you do not accrue service after 1988) • Not eligible for the Survivorship coverage or the Special Disability Survivorship coverage

If you are married and want your benefit paid for your lifetime only, you can reject the applicable option shown above. Your spouse must agree to this decision by giving written consent witnessed by a Plan representative or notary public.

Keep in mind that if you are married for less than one year at the time of your retirement, you will have no Survivorship coverage in effect until your first wedding anniversary.

At that time, you will be covered under the Survivorship coverage or the Special Disability Survivorship coverage, as appropriate, unless you and your spouse elect otherwise.

Notwithstanding the foregoing, if you die during the month the Survivorship coverage was to become effective, you will be deemed to have met the one year eligibility requirement and your surviving spouse will receive the Survivorship coverage elected.

Survivorship Coverage

With this coverage, you receive an income for life and your surviving spouse receives continuing income in the event of your death.

If you are otherwise eligible for Normal or Regular Early Retirement, your spouse will be eligible for this survivor benefit as though you retired on Regular Early or Normal Retirement at death. You must have been married to your spouse for one year at the time of your death.

Your spouse's benefit is based on your Life Income Benefit if you are at least age 62 at the time of your death. Otherwise, it is based on the Life Income Benefit that would have been payable to you at age 62 had you retired on Regular Early or Normal Retirement on the date of your death.

There is a reduction made in your Life Income Benefit paid during your lifetime to provide this survivor protection. If you and your spouse are within five years of each other's age, the reduction is 5%. This percentage reduction will vary by one-half percent for each year more than five that your spouse is younger or older than you.

To illustrate: If your spouse is three years younger than you, and you elect the Survivorship coverage, the percentage of your Life Income Benefit payable to you is 95% (the reduction to your benefit to provide this coverage is 5%).

If Your Spouse Is:	Percentage of Your Life Income Benefit Payable to You*:	Reduction to Your Life Income Benefit to Provide Survivorship Coverage:
15 years younger than you	90%	10%
14 years younger than you	90.5%	9.5%
13 years younger than you	91%	9%
12 years younger than you	91.5%	8.5%
11 years younger than you	92%	8%
10 years younger than you	92.5%	7.5%
9 years younger than you	93%	7%
8 years younger than you	93.5%	6.5%
7 years younger than you	94%	6%
6 years younger than you	94.5%	5.5%
The same age or up to 6 years younger or older than you	95%	5%
6 years older than you	95.5%	4.5%
7 years older than you	96%	4%
8 years older than you	96.5%	3.5%
9 years older than you	97%	3%
10 years older than you	97.5%	2.5%
11 years older than you	98%	2%
12 years older than you	98.5%	1.5%
13 years older than you	99%	1%
14 years older than you	99.5%	0.5%
15 or more years older than you	100%	0%

** The percentage payable may never exceed 100%.*

These reductions in your benefit are effective on the latest of:

- Your retirement date
- The first day of the month following your first wedding anniversary, if married less than one year at retirement
- Your 55th birthday, if you are on Disability Retirement before age 55 with less than 30 years of credited service

After your death, 65% of your reduced Life Income Benefit will be paid each month to your spouse. This amount does not include any Temporary Benefit or Supplemental Allowance that was payable to you.

Special Disability Survivorship Coverage

With this coverage, you receive an income for life, and your surviving spouse receives an income in the event of your death, if married one year. This option remains in effect until you reach age 55. At that time, you may elect the automatic 65% Survivorship coverage or the Optional 75% Surviving Beneficiary Benefit, unless you and your spouse reject the coverage. The Retirement Board will notify you of applicable provisions shortly before your 55th birthday.

There is a reduction made in your Life Income Benefit to provide the Special Disability Survivorship coverage. The reduction is based on your age and your spouse's age, as shown for selected ages in the table below.

To illustrate: If you are age 40 and your spouse is age 35, and you elect the Special Disability Survivorship coverage, the percentage of your Life Income Benefit payable to you is 88.2%.

	Percentage of Your Life Income Benefit Payable to You if the Special Disability Survivorship Coverage Is Elected:		
Your Age When Disability Benefits Begin	**Your Spouse Is 5 Years Younger than You**	**Your Spouse Is the Same Age as You**	**Your Spouse Is 5 Years Older than You**
50	86.8%	87.6%	88.6%
40	88.2%	89.0%	90.0%
30	91.9%	92.5%	93.3%

If you die while this option is in effect, and you have been married for one year, 50% of your reduced Life Income Benefit will be paid to your spouse for the rest of his or her lifetime. Payments will begin on the first of the month following the month you would have been age 55.

Remember, this option remains in effect only until you reach age 55. When you reach age 55, the reduction in your Life Income Benefit for the Special Disability Survivorship coverage will cease. At that time, if you are married, you will be covered by the Survivorship coverage, unless you and your spouse reject the coverage.

If your spouse dies or you are divorced before you reach age 55, the provisions regarding cancellation described earlier would apply.

Under the following circumstances, your surviving spouse will be eligible for the survivor's benefit of a disability retiree if you have applied for Disability Retirement but do not live for the five months normally required for Disability Retirement.

- You must be on a medical leave of absence (except in the case of an occupational illness or injury) for at least one month and have applied for Disability Retirement. If an occupational illness or injury, or terminal illness results in death, then the one-month waiting period does not apply.
- Satisfactory medical evidence must be provided to support that your death was directly or indirectly the result of the medical condition that gave rise to the medical leave of absence (excluding death as a result of homicide, suicide or accidental death) or be the result of an occupational accident or injury.

If your spouse dies or you are divorced before you reach age 55, the provisions regarding cancellation described earlier would apply.

Pre-retirement Survivorship Coverage

If you should die as an employee or former employee and you are not eligible for Regular Early or Normal Retirement, the Pre-retirement Survivorship coverage may apply. This option is automatic for employees and becomes effective when you have five years of credited service or ERISA Service (10 years if you do not accrue service after 1988). If you leave the Company and were eligible for the option at the time you left, the Pre-retirement Survivorship coverage continues in effect until your retirement benefit begins.

Benefit Amount

If you die while the Pre-retirement Survivorship coverage is in effect, your surviving spouse will receive a monthly benefit for life.

The amount paid to your surviving spouse will be 50% of your Life Income Benefit. Your Life Income Benefit is based on the rate in effect at the time of your death. If you have a break in seniority before your death, the Life Income Benefit will be paid at the rate in effect at the time of the break in seniority.

Other Forms of Survivorship

For retirements on or after January 1, 2004, you can elect someone other than a spouse for a survivor's benefit. If you are married, your spouse must consent to this election in writing and have their consent witnessed by a notary. You can also elect your spouse for one of these optional survivorship coverages, but generally the automatic options provide more value for you and your spouse over your lifetimes.

The Optional 50% or 100% Surviving Beneficiary Benefit (effective January 1, 2004) and Optional 75% Surviving Beneficiary Benefit (effective January 1, 2008):

- Provide you a reduced monthly benefit for life and the elected percentage of your benefit to a beneficiary of choice upon your death.
- Reduce your benefit based on your age and your beneficiary's age. The reduction factors are greater than those used in the Automatic Survivorship Coverage Options described earlier.
- Are available to participants who applied for Normal, Regular Early, Special Early or a Deferred Vested retirement.
- Cannot be elected after retirement benefits begin.
- Cannot be cancelled due to death of the beneficiary.
- Cannot be cancelled due to divorce
- Do not go into effect if the participant dies before the Benefit Commencement Date. The election is automatically cancelled.*

**Effective November 23, 2015, if you elected the Optional 100% Surviving Beneficiary Benefit option for benefits commencing on or after December 1, 2015, and were to pass away prior to your Benefit Commencement Date, your election would have continued to apply to your benefit as long as your retirement application was signed and complete prior to your death.*

Note: If you elected either the Optional 100% or 75% Surviving Beneficiary Benefit option, and the beneficiary you elected was not your spouse and is 11 or more years younger than you, the percentage your beneficiary will receive is regulated by Treasury Regulation Section 1.401(a)(9)-6T, A-2(c)(2).

An example of the percentage payable to a beneficiary under this survivorship option is illustrated below.

Non-Spouse 100% Contingent Annuitant Percentage for Beneficiary More Than 10 Years Younger			
Beneficiary Years Younger Than Participant	**Permitted Percentage for Beneficiary**	**Beneficiary Years Younger Than Participant**	**Permitted Percentage for Beneficiary**
10 or less	100%	28	62%
11	96%	29	61%
12	93%	30	60%
13	90%	31	59%
14	87%	32	59%
15	84%	33	58%
16	82%	34	57%
17	79%	35	56%
18	77%	36	56%
19	75%	37	55%
20	73%	38	55%
21	72%	39	54%
22	70%	40	54%
23	68%	41	53%
24	67%	42	53%
25	66%	43	53%
26	64%	44 and greater	52%
27	63%		

Divorce After Retirement or Death of Your Spouse

If you and your spouse divorce after you retire, or your spouse dies before you, and you have the automatic Survivorship coverage in effect, your Life Income Benefit generally will be increased to the amount payable without the automatic Survivorship coverage if:

- You are divorced and the divorce decree specifically provides for the cancellation of the Survivorship coverage, or you obtain notarized written consent from your former spouse on a Company-approved waiver form for the cancellation of survivorship, or you obtain a Qualified Domestic Relations Order (QDRO) that specifically cancels the option. The increase will be effective as of the first day of the month following receipt of documentation that is approved by the Plan Administrator.
- Your spouse dies before you die and you submit a certified copy of your spouse's death certificate to the Retirement Board. The applicable increase will be effective as of the first day of the month following the date of your spouse's death, provided that proper notice and proof of death is submitted within six months. If proper notice and proof of death is provided more than six months after your spouse's death, the increase will be effective six months

The increase is based on the type of Survivorship coverage in effect and the date you elected the coverage.

If you are covered by the Special Disability Survivorship coverage, and your spouse dies before you die, or you become divorced, the provisions regarding cancellation described above would apply.

Marriage or Remarriage After Retirement

You may elect a Survivorship coverage if you marry or remarry after commencing retirement and you:

- Are receiving retirement benefits, other than Deferred Vested Benefits
- Have not previously rejected Survivorship coverage
- Do not have any Survivorship coverage in effect
- Apply before you have been married 18 months*

**If you have a Qualified Domestic Relations Order (QDRO) that designates your former spouse as sole beneficiary of your pension benefits, and your former spouse dies, you have 18 months after the date of your former spouse's death to elect Survivorship coverage for a current spouse.*

If you elect Survivorship coverage after commencing retirement, your benefit amount will be reduced. The amount of your benefit reduction and the percentage that will be payable to your spouse will be determined in accordance with applicable Plan provisions in effect at the time of your retirement.

Contact the Retirement Board if you need information or have any questions about the benefit amount or your eligibility for Survivorship coverage.

Benefit Payments

When Payments Begin

Whether you are an employee or former employee, if you die before age 55, benefits begin on the first day of the month following application by your surviving spouse, but in no event before the month following the day you would have reached age 55.

If you broke seniority before age 55 but die after age 55, benefits start on the first day of the month following your death and receipt of an application from your surviving spouse.

Your spouse will not receive a benefit in any month he or she is receiving a Transition or Bridge Survivor Income Benefit under the Life and Disability Insurance Plan. For more information on Transition or Bridge Survivor Income Benefits, see the *Life Insurance Benefits* section.

Survivor Benefits begin on the first day of the month following receipt of an application for benefits from your surviving spouse or beneficiary after your death. A copy of your death certificate (and marriage certificate for surviving spouse benefits) will be required at the time of your surviving spouse's or beneficiary's application. However, if you are between age 50 and age 55 when eligible for immediate Special Early Retirement, but die before you retire or before benefit payments begin, your spouse will be eligible for a Survivor Benefit beginning when you would have reached age 55 as though you retired on Regular Early Retirement.

If you are a disability retiree with less than 30 years of credited service, you have not reached age 55 when you die and you have a Special Disability Survivorship coverage in effect, payments to your spouse will begin on the first day of the month following the month you would have reached age 55.

If you are a disability retiree with less than 30 years of credited service, you have not reached age 55 when you die and you have a Special Disability Survivorship coverage in effect, payments to your spouse will begin on the first day of the month following the month you would have reached age 55.

Your surviving spouse or beneficiary will not be eligible to receive payments from the Plan in the event of your death if:

- No Survivorship coverage options were available to you at retirement
- You elected the automatic Survivorship coverage and cancelled it due to your spouse's death or divorce
- You elected to waive the automatic Survivorship coverage at benefit commencement, with spousal consent
- You did not elect the Optional Surviving Beneficiary Benefit (for retirements on or after January 1, 2004) at the time of your retirement.

Payment of Small Amounts

If the present cash value of the retirement benefit for any individual — who is not in pay immediately prior to the benefit commencement date — is $5,000 or less, such individual will receive the benefit in a single lump sum.

If the lump sum payment is less than $200, the benefit will be distributed directly to such individual. If the lump sum payment is at least $200, such individual may elect to have any portion of the distribution received as either a direct rollover to an Individual Retirement Account (IRA) or eligible tax-qualified plan, or paid as a cash distribution. Effective January 1, 2008, if the lump sum payment is greater than $1,000 and such individual does not make a distribution election; the benefit will be rolled over to an individual retirement plan designated by the Board of Administration. If a direct rollover is not elected, the taxable portion of the distribution will be subject to mandatory 20% Federal income tax withholding.

For retirement benefits with a commencement date on or after January 1, 2016, the present cash value is converted to a single lump sum by applying the applicable mortality table, as defined at that time under Section 417(e)(3)(B) of the Internal Revenue Code, and the annual rate of interest as defined under Section 417(e)(3)(C), determined for the month of August in the year immediately prior to the benefit's commencement date.

Applying for Benefits

You should apply for retirement benefits before your retirement date. You may run benefit estimates through **myfordbenefits.com** website or by contacting the National Employee Services Center (NESC) at 1-800-248-4444 (TDD: 711).

When you are ready to retire, the NESC or your Union Benefits Representative (UBR) can help you file an application. You must apply for benefits before any payments from the Plan can begin. Approximately 30 to 180 days before you want your benefits to begin, you should contact the NESC at 1-800-248-4444 or visit **myfordbenefits.com** to request an application package. All required forms must be completed and returned to the NESC before payment will begin.

Taxes on Retirement Benefits

Your retirement benefits are taxed as you receive them.

When you receive benefits from the Plan, those benefits are taxed as ordinary income.

Federal tax law requires the Company to withhold income taxes from your benefits unless you request no withholding. Whether or not you want tax withheld, or if you want to change your current withholding, you should complete Form W-4P and submit it to the Retirement Board. Form W-4P is available from the NESC, the Retirement Board or a local office of the Internal Revenue Service (IRS).

If you do not submit any Form W-4P, the Company automatically will withhold taxes from your benefits and will assume you are married and claim three withholding allowances at the Federally mandated rate.

If no taxes are withheld from your benefit, or if the amount withheld is not enough to cover the actual taxes due, you may be required to make estimated tax payments.

State tax withholding will apply in those states that require withholding. As with Federal withholding, the Company will withhold State income tax unless you tell the Company not to withhold State income tax. You may elect voluntary State tax withholding in those states that permit voluntary withholding.

Circumstances Affecting Your Retirement Benefits

The Plan is designed to provide you with a continuing source of income when you retire. However, some situations could affect Plan benefits. Those situations are summarized here.

If you leave the Company permanently for any reason before age 65 and you have less than five years of credited service or ERISA service (10 years of such service if you do not accrue service after 1988), no benefits are payable to you or your surviving spouse.

Receiving Retirement Benefits After Termination or Death

Payment of your retirement benefits is made by State Street Bank (the trustee is Northern Trust Company). All retirement payments are dated the first day of the month and represent payment in advance for that month. Your pension check will be mailed to your home unless you elect to have payment electronically transferred to a bank or other financial institution of your choice. You may change these arrangements by advising the Retirement Board of the change.

Checks are mailed to your home or electronically transferred to the financial institution you have designated on the last business day of the prior month. If the last calendar day of the month falls on Saturday, Sunday, or a holiday, checks will be mailed and wire transfers done on the work day immediately before the weekend or holiday.

Divorce or Legal Separation

Benefits under qualified retirement plans generally may not be assigned or alienated, except according to a judgment, decree or Domestic Relations Order (DRO) issued under a state domestic relations law relating to child support, alimony or marital property rights of your spouse, former spouse, child or other dependent. The order must meet the requirements of a Qualified Domestic Relations Order (QDRO), as defined in Section 206(d) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), as determined by the Company.

You can get a copy of the Company's QDRO procedures and model language on qocenter.com or by calling the NESC at 1-800-248-4444 and requesting that a copy be mailed to you.

If you would like to submit your DRO for review, send it to:

Ford National Employee Services Center
Attn: Qualified Order Center
P.O. Box 1590
Lincolnshire, IL 60069-1590
Fax: 1-847-883-9313 (draft orders only)

If the DRO is acceptable, you will be notified and the QDRO will be implemented according to its terms. Other forms of marital dissolution documents may be acceptable as QDROs if they comply with the legal requirements set forth in ERISA Section 206(d) as determined by the Plan Administrator.

Send any of the following documents to the above address:

- DROs (original, true or court certified copies of original Orders filed in a court of competent jurisdiction)
- Proposed orders/draft orders or
- Decrees of divorce, judgments and/or property settlement agreements.

Failure to Provide Information

If you do not make proper application for benefits, provide the necessary information or provide the Company with your current address, your benefits may be delayed or temporarily suspended. Payments may be resumed once the necessary information is provided.

Incapacitation

If the Plan Administrator or Retirement Board finds that any person to whom a benefit is payable is unable to handle his or her affairs, payments may be made to a duly appointed representative, as determined by the Plan Administrator or Retirement Board.

Guardianship

If you are physically or mentally unable to handle your affairs, or if your beneficiary is a minor, payments may be made to a legal guardian or representative on your behalf or on behalf of your beneficiary.

Durable Power of Attorney

In limited circumstances, the Plan will recognize a Durable Power of Attorney (DPOA) to conduct certain transactions on your behalf if you are incapacitated or otherwise unable to handle your personal affairs. For example, a DPOA can direct the monthly retirement check to a new address or affect a direct deposit transfer to your financial institution.

A DPOA is also authorized to assist you with the retirement application process. For example, if your spouse holds DPOA, he or she may sign your retirement application.

A general power of attorney will not be accepted for any transaction.

Federal Garnishment

A Federal Writ of Garnishment against your pension benefit may be obtained by the U.S. Government following procedures authorized by the Federal Debt Collection Procedures Act of 1990 (FDCPA), 28 U.S.C. §3001-3308, and the Mandatory Victims Restitution Act, 18 U.S.C. §3614 (c). The Federal garnishment will attach a lien to your pension benefit. Recovery of the Federal garnishment will begin once you begin receiving your pension benefit.

Assignment of Benefits

Generally, your retirement benefits cannot be assigned, transferred, pledged, sold or attached. However, certain court orders could require that part of your benefit be paid to someone else, such as your spouse, former spouse, child or other dependents. You will be notified if the Plan receives any such order.

Deductions

The Trustee may be authorized by the Ford-UAW Retirement Plan Board of Administration, or approved by you, to make deductions from your retirement benefits. These deductions may include the following:

- V-CAP (UAW Voluntary Community Action Program) contributions
- Optional Life Insurance premiums
- Union dues
- UAW Retiree Medical Benefits Trust premiums
- Repayments
- Benefit plan overpayments
- Taxes as required by law or
- Certain Workers' Compensation payments (if the claim is filed later than two years after retiring or after breaking seniority).

Claims and Appeals

A claim for benefits is a request for a Plan benefit or benefits that you (or your authorized representative) make in accordance with reasonable Plan procedures for filing benefit claims. A claim for benefits does not include casual inquiries about benefits or the circumstances under which benefits might be paid.

As an active employee, if you have a claim for benefits under the Plan, you may contact the NESC. The NESC will attempt to resolve your concerns informally. Otherwise, submit your claim in writing for review with Claims and Appeals Management (CAM) to:

Claims and Appeals Management (CAM)
Ford Motor Company
P.O. Box 1407
Lincolnshire, IL 60069-1407
Fax: 1-847-554-5104

As a retiree, if you have a claim for benefits under the Plan, you may contact the Retirement Board at 1-800-829-8833. The Retirement Board will attempt to resolve your concerns informally. Otherwise, submit your claim in writing to Claim and Appeals Management at the above address.

If a claim for benefits or participation is denied, in whole or in part, you will receive written notification within 90 days (or 45 days for a disability pension claim) from the date the claim for benefits or participation is received. The notice is considered given upon mailing, full postage prepaid in the United States mail, or on the date sent if provided electronically.

The decision will be in writing and it will include:

- The specific reason(s) for the denial
- Reference to the specific Plan provision(s) on which the denial is based, along with a copy of the Plan provision(s) or a statement that one will be provided to you at no charge upon your request
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary
- A description of the Plan's review procedures and the time limits applicable to such procedures, along with a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), following a denial for benefits on review

If the denial is because of a disability claim, the denial of claim will also include:

- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the claim denial, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion that was relied upon in making the claim denial will be provided free of charge to you at your request, and
- If the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that the explanation will be provided free of charge upon your request.

If the Plan Administrator or employee of the Board of Administration determines that an extension of time for processing is required, written notice of the extension will be provided to you before the termination of the initial 90-day period (or 45-day period for disability pension claims). In no event will the extension exceed a period of 90 days (30 days for disability pension claims) from the end of the initial period.

If the Plan Administrator or employee of the Board of Administration determines that an extension of time for processing is required, written notice of the extension will be provided to you before the termination of the initial 90-day period (or 45-day period for disability pension claims). In no event will the extension exceed a period of 90 days (30 days for disability pension claims) from the end of the initial period.

For a disability pension claim, if before the end of the first 30-day period, the Plan Administrator or employee of the Board of Administration determines that, due to matters beyond the Plan's control, a decision cannot be made within the extension period, the period for making the determination may be extended for up to an additional 30 days.

The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator or employee of the Board of Administration expects to make the determination.

If an extension is required because the information in the disability claim is incomplete, the extension notice will specifically explain:

- The standards on which entitlement is based
- The unresolved issues that prevent a decision
- The additional information required for a decision, and
- That you have at least 45 days to provide the information requested.

If additional information is required, the period between the date of the request and the date of your response is not included when calculating the decision deadline.

Claims and Appeals Timelines and COVID-19

During the COVID-19 Outbreak Period (as defined by Federal law and regulations), the deadlines for you to file claims, appeals and external review requests with the Plan have been modified. You will have until the earlier of (i) one year from the date you were eligible for the COVID relief or (ii) the time period from March 1, 2020 until 60 days after the end of the National Emergency. Neither period will be counted in determining whether the date for individuals to notify the Plan of a determination of disability is timely.

For example, if you receive a claim denial letter dated July 10, 2020, and wish to appeal the denial, you will have until January 6, 2021 (180 days from the date of the claim denial), or the date that is 60 days following the end of the COVID-19 Outbreak Period, whichever is later, to submit your appeal.

Review of Denied Claim

If the Plan Administrator or employee of the Board of Administration denies a claim, you may:

- Request a review upon appeal by written application to the Board of Administration within 60 days (or 180 days for a disability pension claim) after the date of the written notification you received advising you that your claim has been denied
- Review pertinent documents
- Submit any issues, comments, documents, records or other information relating to your claim in writing
- Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim

The Board of Administration will take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

For a disability pension claim, the Board of Administration:

- Will not give deference to the earlier decision
- Will provide for review by a named fiduciary who did not make the initial decision and who is not a subordinate of the initial decision maker
- Will, if the decision involves a medical judgment, provide that named fiduciary must consult with a health care professional who is independent of any health care professional involved in the initial denial, and
- Provide for identification of all medical or other experts consulted who have appropriate training and experience in the field of medicine involved in the medical judgment.

A decision will be made within 60 days (45 days for a disability pension claim) of the receipt of your request for review, unless special circumstances require an extension for processing. One 60-day extension (45-day extension for a disability pension claim) will be available to the Board of Administration if necessary with written notice to you. The extension notice will specify the circumstances requiring the extension and the expected date of the determination.

Review Decisions

The decision of the Board of Administration will be in writing and if adverse, it will include:

- The specific reason(s) for the denial
- Specific reference to pertinent Plan provision(s) (including any applicable policy) on which the denial is based, along with a copy of such Plan provision(s) or a statement that one will be provided at no charge upon your request
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
- A statement of your right to bring suit against the Plan under ERISA Section 502(a)

In addition, if the appeal is on a disability pension claim, the notice will include:

- If an internal rule, guideline, protocol or other similar criterion was relied on in making the determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that the rule, guide line, protocol or other similar criterion that will be provided free of charge upon request If the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to your medical circumstances, or a statement that the explanation will be provided free of charge upon request, and
- A statement that you and the Plan may have other voluntary alternative dispute resolution options, such as mediation.

All notices are considered given upon mailing, full postage prepaid in the United States mail or on the date sent if provided electronically.

Limitations Period

No legal action for Plan benefits may be brought against the Plan until after the claims and appeal procedures have been exhausted. Unless the Employee Retirement Income Security Act of 1974, as amended (ERISA), specifically provides a different limitations period, legal actions under the Plan for benefits must be brought no later than two years after the date of the denial of your appeal. Any other legal action must be brought against the Plan no later than six months after the date of the last event that gave rise to your claim.

A participant or beneficiary must bring an action in connection with the Plan in a United States District Court having jurisdiction over the claim.

Board of Administration Decisions

Decisions of the Board of Administration are final and conclusive, binding on all participants and beneficiaries and are only subject to the arbitrary and capricious standard of judicial review.

General Information

Plan Name and Number

Ford Motor Company — UAW Retirement Plan, 001

Plan Administrator and Plan Sponsor

Ford Motor Company
1 American Road
Dearborn, MI 48126
1-800-248-4444

The Plan is administered by Ford Motor Company with administrative services provided by Ford Motor Company and Alight Solutions LLC, a third-party administrator under contract.

Retirement Board of Administration

Ford Motor Company
P.O. Box 6050
Dearborn, MI 48121
1-800-829-8833

Employer Identification Number (EIN)

The Federal government has assigned Ford Motor Company an employer identification number for tax purposes. It is EIN 38-0549190.

Plan Year

The Plan Year is the same as the calendar year, from January 1 through December 31.

Agent for Legal Process

The agent for service of legal process is the Secretary, Ford Motor Company. The Secretary may be contacted at the Company's main address:

Secretary
Ford Motor Company World Headquarters
1 American Road
Dearborn, MI 48126
1-313-322-3000

Alternatively, legal process may be served on the Plan Trustee.

Plan Type and Funding

This Plan is a defined benefit pension plan providing retirement benefits.

The Plan is Company funded, and Company contributions are determined by an independent actuary according to the funding policy adopted by the Company. Plan assets are held in a trust. The money in the trust is used only to pay benefits and administrative costs of the Plan.

Plan Trustee

The Plan Trustee is:

The Northern Trust Company
50 S. LaSalle Street
Chicago, IL 60675
1-312-630-6000 or 1-800-248-4444

The Plan Trustee makes all payments for the Plan. Trust investments are made by investment managers appointed under the Company's Master Trust Fund. These investment managers are banks, trust companies and investment advisors. If you would like a list of investment managers, contact an NESC representative.

The Plan has claimed an exclusion from the definition of the term "commodity pool operator" pursuant to the Commodity Exchange Act, and therefore is not subject to registration or regulation as a pool operator.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or Plan assets transferred to another plan, your benefit is protected. The law requires that your benefit immediately after any merger, consolidation or transfer cannot be lower than the benefit accrued just before the merger, consolidation or transfer. Upon sale of any of the Company's businesses, the Company retains the sole discretion to determine how benefits accrued under the Plan will be handled in the sale.

Plan Amendment or Termination

Your benefits are governed by the terms of the applicable official Plan document and Collective Bargaining Agreement. The Company intends to continue the Plan indefinitely; however, the Company reserves the right to end, suspend or amend the Plan, subject to the applicable Collective Bargaining Agreement.

Amendments also will be made to comply with applicable statutes and regulations. If changes are made, you will be notified.

Neither the Company nor the UAW may amend or terminate the Plan while the 2019 Collective Bargaining Agreement is in effect without the consent of the other party. The Agreement expires on September 14, 2023. At that time, the Plan may be renewed automatically for successive one-year periods, unless Ford or the UAW gives written notice at least 60 days before the applicable expiration date. When notice is given, the Agreement and Plan may be modified, amended or terminated.

Until a change is officially announced, no Plan fiduciary or any other Company representative is authorized to disclose any information about a change. You should rely on officially announced information and Plan materials.

If there is any difference between the official Plan document, negotiated Agreement and this SPD, the official Plan document and negotiated Agreement always will govern.

The Trust Fund is for the use of Plan participants and their beneficiaries, and the payment of Plan expenses. If the Plan is fully or partially terminated, benefits earned up to the date of Plan termination would be non-forfeitable to the extent they are funded. Assets in the fund would be used to pay plan benefits to the extent they are sufficient.

Pension Benefit Guaranty Corporation (PBGC)

Pension benefits under this Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a Federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay benefits. Most participants will receive all of the pension benefits they would have received under the Plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits
- Disability benefits if you become disabled before the Plan terminates and
- Certain survivor benefits

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the Plan Year in which the Plan terminates
- Some or all of the benefit increases and new benefits based on Plan provisions that have been in place for fewer than five years at the time the Plan terminates Benefits that are not vested because you have not worked long enough for the Company
- Benefits for which you have not met all of the requirements at the time the Plan terminates
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's Normal Retirement age, and
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if some of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, contact:

PBGC's Technical Assistance Division
1200 K Street N.W., Suite 930
Washington, D.C. 20005-4026
1-202-326-4000 (not a toll-free number)

TTY/TDD users may call the Federal relay service toll-free at 1-800-877-8339 and ask to be connected to 1-202-326-4000.

Additional information about the PBGC's pension insurance program is available through the PBGC's website at **pbgc.gov**.

No Guarantee of Employment

Nothing in this document is meant as a contract of employment between you and Ford Motor Company or as a right to continued employment with the Company.

ERISA Rights

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that you are entitled to the rights described in this section.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office or other specified locations, such as worksites and union halls, all documents governing the Plan. These include insurance contracts and copies of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Request copies of documents governing the operation of the Plan. These include copies of the latest annual report (Form 5500 series) and current Summary Plan Description. A reasonable charge may be required for the copies.
- Receive a summary of the Plan's latest annual funding notice, which is required by law to be provided to each participant.
- Request a statement explaining your vested rights and if you have a right to receive a benefit at your Normal Retirement age, as defined by the Plan. If you do not have vested rights, the statement will tell you how many more years you have to work to acquire vested rights. This statement, which is available at no cost, must be requested in writing and is not required to be given more than once a year.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a retirement benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision (without charge) and to appeal any denial, all within certain times. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claim and appeal procedures.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of a Plan document or the latest annual funding notice from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In this case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If the Plan fiduciaries misuse the Plan's money or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Questions

If you have any questions about the Plan, you should contact the National Employee Services Center (NESC) at 1-800-248-4444. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in getting documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration (EBSA)
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
1-866-4-USA-DOL (1-866-487-2365),
TTY: 1-877-889-5627

For certain publications about your rights and responsibilities under ERISA, call the publications hotline of the EBSA.

Contacts for Additional Help

To assist with any questions you may have about this Plan, you may:

- Visit **myfordbenefits.com**
- Contact the NESC at 1-800-248-4444 to speak with a retirement representative
- Contact your Union Benefits Representative

Tax-Efficient Savings Plan for Hourly Employees (TESPHE) 401(k) Benefit

TESPHE 401(k) Benefit Summary Plan Description, November 2021

For UAW-Ford Represented:

- **Legacy Employees**: Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees**: Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees**: Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

For UAW-Ford Retirees

Tax-Efficient Savings Plan for Hourly Employees (TESPHE) Overview

The Tax-Efficient Savings Plan for Hourly Employees (TESPHE) is intended to constitute a plan described in Section 404(c) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), and Title 29 of the Code of Federal Regulations Section 2550.404c-1. The fiduciaries of the TESPHE may be relieved of the liability for any losses which are the direct and necessary result of investment instructions given by a participant or beneficiary.

The detailed provisions of TESPHE, not the summary, govern the actual rights and benefits to which you may be entitled. If there is a conflict between this summary and the plan document, the plan document will control.

The TESPHE is a retirement savings plan that provides you with a convenient way to save and invest money to help you achieve your long-term financial goals. The TESPHE offers several advantages:

- **A systematic savings and investment program.** You can save up to 50% of eligible pay from each paycheck. You also can allocate all or part of any profit sharing and certain other bonus payments to the TESPHE.
- **Automatic enrollment.** You are automatically enrolled in the TESPHE, starting at a 3% pre-tax rate, if you do not opt out.
- **A choice of pre-tax, Roth and/or after-tax contributions.**
- **Additional pre-tax or Roth catch-up contributions** for employees at least age 50 by December 31 of a given year.
- **Unique tax advantages.** Your pre-tax contributions are deducted from your eligible pay before Federal and most State and local income taxes are withheld. Earnings on all contributions are sheltered from taxes while they are in the Plan. Other tax advantages also may be available upon distribution of your account.

  Generally, assets attributable to pre-tax and Roth contributions cannot be withdrawn prior to age 59½, while you are still employed, except under certain circumstances. For more information, refer to the *Plan Loans*, *Withdrawals* and *Special Tax Notice* sections.
- **Investment options.** You may choose among investment options that offer a range of risk and return characteristics and that will allow you to accommodate different investment goals. They include target-date funds, stock funds, bond funds, a real asset fund, a stable value fund and a Company stock fund.
- **Daily transactions.** You can make transfers between most investment options, withdraw assets or initiate loans on any business day. Generally, transactions you request before 4 p.m. ET, will be effective at the close of the business day. From time to time, there may be limits imposed on transfers into investment options. See additional information in the *Fund Transfers* section.
- **Daily account valuation.** Your account will be valued each business day to provide up-to-date account information.
- **Deferred distribution.** In most cases, you may elect to leave your assets in the TESPHE after you leave Ford Motor Company.
- **Administration**. Most account details and transactions can be viewed or initiated using **myfordbenefits.com**. You also may contact the National Employee Services Center (NESC) at 1-800-248-4444 for help.

Account Statements

Account statements are provided as soon as practicable after the end of each quarter online at **myfordbenefits.com** or by mail. The statement shows your savings and investments, transactions during the statement period, any fees deducted from your account, the value of your account, and other information regarding your account. It is considered accepted by you or your beneficiaries as correct unless the NESC receives written notice to the contrary within 30 days after the statement has been delivered to you.

To view a statement for any time period from January 1, 2019 to the present, go to **myfordbenefits.com** > *Other Resources* > *Print Savings Overview*.

Performance History

If you are a participant, quarterly fund performance history is provided with your quarterly statement. The most recent quarterly performance also is available on **myfordbenefits.com** or by contacting the NESC at 1-800-248-4444. To see your personal rate of return, go to **myfordbenefits.com** > *Build Your Savings & Retirement > Your Savings and Retirement Plan Details.*

Note to Members Who Are Not Active Employees:

As you review this document, keep in mind that some of the TESPHE features, such as making contributions and requesting loans or hardship withdrawals, do not apply to retirees, terminated employees, alternate payees and beneficiaries, and certain other members who are not active employees, unless stated otherwise.

Plan Eligibility and Participation

Eligibility

You are eligible to participate in the TESPHE immediately upon your initial date of hire if:

- You are an hourly employee of the Company or a participating subsidiary
- You are on the active employment roll as a full-time or part-time employee

If you leave Ford and later return, your eligibility continues to be based on your original date of hire.

Participation

Participation in the TESPHE is voluntary. However, to make saving under the TESPHE easier, if you are hired on or after July 25, 2016, you are enrolled automatically in the TESPHE at a 3% pre-tax contribution rate that is deducted from your base pay.

Automatic enrollment also includes an automatic escalation feature. On the first of the month following the anniversary of the effective date of your first automatic contribution, your contribution rate will increase by 1%. This automatic increase will repeat annually until your contribution rate equals 6% (10%, effective February 4, 2022) of your base pay. Unless you delete or change the automatic increase, the increased amount will be deducted from your base pay as soon as administratively possible following the effective date of the increase. The automatic escalation feature helps you plan for the future now, so that you do not have to remember to increase your savings later. You can always contribute more than the automatic escalation maximum rate, up to the Plan contribution limit described below. There is a minimum 45-day waiting period after your hire date until your automatic enrollment is sent to the Ford payroll system. This is to allow you time to opt out of the enrollment.

After the 45 days, it may take up to two pay periods before your initial enrollment is reflected in your paycheck. Be sure to notify the NESC if your contributions are not being deducted from your paycheck after this time. If you want your contributions to start sooner, you must enroll manually by changing the pending automatic enrollment in your mailbox on **myfordbenefits.com**.

Note: Automatic enrollment does not apply to individuals who are rehired (i.e., return to employment with the Company). In these cases, you must elect or re-elect to make contributions if you want to participate in the Plan, even if you had previous contribution elections. You may enroll or re-enroll in the TESPHE on **myfordbenefits.com** or by calling the NESC at 1-800-248-4444.

If you do not elect otherwise, your contributions will be invested in the TESPHE Qualified Default Investment Alternative (QDIA), presently a BlackRock LifePath® Index NL Fund, appropriate for you based on your age as of December 31. You can change how your TESPHE contributions are invested at any time.

You may enroll in the TESPHE at any time by accessing the website at **myfordbenefits.com** or by calling the NESC at 1-800-248-4444. It could take up to two pay periods before your elections become effective after you enroll. Be sure to look at your paycheck to confirm deductions have started, and notify the NESC if deductions do not commence within two pay periods following your enrollment.

When you elect to participate, you must indicate the percentage of your eligible pay to be contributed to the TESPHE. You also must choose how your contributions will be invested among the available investment options. If you do not provide instructions on how to invest your contributions, the contributions will be invested in the TESPHE QDIA. You may change your contribution percentages at any time.

Account Access

You can manage your TESPHE account almost entirely on **myfordbenefits.com** or via phone through the NESC at 1-800-248-4444. To access your TESPHE account, you will need to enter your User ID and your password. To access the NESC via phone, you will need your Personal Identification Number (PIN). To avoid unauthorized access to your TESPHE account, it is very important to keep your User ID, password and PIN confidential at all times.

Customer Care Representatives are available Monday through Friday, 9 a.m. to 9 p.m., ET, except on weekends and holidays. Most transactions, including changing your contribution percentages, investment elections, fund transfers, loans and withdrawals, may be initiated online and do not require paper forms.

You may obtain your account balance, verify your contribution percentage, or determine the amount available for a loan by contacting an NESC Customer Care Representative.

Conversations with an NESC Customer Care Representative are recorded.

Note:

- To speak with an NESC Customer Care Representative, call 1-800-248-4444 (TDD: 711).
- From overseas, call 1-312-479-9571, supported by AT&T Direct.

User ID, Password and Personal Identification Number (PIN)

A User ID and password are required to access **myfordbenefits.com**. The first time you log on, use your temporary password as provided. You will then be prompted to choose a User ID, new password and PIN. Use your PIN when calling the NESC.

Transaction Deadlines

Changes in Contribution Rates, Investment Elections, Fund Transfers, Loans and Withdrawals

Transactions can be completed on **myfordbenefits.com** or by calling the NESC at 1-800-248-4444.

Your transactions will be effective as of the close of the market (usually 4 p.m., ET) on that day. If your request is made or confirmed after this time or on non-business days, such as weekends or holidays, your transaction will be effective as of the close of business on the next business day. A business day is any day the New York Stock Exchange is open for trading. Generally there is high call volume near the close of the market. Consider calling early to be sure your request is made by the 4 p.m. deadline.

Changing Contribution Elections

Generally, it could take up to two pay periods before changes to your contribution election are reflected in your paycheck. Be sure to notify the NESC if your contributions are not being deducted from your paycheck after this time.

If you have any questions about the TESPHE after reading the information in this Summary Plan Description, please contact the NESC at 1-800-248-4444.

Naming a Beneficiary

You should designate whom you want to receive your TESPHE account balance to avoid issues after your death. Make sure you update your beneficiary designations as your family status changes.

If you die before your account is distributed to you, your beneficiary will be entitled to your benefit as follows:

- If you are married at the time of death, your surviving spouse will be entitled to your vested account balance, unless you designate someone else as your beneficiary. Your spouse must consent to this alternative beneficiary in writing by providing signed, notarized consent.
- If you are not married at the time of death, your vested account balance will be distributed to your designated beneficiary. If you do not designate a beneficiary, your vested account balance will be distributed to your estate.
- Beneficiaries may not designate beneficiaries. The account balance of deceased beneficiaries will be distributed to their estate.

You may submit beneficiary designation(s) for your TESPHE account on **myfordbenefits.com** > *Your Profile* > *Beneficiaries* > *Tax-Efficient Savings Plan for Hourly Employees*.

You may also call the NESC at 1-800-248-4444 to designate beneficiaries. You may change or revoke your beneficiary designations at any time.

Incapacitation

If you or your beneficiary is incapacitated, any payments from your account may be deferred until a legal representative is appointed by a court. The person or party may include a private or public institution, a trust for the benefit of such person (e.g., a conservator or guardian approved by a court for the benefit of such person when such conservator or guardian is supervised or required to provide periodic accountings to the court or agency of the court). The TESPHE does not accept any type of power of attorney to act on behalf of your beneficiary or you.

Contributions

There are four ways money may be contributed to your TESPHE account:

1. Contributions deducted directly from your eligible pay each pay period
2. Contribution of all or a portion of any profit sharing and certain other bonus payments (and any discretionary payments paid with but not part of your profit sharing and certain other bonus payments)
3. Rollover from eligible retirement plan
4. Company contributions made on behalf of certain employees

When you enroll in the TESPHE, you decide how much to save and whether you will save through pre-tax contributions, Roth contributions, after-tax contributions, or any combination of these contribution types. You can save from 1% to 50% of your eligible wages in any combination of pre-tax, Roth, and after-tax contributions, in whole percentages, as long as the combined percentages do not exceed 50%. If you are at least age 50, or will reach age 50 by December 31, you also may make additional pre-tax or Roth contributions (catch-up contributions) of 1% to 50% of your eligible wages in whole percentages. For purposes of the Plan, your eligible wages do not include any additional compensation or any other special compensation.

You may change or stop the percentage of eligible wages you contribute to the TESPHE at any time on **myfordbenefits.com** or by calling the NESC at 1-800-248-4444. Such changes will be effective as soon as administratively feasible. It could take up to two pay periods before you see the change in your paycheck.

Contributions are subject to annual limits imposed under the Internal Revenue Code of 1986, as amended (Code). These limits are available on **myfordbenefits.com** and may be adjusted annually for inflation.

Pre-tax Contributions (Including Pre-tax Catch-up Contributions)

Your pre-tax contributions are deducted from your eligible pay before Federal and most State and local income taxes are withheld. In effect, your taxable pay for current Federal income tax purposes is reduced by the amount of your pre-tax contributions. Social Security taxes apply to your gross pay, including pre-tax contributions.

You eventually will pay income taxes on the value of your pre-tax contributions, including any related earnings, when they are withdrawn or distributed from your TESPHE account. For more information on tax treatment at the time of withdrawal or distribution, see the *Special Tax Notice* section.

Roth Contributions (Including Roth Catch-up Contributions)

Roth contributions are made after taxes are withheld from your eligible pay and do not reduce your taxable income when contributed to the TESPHE. However, you won't pay taxes on any Roth contributions, including any related earnings, when they are withdrawn or distributed from your TESPHE account. For more information on tax treatment at the time of withdrawal or distribution, see the *Special Tax Notice* section.

After-tax Contributions

After-tax contributions are made after taxes are withheld from your eligible pay and do not reduce your taxable income when contributed to the Plan. Any taxes on investment earnings are deferred until the earnings are paid to you and will be taxed at that time. However, you won't pay taxes again on any after-tax contributions upon distribution. For more information on tax treatment at the time of withdrawal or distribution, see the *Special Tax Notice* section.

Contribution Spillover Election

The contribution spillover election helps you preserve your rate of savings should you reach the annual IRS regulatory limit on pre-tax/Roth contributions before the end of the year. When activated, this election authorizes the Company to automatically deduct up to 10% of your eligible pay as after-tax contributions instead of pre-tax/Roth contributions after you reach the annual IRS limit.

Example: *If your pre-tax contribution rate is 15% and you activate the spillover feature, 10% will be deducted from your eligible pay on an after-tax basis after you reach the annual IRS limit. If your pre-tax contribution rate is 5% percent, 5% will be deducted from your eligible pay on an after-tax basis after you reach the annual IRS limit.*

If the spillover election is activated *and* you have made a separate after-tax election, an amount equal to your pre-tax/Roth contribution rate (up to 10%) will be added to your separate after-tax deduction percentage after you reach the annual IRS limit.

Example: *If you elect a 15% pre-tax deduction, a 15% after-tax deduction and activate the spillover election, a total of 25% will be deducted from your paycheck in after-tax contributions after you reach the annual pre-tax limit.*

After-tax contributions attributable to your spillover election will be invested in accordance with your investment election(s) on file, if any, or the TESPHE default investment option (the QDIA) if you do not have any on file.

Catch-up Contributions

If you are age 50 or older, or will reach age 50 or older on or before December 31 of the current year, you may contribute from 1% to 50% (in whole percentages) of your eligible wages on a pre-tax or Roth basis as catch-up contributions. This catch-up election is in addition to your regular contribution election.

If your regular contribution deductions stop because you have reached certain IRS regulatory limits during the year, you may continue making catch-up contributions up to the annual IRS regulatory catch-up limit. You do not have to wait until you reach the regular IRS limit to begin making catch-up contributions; you may make a dual election (e.g., elect to make pre-tax or Roth catch-up contributions and regular pre-tax or Roth contributions at the same time.) When you reach the IRS catch-up contribution limit, your catch-up contributions will stop automatically.

You can make changes to your catch-up contribution election at any time. Generally, changes are effective within one to two pay periods. Your catch-up contribution election will carry over from year to year, unless you change it, similar to your regular election.

Your catch-up contributions are invested in the same investment options as your regular contributions. They do not appear on your paycheck stub as a separate line item, but will be included in your year-to-date pre-tax or Roth deductions.

Eligible Pay for Contribution Deductions

Under TESPHE, your “eligible pay” is listed below.

- Straight-time pay
- Overtime pay
- Holiday and vacation pay
- Incentive pay
- Bereavement pay
- Jury duty pay
- Short-term military duty pay
- Any cost-of-living allowance applicable to eligible pay listed above

Your eligible pay under the TESPHE does not include Christmas bonus, shift differential, weekend premiums, or other special payments.

Note: If you want to contribute a portion of your overtime pay to the TESPHE**, you must elect to do so**. You can make this election on **myfordbenefits.com** or by calling the NESC at 1-800-248-4444.

Profit Sharing and Certain Other Bonus Payments

You may elect to have all or a portion of any profit sharing and certain other bonus payments (along with any Company discretionary payments distributed with but not part of the profit sharing and certain other bonus payments) allocated to the TESPHE as pre-tax or Roth contributions. All such contributions count toward the annual limit and will be invested in accordance with your investment elections. Otherwise, they will be invested in the TESPHE's designated default investment option.

You can make an election to allocate the profit sharing and certain other bonus payments to the TESPHE by going to **myfordbenefits.com** > *Build Your Savings & Retirement > Savings Plan > Change Contributions > Bonus Election*. Your election will remain in effect for future bonuses until changed. You do not have to be enrolled in the TESPHE to make this election. However, to have TESPHE contributions deducted from your regular paycheck, you must enroll.

Rollover Contributions

Active employees may arrange for a rollover of the taxable portion of a cash distribution from an eligible retirement plan as either a direct rollover (distribution check made payable to the TESPHE for your benefit) or an indirect rollover (distribution check made payable to you). Indirect rollovers must be made within 60 days from the date of distribution (60-day rollover).

Eligible retirement plans include:

- 401(k) plans like the TESPHE
- Defined benefit plans like the Ford-UAW Retirement Plan
- Conduit IRA — an IRA that holds a distribution from your prior employer’s plan, plus earnings, and is not mixed with annual IRA contributions made on an after-tax basis
- 403(b) arrangements (tax-free annuities)
- 457(b) plans (governmental plans)
- Traditional IRAs

The TESPHE will accept after-tax amounts from eligible retirement plans only in a direct rollover from your prior employer plan to the TESPHE. The TESPHE may not accept after-tax or Roth monies from an IRA under existing regulations.

You also may roll over an eligible distribution from your deceased spouse or former spouse (due to a Qualified Domestic Relations Order) from the eligible plans listed above.

Employees with a TESPHE account who retire from the Company under the Ford-UAW Retirement Plan or the General Retirement Plan (GRP) as a result of a separation program may roll over to the TESPHE any lump-sum enhancement retirement plan incentive payments from the respective retirement plans.

Employees with a TESPHE account who retire from the Company under the GRP and who elect a lump-sum distribution from the GRP may roll over such distribution to the TESPHE.

Once your assets are transferred to the TESPHE, they are subject to TESPHE withdrawal and distribution rules. See the *Withdrawals* and *Distributions* sections for more information on access to assets in your TESPHE account. Contact the NESC at 1-800-248-4444 for more information if you would like to arrange a rollover and to obtain the necessary form that has important information you need to complete the rollover.

Company Contributions for Certain Employees

You are eligible to receive Company contributions if you are a Seniority Non-Skilled employee hired on or after November 19, 2007, a Skilled Trades employee hired on or after November 19, 2007 (for Supplemental contributions only), a New Skilled Trades employee hired on or after October 24, 2011, or a New Traditional employee. These contributions are made automatically to your TESPHE account. You do not have to enroll in the TESPHE or make a contribution election to receive Company contributions.

If you convert to a Seniority Non-Skilled employee hired on or after November 19, 2007 from Temporary Full-Time (TFT) status, generally, your eligibility is based on the effective date of the conversion date.

Supplemental Contributions

You are eligible to receive Supplemental contributions immediately upon hire or rehire of $1 per compensated hour, capped at 2,080 hours annually (effective January 1, 2013). Effective January 1, 2016, eligibility for supplemental contributions begins immediately upon hire or rehire.

Eligible Compensated Hours

- Straight time work hours
- Overtime hours
- Regular vacation hours
- Paid holiday hours
- Paid excused absence hours
- Bereavement hours
- Jury duty hours
- Short-term military hours
- Call-in hours
- Grievance pay hours
- Wash-up hours
- Apprentice hours

Retirement Contributions

You are eligible to receive Retirement contributions immediately upon hire or rehire based on the effective dates below:

- Date of hire or rehire for Seniority Non-Skilled employees with a Ford Service Date (FSD) on or after November 19, 2007
- Date of hire or rehire for New Skilled Trades employees with an FSD on or after October 24, 2011
- Date of transition for New Traditional employees in 2015

Contribution Rate

- FSD between November 19, 2007 and October 23, 2011: 6.4%
- FSD on or after October 24, 2011: 4.0%; effective November 23, 2015: this rate increased to 6.4%

Eligible Wages

- Straight-time portion of base hourly wages received for hours worked and holiday pay, capped at 40 hours in any one weekly pay period, plus COLA if any straight-time portion of any paid time off (i.e., excused absence, vacation, jury duty, bereavement, holiday, short-term military leave); excludes any grievance pay

Alternative Work Schedule (AWS)

If you are on a qualified Alternative Work Schedule (AWS) programmed in the payroll system, and you work the maximum number of straight-time hours (regular hours) required under the AWS, your Supplemental contributions will be calculated using 40 hours.

If you are on a qualified AWS, your Retirement contributions will be calculated using 40 hours straight-time pay multiplied by the appropriate contribution rate if you work the maximum number of straight-time hours (regular hours) required under the AWS.

Access to Company Contributions

- Retirement contributions are available for withdrawal only after you separate from employment. You may withdraw your Supplemental contributions while still employed at age 59½.
- Company contributions are not available for loans or hardship withdrawals.

Investing of Company Contributions

- Retirement contributions may be invested in any investment option available under the TESPHE except the Ford Stock Fund. Supplemental contributions may be invested in any investment option, including the Ford Stock Fund.
- Initial Company contributions will be invested in the default investment option (target-date fund based on your age). You may change how your future Company contributions are invested at any time.
- You can transfer your Company contribution balances between investment options at any time subject to any restrictions imposed by investment options or the TESPHE.

Contributions Following Qualified Military Service

If you are a participant in the TESPHE and you are reinstated following qualified military service as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may elect to have contributions made to the TESPHE for the period of time when contributions were not otherwise possible due to military service, for up to eight years. These contributions must be made from your wages paid following qualified military service.

Should you elect military make-up contributions, the maximum amount of contributions allowed is calculated using the base wages, and should you elect, any profit sharing and certain other bonus payments you would have received, but for military service, for up to eight years. Such contributions are subject to the provisions of the TESPHE in effect during the applicable period of military service. After you are reinstated to employment, you will have until the lesser of five years, or the actual period of military service, multiplied by three, to make up contributions missed while on qualified military leave.

The military make-up contributions will not be taken into account in the year in which they are made for purposes of any regulatory limit. However, if you contribute to any other employer plan (such as the Federal Thrift Savings Plan), those contributions plus any make-up contributions to the TESPHE cannot exceed the annual regulatory limit for each year you are on qualified military leave.

Payments on any outstanding loan(s) in good standing (no delinquent payment due) prior to the commencement of your military service may be suspended for the period of time you are on military leave. However, you may elect to continue payments by setting up a direct debit from your bank account on **myfordbenefits.com** or via coupons that you can request by calling the NESC at 1-800-248-4444.

Upon reinstatement, your loans will be re-amortized and extended for a period of time equal to the period of qualified military service.

If you are eligible to receive Company contributions, such contributions will be made retroactively if you are reinstated to employment with the Company following qualified military service or if you die while on qualified military service, as defined under USERRA, for up to eight years.

Such Company Contributions are determined as follows:

- Supplemental contributions are determined based on 40 hours per week during each week of qualified military service, not to exceed 2,080 hours in any one year.
- Retirement contributions are determined by applying the applicable retirement contribution rate times the base hourly rate times 40 hours per week during each week of qualified military service, not to exceed 2,080 hours in any one year.

Limitations on Contributions and Eligible Pay

Complex tax rules govern contribution levels to plans like the TESPHE. The following addresses certain Plan provisions and regulatory limits related to savings rates of employees at different pay levels, maximum total contributions to the TESPHE and the maximum amount of eligible pay that can be considered. These regulatory limits may be adjusted for inflation each year. To view this year's regulatory limits, go to **myfordbenefits.com** > *Build Your Savings & Retirement > Savings Plan > Change Contributions > Documents and Resources > Contribution Limits.*

- The tax law encourages fair rates of savings among employees at all pay levels. If the savings rates of TESPHE participants do not meet regulatory requirements, the Company is required to return excess contributions of Highly Compensated Employees (HCEs) to comply with these requirements. HCEs are those employees who received compensation from the Company in the prior year in excess of the regulatory limit for HCEs for that year and who, when ranked based on compensation, are in the top 20% of employees.
- Whether or not contributions for HCEs will be returned depends on the amount of contributions made by non-highly compensated participants, as determined through regulatory testing. If, as a result of such testing, contributions for HCEs must be returned, you may not be able to save the maximum otherwise allowed under the TESPHE.

- The sum of all contributions to the TESPHE (e.g., pre-tax and Roth contributions, excluding any catch-up contributions), after-tax contributions, and Company contributions to the TESPHE cannot exceed the lesser of the regulatory annual additions limit or 100% of your compensation. For this purpose, compensation is your gross earnings for the period April 1 through March 31. The annual additions limit may be adjusted for inflation each year.
- The annual additions limit is divided by the number of annual weekly pay periods. Your weekly contributions may not exceed this prorated amount on a cumulative basis. You may be affected by this weekly limit if you are contributing on a weekly basis at or near the maximum TESPHE contribution rate of 50%. contributions, including any profit sharing payments and any Company discretionary payments distributed with the profit sharing payments you elect to defer, will be adjusted to comply with these limits.

  Note: *This limit is tracked on a per-pay-period basis. So, through six months of the Plan tax year (September 30) 50% of the annual additions limit will be available for contributions into the Plan. If contributions made up to that point in the year cause you to exceed the available limit, contributions will be cut back. If you reach the available limit, it will reflect on the bottom of your paystub as a cutback amount.*
- There also is an annual limit on the amount of eligible pay that can be considered for the purpose of determining your TESPHE contributions. This limit is prorated each pay period and your contribution percentage is applied to this prorated amount. The regulatory limit on eligible compensation may be adjusted for inflation annually.

How Other Benefits Are Affected by Pre-tax Contributions

Pension, Company contributions, life insurance, disability and most other employee benefits for which you are eligible will continue to be based on your pay before adjustments for pre-tax contributions.

Vesting

"Vesting" is the process of obtaining a non-forfeitable interest (or ownership right) in your Company contributions. You are always vested in the contributions you make to the TESPHE.

Vesting of Company Contributions

Company contributions vest three years elapsed time from your original date of hire if you are employed at that time. Any Company contributions in your TESPHE account become vested at that time, and any future Company contributions will be vested when credited to your account.

Your Company contributions also will vest immediately if, while actively employed, you die, reach age 65 or if the TESPHE is terminated.

Forfeiture and Restoration of Company Contributions

Non-vested Company contributions will be forfeited following separation from employment if you take a total withdrawal of the money you contributed to your TESPHE account, or five years following separation, whichever comes first.

If your Company contributions are forfeited because you take a total withdrawal of the money you contributed to your TESPHE account, those Company contributions may be restored to your account if you are rehired prior to the end of the fifth year following separation and repay the money you withdrew from your account. The amount withdrawn must be repaid in cash in a lump-sum prior to the end of the fifth year following rehire. The amount restored to your account upon repayment will be the amount forfeited.

Investing

The TESPHE is intended to constitute a plan described in Section 404(c) of the ERISA, and Title 29 of the Code of Federal Regulations Section 2550.404c-1, and the fiduciaries of the Plan may be relieved of the liability for any losses which are the direct and necessary result of investment instructions given by a participant or beneficiary.

Investment Elections for Future Contributions

Contributions must be invested in increments of 1% for each investment option you select. Your contributions deducted from your weekly paycheck, along with any Retirement contributions for eligible employees, will be invested in the options you select as soon as possible, usually within two business days after pay day. If you are eligible to receive Supplemental contributions, you may invest them the same way you invest the contributions deducted from your check, or you may choose different investment options.

Note: Retirement contributions, any lump-sum distribution from the General Retirement Plan or distribution from the Personal Retirement Plan rolled over to the TESPHE may not be invested in the Ford Stock Fund.

You may change your investment elections for future contributions at any time by going to **myfordbenefits.com** > *Build Your Savings & Retirement* > *Savings Plan* > *Investments* > *Change Investments*, or by calling the NESC at 1-800-248-4444. Your new investment elections will be effective the next business day.

If your request is confirmed after this time, or on non-business days, such as weekends or holidays, your new investment elections will be effective as of the close of business on the next business day.

Member Responsibility

Under the TESPHE, you are solely responsible for the selection of your investment options. Ford Motor Company, the trustee, any appointed fiduciary, the NESC, and employees and agents of Ford Motor Company are not authorized to provide investment advice unless specifically engaged by the Company. For this purpose, the Company engaged Edelman Financial Engines to provide online investment advice (at no additional cost to you) and fee-based professional management under the Plan. These services are optional and may be used at your discretion. The fact that an investment option is available for investment under the TESPHE should not be construed as a recommendation for investment in that option.

The market price and the rate of return on each investment option may fluctuate over time and in varying degrees. Accordingly, the proceeds realized from such investments, if any, will depend on the prevailing market price of the investments at a particular time, which may be more or less than the amount initially invested. There is no assurance that the investment options will achieve their objective.

Designated Default Investment Option

The TESPHE default investment option is a target-date fund, presently the BlackRock LifePath® Index NL Funds. Any contributions for which you do not provide investment direction are automatically invested in the default investment option. If your contributions default to a target-date fund, you have the right to direct the investment of your existing balances and future contributions to any available investment options under the TESPHE, subject to any restrictions imposed by any of the other available options under the Plan.

The BlackRock LifePath® Index NL Fund chosen as the investment option default is based on your age as of December 31, and on the assumption that you will start withdrawing money from your account at age 65. Each LifePath® NL Fund's investment strategy is based on a particular time horizon and level of risk that the investment manager deems appropriate for that timeframe. The investment strategy evolves as the fund approaches its target date. For instance, in the early years, when you have more time to bear short-term fluctuations in the stock market, each fund's asset allocation favors stocks to try to maximize returns. Then, as the fund gets closer to its "target date," a team of investment managers gradually moves more money out of stocks and into more conservative investments, like bonds, to try to preserve the accumulated value of your account. No action is required on your part to rebalance your account.

BlackRock LifePath® Index NL Fund Default Schedule

If Date of Birth Is…	The Default BlackRock LifePath® Fund Is:
In or before 1957	BlackRock LifePath® Index Retirement NL Fund
From 1958 through 1962	BlackRock LifePath® Index 2025 NL Fund.
From 1963 through 1967	BlackRock LifePath® Index 2030 NL Fund.
From 1968 through 1972	BlackRock LifePath® Index 2035 NL Fund
From 1973 through 1977	BlackRock LifePath® Index 2040 NL Fund
From 1978 through 1982	BlackRock LifePath® Index 2045 NL Fund
From 1983 through 1987	BlackRock LifePath® Index 2050 NL Fund
From 1988 through 1992	BlackRock LifePath® Index 2055 NL Fund
From 1993 through 1997	BlackRock LifePath® Index 2060 NL Fund
In 1998 or after	BlackRock LifePath® Index 2065 NL Fund

Available Investment Options

Investment Objective	Tier 1 Target Date Funds	Tier 2 Core Funds	Tier 3 Extended Core Funds
Professionally Managed Asset Allocation	BlackRock LifePath Index NL 2065 Fund BlackRock LifePath Index NL 2060 Fund BlackRock LifePath Index NL 2055 Fund BlackRock LifePath Index NL 2050 Fund BlackRock LifePath Index NL 2045 Fund BlackRock LifePath Index NL 2040 Fund BlackRock LifePath Index NL 2035 Fund BlackRock LifePath Index NL 2030 Fund BlackRock LifePath Index NL 2025 Fund BlackRock LifePath Index NL Retirement Fund		
Growth		Vanguard US Large Cap Index Vanguard US Small/Mid Cap Index BlackRock International All Cap Equity Index NL Fund State Street Global All Cap Equity Index NL Series Fund – Class A	Fidelity Growth Company Fund CP Neuberger Berman Genesis Fund SA T. Rowe Price International Small-Cap Equity Trust Ford Stock Fund
Income		BlackRock Bond Index Fund NL	
Capital Preservation		Interest Income Fund	
Inflation Protection		State Street Real Asset Fund – Class A	

Before you invest in any of the investment options, be sure to review its information by clicking on the fund's name anywhere on **myfordbenefits.com** or by calling the NESC at 1-800-248-4444 to obtain a copy.

Fund Transfers

Transferring Assets

Assets may be transferred from any investment option directly to any other investment option, subject to certain restrictions. There is a limit of one transfer transaction per day. If you want to add to or change a pending transfer from earlier the same day, you must first cancel the original transaction.

You may request a transfer on **myfordbenefits.com** or by calling the NESC at 1-800-248-4444. Your transfer will be effective as of the close of business on any business day if your request is confirmed prior to the close of the New York Stock Exchange (NYSE) (usually 4 p.m., ET) on that day. If your request is made or confirmed after this time, or on a non-business day such as a weekend or holiday, your transfer will be effective as of the close of the next business day. You may wish to call early to be sure your request is confirmed before the deadline. A business day is any day that the NYSE is open for trading.

You may request a transfer in:

- Dollars; or
- Percentage of current fund balance in 1% increments

Note: It is important to review your transactions. If you make a mistake or change your mind, canceling the transaction is your responsibility. If you have any questions regarding a transaction that has not been processed yet, call the NESC at 1-800-248-4444.

Trading Restrictions (or Purchase Blocks)

The investment options available in the TESPHE may impose limits on how frequently you may transfer into the investment option. For example, a fund may not allow you to transfer back into the fund if you have transferred out of the fund within the previous 30 days. Information on fund trading restrictions is available at **myfordbenefits.com** > *Plan Documents* > *Plan Disclosures* > *Annual Participant Disclosure Statement*, or you may contact the NESC to obtain a copy.

Short-Term Redemption Fees

Funds in the TESPHE may impose a short-term redemption fee to discourage short-term buying and selling of fund shares. There are presently no short-term redemption fees for any of the funds. However, fees are subject to change at any time by the fund. You may review any short-term redemption fees at **myfordbenefits.com** > *Plan Documents* > *Plan Disclosures* > *Annual Participant Disclosure Statement*, or you may contact the NESC to obtain a copy.

Transfer Privileges

The investment options available under the TESPHE reserve the right to modify or withdraw transfer privileges at any time, including rejecting any transactions deemed to be disruptive to the fund manager's ability to manage the fund's portfolio. This may include, but is not limited to, substantive dollar amount and/or frequent "round-trip" transactions. (Generally, a "round-trip" is defined as a transfer into and out of, or out of and into, the same fund.) You are able to transfer out of a fund at any time.

If your transaction is rejected by the fund, Alight Solutions LLC (Alight), as the provider of recordkeeping and administrative services for the TESPHE, is not notified until the following business day. At that time, the transaction is reversed (monies are reinvested into the fund(s) from which the transfer was originally processed) at the current fund price.

Fund managers also may instruct Alight to disallow investment of contributions in their funds if they determine you have engaged in market timing. If this occurs, your contributions will be invested in the TESPHE's default investment option and you will be notified so that you can elect another investment option(s) for your contributions, if desired. Please note that neither Ford nor Alight has the ability to influence the fund's decision with respect to modifying or withdrawing transfer privileges.

Transfer Privileges Regarding the Ford Stock Fund

You may transfer assets out of or into the Ford Stock Fund at any time. Presently, there are no restrictions. As with other investment options, be sure to confirm any trading restrictions for the Ford Stock Fund on **myfordbenefits.com** or by calling the NESC at 1-800-248-4444 prior to investing in this Fund.

Independent Fiduciary and Investment Manager for the Ford Stock Fund

Newport Trust Company (Newport) is the independent fiduciary and investment manager for the Ford Stock Fund. Newport has no responsibility for any investment fund under the TESPHE other than the Ford Stock Fund.

The Ford Stock Fund is invested exclusively in shares of Ford common stock, except for a small portion invested in short-term securities to provide liquidity for daily transaction activity. As independent fiduciary for the Ford Stock Fund under the Employee Retirement Income Security Act (ERISA), Newport has the sole fiduciary authority under the TESPHE and ERISA for deciding whether to restrict or prohibit investment in the Ford Stock Fund, or to sell or otherwise dispose of all or any portion of the Ford common stock held in the Ford Stock Fund, subject to the terms of the Plans and any legal and/or practical restrictions. Under the terms of its engagement, Newport will continue to maintain the Ford Stock Fund as a Plan investment option in accordance with the terms of the TESPHE unless otherwise prohibited by ERISA.

Newport will not be in possession of any inside information concerning Ford or its financial condition, and will make any decisions regarding the Ford Stock Fund solely on the basis of publicly available information. While Newport intends to communicate to participants any significant action it takes with respect to the Ford Stock Fund, circumstances may require Newport to act prior to doing so.

Check the Newport website established for TESPHE members at **newportgroup.com/fordplans** periodically for communications from Newport concerning the Ford Stock Fund.

If you have questions or comments about the Ford Stock Fund, please contact Newport at **fordmotorco@newportgroup.com**. You may also contact Newport by mail at:

Ford Participant Inquiry
c/o Newport Trust Company
601 S. Figueroa Street, 44th Floor
Los Angeles, CA 90017

Fees and Expenses

Administrative and Transactional Fees

Plan administrative and recordkeeping expenses are the costs of maintaining the TESPHE's day-to-day operations. They include costs for processing contributions and loan repayments, providing daily participant account valuation and plan accounting, calculating account balances, generating transaction statements, etc. Other expenses are incurred to ensure that the Plans meet legal and tax requirements and to provide other services (e.g., education, online investment advice, communications and postage, legal fees, website access, and maintenance and operation of the NESC). Generally, administrative, recordkeeping and other expenses incurred by the TESPHE are paid by the Company or from forfeitures or other nonparticipant TESPHE assets.

Your TESPHE account is not assessed fees for participant transactional services (e.g., loans, withdrawals, Qualified Domestic Relation Order processing, etc.). However, your account is charged if you request expedited mail delivery for check distributions. Before requesting this service, be sure you understand the specific cost.

Total Annual Operating Expenses (Expense Ratio)

The expense ratio is the percentage of the fund's assets used to pay for the fund's total annual operating expenses. Examples of expenses included in the expense ratio are:

- **Management fees** are paid to the fund's investment manager or advisor for overseeing the portfolio.
- **12b-1 fees** (or distribution fees) are used to cover marketing and advertising costs.
- **Other expenses** include administrative services (e.g., transfer agent fees, shareholder reports, auditing and financial statement preparation fees, participant recordkeeping, custodial fees, etc.).

Total annual operating expenses are reported as a percent or "basis points." One basis point is 1/100 of one percent.

Example: *If a fund charges an expense ratio fee of 0.55% or 55 basis points, the fund's return is reduced by 55/100 of 1% (.0055) annually to cover total annual operating expenses. For each $10,000 invested in that hypothetical fund, $55 annually ($10,000 X .0055) is deducted from that fund.*

Expense ratio fees accrue daily on the average daily fund balance and are assessed monthly. The total is deducted from the fund's assets. Generally, they reduce fund returns. These fees are factored into the daily share price, or net asset value (NAV), and are not charged directly to your account.

Additional Information

The Annual Participant Disclosure provides additional fee information for the Plan, including fund expense ratios. It is available on **myfordbenefits.com** > *Plan Documents > Plan Disclosures > Annual Participant Disclosure Statement*. You can get additional information by clicking on the fund name anywhere on the website.

Plan Loans

You may borrow from your account if you are an active employee, either full-time or part-time. Generally, you may initiate a loan while on a leave of absence from the Company, unless you have an outstanding defaulted loan balance at the time your leave status is recorded. The maximum loan amount available to borrow is located on **myfordbenefits.com**. Or, you may contact the NESC at 1-800-248-4444 for this information.

Know the facts before you act!

- **The more you borrow, the less money you have to potentially grow for your retirement or other long-term savings goals. Leave your money untouched to maximize the potential for your TESPHE account to grow.**
- **The money you borrow from your account misses out on growth opportunities in a rising market. You want your money invested when the market is rising. In addition to contributions, market appreciation is how money invested in your TESPHE account grows. But if you take out any of your TESPHE account for a loan, that money is not invested and, therefore, is missing an opportunity for growth.**
- **If your loan defaults, the Internal Revenue Service (IRS) considers the outstanding balance (including accrued interest) a distribution. The distribution will be subject to ordinary income taxes, and possibly a 10% early withdrawal penalty if you are younger than age 59½.**

Your assets will be sold proportionately from each investment option to finance your loan; however, you have the option of excluding the Ford Stock Fund. You pay back the amount you borrowed (with interest) to your account over the loan repayment period you elect. You may repay the total outstanding loan amount at any time without penalty.

Eligible Assets

In general, eligible assets are pre-tax contributions, Roth contributions, after-tax contributions and any rollover contributions that have been credited to your account. You may not borrow from Company contributions made on your behalf.

Loan Limitations

The maximum loan amount is the lesser of:

- 50% of the aggregate value of the eligible assets in your TESPHE account (excluding some money types not available for funding the loan), or
- $50,000 reduced by the highest loan balance under all Ford plans during the previous 12 months

The minimum loan amount is $1,000. Loan amounts over this minimum may be requested in $100 increments.

Loan Application

You can apply for one loan each calendar year, and you may have up to four loans outstanding at any time (including any defaulted loans). All repayment periods are in one-year increments. Pre-approved, general loans have a loan repayment period of up to five years. If the loan is being used to buy or construct your principal (or primary) residence, you may select a repayment period of up to 10 years. A primary residence loan may not be taken to refinance an existing residence, make a balloon payment on an existing mortgage, or purchase a second home or land.

You may request a loan by calling the NESC at 1-800-248-4444 or using **myfordbenefits.com**. A five-year, pre-approved loan does not require documentation. When you request a primary residence loan on **myfordbenefits.com** or through the NESC, an application will be mailed to your address of record. You must return the completed application and documentation requested to the address on the application. Your primary residence loan must be issued before the closing on the purchase of your primary residence.

Your loan will be effective as of the close of business on any business day if your request is made and confirmed prior to the close of the NYSE (usually 4 p.m. ET) on that day. (Primary residence loans are processed after the documentation is received and approved.) If your request is made and confirmed after this time or on non-business days such as weekends or holidays, your loan will be effective as of the close of business on the next business day. A business day is any day that the NYSE is open. Because of potentially high call volume near the close of the market, you may wish to call early to be sure your request is confirmed before the deadline.

Your loan check will be mailed to you within three to five business days following your loan effective date or direct deposited if you supplied your bank account information on **myfordbenefits.com**. Interest on your loan begins accruing on the first day following the loan effective date. A Loan Promissory Notice with important information regarding loan terms will be mailed separately. Endorsement of your check is considered an acceptance of these terms.

Interest Charges

Loan interest rates are set monthly but do not change during the term of the loan. The interest rate will be the prime rate as of the 15th day of the month preceding the month in which the loan is taken. Interest paid on your loan will be credited to your account. Under current tax laws, you may not deduct your interest payments for loans obtained after 1986 on your tax return.

Loan Repayment

You can make additional loan payments or pay off your loan in full, without penalty, at any time. Go to **myfordbenefits.com** to set up an electronic loan payment via direct debit from your bank account or call the NESC at 1-800-248-4444 to request an Early Loan Payoff invoice. Payments must be made in the form of a cashier's check, certified check or money order.

Regular loan repayments are deducted from your paycheck. The information below describes how these payments are made depending on your employment status:

- **Active Employees**. Your loan repayments will be deducted from your weekly paychecks, with the first repayment deduction set for the fourth pay date following the request. You should verify that the deductions are being made from your paycheck. If deductions are not made, notify the NESC at 1-800-248-4444 immediately so that corrective action can be taken.

  Note: Be sure you confirm that your take-home pay from your regular paycheck is sufficient to cover the total repayment amounts for all outstanding loans for which deductions are required. If your take-home pay is not sufficient, Ford Payroll will not withhold any loan repayments, resulting in delinquent loan payments and possibly loan defaults if the delinquent amounts are not paid in full within the timeframe required.

- **Employee Transfer (to a nonparticipating subsidiary).** You may set up electronic loan repayment through direct debit from your bank account on **myfordbenefits.com** or coupons are available upon request for your use in making monthly loan repayments directly to the NESC.
- **Layoffs (except temporary layoffs), Leaves, Transfers to Salaried.** Required loan repayments will be suspended while you are on a non-military leave of absence or layoff for up to one year. However, if you choose, you may continue to repay your loan. If you do not have any loans in default, you may set up a direct debit from your bank account on **myfordbenefits.com** or coupons are available upon request for your use in making loan repayments directly to the NESC. When you return to work from leave or layoff, your loan will be re-amortized and higher deductions will begin again automatically. This is because, by law, the original loan term cannot be extended. Be sure to verify that deductions from your paycheck have resumed. If deductions are not made, contact the NESC at 1-800-248-4444 immediately so that corrective action can be taken.

  Note: Until you have been on medical leave for 90 days and are removed from the active roll (medical leave expired status), you will not receive coupons. However, you are still required to make loan repayments during that 90-day period. Go to **myfordbenefits.com** to set up electronic loan repayments through direct debit from your bank account or call the NESC to request coupons that must be used to remit your loan repayments to ensure your payments are applied appropriately. Acceptable forms of payment include a cashier's check, certified check or money order.
- **Military Leave.** Repayments for loans in good standing (e.g., no delinquent loan repayments) will be suspended while you are on military leave. However, if you choose, you may continue to repay your loans by setting up electronic loan repayments through direct debit from your bank account on **myfordbenefits.com**. You also may call the NESC to request coupons for loan repayments directly to the NESC. If you receive differential pay from the Company, loan repayments will be deducted to the extent the differential payment is sufficient to cover the full loan repayment amount for all outstanding loans.
- **Temporary Layoffs.** You will not receive coupons while you are on temporary layoff. Unless you send in payments, your loan(s) may default. Go to **myfordbenefits.com** to set up direct debit from your bank account or call the NESC to request coupons that must be used to remit your loan repayments to ensure your payments are applied appropriately. The payment must be in the form of a cashier's check, certified check or a money order. Generally, when you return to work from a temporary layoff and your paychecks resume, loan repayments through payroll deduction will begin automatically.
- **Retirement/Termination.** If you do not repay your loans in full at retirement or termination, you may set up direct debit payments from your bank account on **myfordbenefits.com** or request coupons from the NESC to continue loan repayments (unless you have a history of loan default), or your loans will default. Coupons are not automatically provided to terminated or retired participants.

If you are eligible to make loan repayments via coupons, the NESC can mail a supply of coupons for six months. You may request an additional supply to continue loan repayments beyond six months, if needed. If

you do not receive coupons within 15 days of the effective date of your status change (e.g., leaves, transfers, layoff (other than temporary layoff), etc.), contact the NESC immediately at 1-800-248-4444. If you are coupon eligible, you may also set up electronic loan repayment on **myfordbenefits.com** or by contacting the NESC.

Note: Regulations governing Plan loans require that, if you have a history of loan default (e.g., outstanding defaulted loan balances), loan repayments must be made through payroll deduction. As a result, if you are on leave or layoff status (removed from active status and no longer receiving a regular Company paycheck from which loan repayments are deducted), terminate or retire, you must repay such loans in full or else they will default.

Examples:

- *Susan Jones defaulted on a TESPHE loan in 2019 and elects not to pay off the defaulted loan balance. In February 2021, Susan takes out a new loan and later is laid off and removed from active status effective May 1, 2021. Under the regulations governing TESPHE loans, Susan will not be permitted to continue repayment of the February 2021 loan via coupons or electronic loan repayment while on layoff because she has an outstanding defaulted loan balance at the time of her layoff. She must either pay off the outstanding balance of the loan initiated in February 2021 in full, or the loan will default.*
- *John Smith takes out a loan in March 2021. John is laid off effective May 1, 2021. Because he does not have an outstanding defaulted loan balance at the time of his layoff, he may continue loan repayments via coupons or electronic loan repayment while on layoff.*

Ultimately, you are responsible for making your loan repayments. If loan repayments are not being deducted from your paycheck (active employees), or if you need coupons to make loan repayments (e.g., employees on leave, layoff or transfers to salaried status), you must contact the NESC immediately. Coupons will not be provided automatically. If you are on a temporary layoff or on a medical leave for less than 90 days, you must send in payments or your loan(s) will become delinquent. Set up electronic payments on myfordbenefits.com or request coupons from the NESC to make your payments.

Loan Default Process

If you do not comply with the TESPHE loan repayment provisions (i.e., fail to make payments on time), the delinquent loan payments will subject your loan to default. A Loan Delinquency Notice (Notice) will be mailed to your address of record under the TESPHE if loan repayments are missed. The deadline date applicable to each payment that was missed will be provided in the Notice.

If you fail to remit the total delinquent payments by the due date and in the form of payment required as stated in the Notice, your loan will default. The outstanding loan balance (principal and accrued interest) will be treated as a distribution in the year of default and will be subject to Federal income taxes and early withdrawal penalties. The taxable amount of this distribution will be reported to the IRS. You will receive a Form 1099-R for the tax year in which the loan defaults.

You may elect to pay off your defaulted loan, but you are not required to do so. Interest continues to accrue on defaulted loans as long as you are an active employee. The outstanding defaulted loan balance (including accrued interest on such loan) is considered in determining the amount available for future loans.

Investment of Loan Repayments

Loan repayments, including interest, are invested in accordance with your most recent investment elections for your contributions. Otherwise, your loan repayments, including interest, will be invested in the TESPHE designated default investment option. You may transfer your assets out of the designated default investment option at any time. See the *Fund Transfers* section for more information.

Withdrawals

The TESPHE is intended to help you save for the long term. However, the Plan allows access to your TESPHE account, with certain restrictions. Withdrawal rules vary, depending on the type of assets, your age and other factors. You can see your available withdrawals on myfordbenefits.com or by calling the NESC at 1-800-248-4444. For information on the tax implications of withdrawals, including the tax penalty for certain withdrawals before age 59½, refer to the Special Tax Notice section. Or, the NESC can advise which portion of your withdrawal is taxable.

Your assets will be sold proportionately from each investment option to fund your withdrawal.

After-tax Contributions

You may withdraw all or a portion of your after-tax monies (including any monies attributable to after-tax rollovers) at any time. You are required to withdraw some portion of associated earnings on after-tax contributions made after 1986.

Pre-tax and Roth Contributions

You may withdraw all or a portion of your pre-tax and Roth contributions and associated earnings after you reach age 59½ or terminate employment. If you make a withdrawal at age 59½, or later, while you are still employed, your contributions will continue unless you cancel them. You may only withdraw Roth contributions without penalty if at least five years have passed since your initial Roth contribution. The five-year period starts January 1 in the year you make your initial Roth contribution.

Prior to age 59½ while you are still employed, you may withdraw your pre-tax and Roth contributions only if you have an approved financial hardship.

You also may withdraw your account balance if you have a "severance from employment," an event that occurs if you transfer to an unrelated employer as a result of a corporate action (e.g., sale, disposition or reorganization of one of the Company's businesses).

Hardship Withdrawals

Under the regulations governing hardship withdrawals from the TESPHE, before you can take a hardship withdrawal, you must use all other withdrawal/distribution options available under the Plan (e.g., loans, age 59½ withdrawal, after-tax withdrawal and Ford Stock Fund dividends).

To qualify for a financial hardship:

- You must have an immediate and heavy financial need.
- Withdrawal must be necessary to satisfy such financial need.
- Amount of hardship withdrawal cannot be in excess of the heavy financial need.

Generally, a hardship withdrawal will provide you with pre-tax or Roth monies attributable to your pre-tax or Roth contributions and pre-tax monies rolled over from another plan described in the *Rollovers and Conversions* section. The portion of your account available for a hardship withdrawal is available on **myfordbenefits.com**. You can also contact the NESC at 1-800-248-4444 for this information. A hardship withdrawal cannot be rolled over to another eligible plan or IRA.

Since hardship withdrawals cannot be rolled over, they are not subject to the mandatory 20% withholding requirement. However, such withdrawals are subject to income taxes and the 10% early withdrawal penalty.

Note: The 10% penalty does not apply to hardship distributions for the purpose of satisfying certain medical expenses. You are responsible for appropriately reporting any hardship distributions on your tax return and maintaining the appropriate documentation to support the 10% exclusion.

You should consult with a tax professional and/or review IRS Publications 575, “Pension and Annuity Income” and 502, “Medical and Dental Expenses” for more information.

You may elect to defer applicable taxes until you complete your tax return or voluntarily have the taxes withheld from the hardship distribution. If you want taxes withheld at the time of distribution, your hardship withdrawal amount may be increased.

You may contact the NESC at 1-800-248-4444 to initiate a hardship withdrawal and to obtain more information.

How Withdrawals Are Paid

With the exception of the Ford Stock Fund, assets sold from your investment options will be paid in cash. You may request that the balance represented by your units in the Ford Stock Fund be issued in shares of Ford common stock instead. Any fractional shares will be paid in cash.

If you separate from the Company (including a severance from employment as a result of a corporate action involving a sale, disposition or reorganization of one of the Company’s businesses), or reach age 59½ (while still employed), the following withdrawal options are available under the TESPHE:

- Lump-sum and partial withdrawals
- Systematic withdrawals with a series of payments

You may elect to receive payment of your TESPHE account in monthly, quarterly, semi-annual or annual installments over a period of time you specify. You may choose any period of time in whole years over which you would like payments to be made. That period must be at least one year, and no greater than a number of years approximately equal to your life expectancy at the time you make the election, or a number of years approximately equal to your joint life expectancy with your spouse or other beneficiary. Using IRS tables, the NESC will inform you of the average life expectancy based on your age and information on the age of your Plan account beneficiary.

Regardless of how you choose the number of years over which you want systematic payments to be made, the manner of determining the amount of each payment will be the same and will be based on the value of your account on the effective date of payment of each installment and the number of installments remaining to be paid.

For example, if you specify a period of 12 years and monthly payments, the number of installments would be 144. The amount of the first payment will be equal to the value of your account on the effective date of payment divided by the total number of installments; that is, 144. The amount of the next installment would be based on the value of your account at the time of the next installment payment divided by the number of installments remaining; that is, 143. For the last installment, the entire value of your account would be paid to you. The amount of each installment will be withdrawn proportionally from your investment options on the effective date of each installment.

Non-active Employees

If you have been removed from the hourly active employment rolls as a result of a leave of absence or layoff, or transfer to salaried roll or to a nonparticipating subsidiary, you are subject to the same withdrawal provisions as an active employee (e.g., after-tax, hardship and age 59½ withdrawals.)

If you are an alternate payee with a TESPHE account established under a Qualified Domestic Relations Order (QDRO), you will be treated in accordance with the terms stated in the court order. For more information, see the *Situations and Events Affecting TESPHE Benefits* section.

If you are a spousal beneficiary, you may withdraw your TESPHE account balance at any time in a lump-sum, partial or installment payments.

Making a Withdrawal

You may request a withdrawal of your vested assets on **myfordbenefits.com** or by calling the NESC at 1-800-248-4444. Your withdrawal is effective as of the close of business on any business day if your request is made and confirmed prior to the close of the NYSE (usually 4 p.m., ET) on that day. If your request is confirmed after this time or on non-business days such as weekends or holidays, your withdrawal will be effective as of the close of business on the next business day. A business day is any day that the NYSE is open for trading. Because of high call volumes at the close of the market at times, you may wish to call early to ensure your transaction is confirmed before the deadline.

Rollovers and Conversions

Direct Rollover

You or your beneficiary may instruct the NESC to make a direct rollover of monies that can be rolled from the TESPHE to:

- Qualified plans described under Code Section 401(a), 401(k) plans, profit-sharing plans, stock bonus plans, money purchase plans or 403(a) annuity plans
- 403(b) tax-sheltered annuity contracts maintained for tax-exempt organizations and educational organizations of State or local governments
- 457(b) plans maintained for governments and governmental agencies
- An IRA or annuity described in Code Sections 408(a) or (b)
- An inherited IRA established for the benefit of non-spousal beneficiaries
- A Roth IRA

In a direct rollover, you can continue to defer taxes on assets transferred to an IRA or to an eligible employer plan. To qualify as a direct rollover, the withdrawal or distribution check should be made payable to the receiving eligible plan for your benefit. Generally, your assets attributable to pre-tax and Roth contributions (including catch-up contributions) and all associated earnings are eligible for direct rollover. After-tax contributions may be rolled over to an IRA or annuity described in Code Sections 408(a) or (b), or to a qualified plan described in Code Sections 401(a) or 403(b), that agrees to account for the transferred after-tax amounts separately. You can arrange for a direct rollover when requesting your withdrawal on **myfordbenefits.com** or through the NESC.

Indirect Rollover

If you receive a withdrawal or distribution from the TESPHE and you do not elect a direct rollover, the taxable portion of the withdrawal or distribution is subject to a mandatory 20% Federal income tax withholding from any cash distributed that is eligible for rollover. You may roll over a distribution paid to you, but the 20% withholding on the taxable portion of the withdrawal or distribution from TESPHE still applies. Special tax rules apply to a direct rollover of a distribution to a Roth IRA. For more information, refer to the *Special Tax Notice* section. You should consult your personal tax advisor to ensure that any actions you take are to your best advantage.

Roth Conversion

You can elect to have eligible assets not currently in your Roth contributions account converted to Roth by transferring the assets into your Roth contributions account, in accordance with Code Section 402A(c)(4). You will be responsible for paying any applicable taxes as a result of the conversion. You are allowed to make up to six Roth conversions per calendar year.

Distributions

All or a portion of your TESPHE assets will be distributed to you after termination of employment under certain circumstances, even if you do not request them. You may wish to consult your tax advisor regarding alternative methods of distributions available to you. Distributions are paid in a similar manner as withdrawals (See* Withdrawals *section). Under some circumstances, the distributions described in this section may be rolled over as described in the* Rollovers and Conversions *section. See exceptions in the* Special Tax Notice *section.

Accounts Valued at $1,000 or Less

If the vested market value of your account is at or below the small account threshold of $1,000, your vested account balance will be distributed to you in cash, as soon as administratively feasible after a five-year waiting period following termination. Rollover amounts are included when determining this threshold.

Participants receiving installment payments, including participants subject to the minimum required distribution provisions described below, are not subject this involuntary small account distribution.

Required Minimum Distributions (RMDs)

When you attain age 72, the TESPHE is required to distribute a portion of your account by the required beginning date. The portion of your account distributed to you is referred to as a Required Minimum Distribution, or RMD. The required beginning date is April 1 of the calendar year following the later of the calendar year in which you attain age 72, or terminate employment. Thereafter, the RMD must be distributed by December 31 of each year.

In general, the applicable factor used to determine the RMD amount for each year is obtained from the Uniform Lifetime Table provided under the Internal Revenue Code and is based solely on your age in the relevant RMD calendar year, unless the sole beneficiary for your Plan account for the entire year is your spouse who is more than 10 years younger than you. In that case, you may elect to have your RMD calculated based on the joint life expectancy of your spouse and you. Using the applicable factor from the Joint Life Expectancy Table provided under the Internal Revenue Code could reduce your RMD even further.

Generally, payout under the distribution schedule for age 72 would permit you to leave your assets in the TESPHE for the longest possible period following termination of employment. The mandatory age 72 payment for the year is reduced by the amount of any distribution payments made earlier in the year under any other withdrawal election. For example, assume during any given year you requested a $1,000 withdrawal from your account. The mandatory age 72 distribution for the year is $4,000. Only $3,000 would be distributed to you by December 31 of that year to satisfy the remaining RMD payment.

Similarly, in the event the payments made under the systematic withdrawal you have elected are less than the required RMD, an additional amount will be distributed to you in December of each year in an amount necessary to satisfy the RMD for that year.

While RMD rules impose a minimum amount that you must receive, you may elect to receive a greater amount under other withdrawal options. See the *Withdrawals* section for more information.

Timing of Your RMD

When you first become eligible to receive your RMD, you have the option of receiving your RMD either in the year you attain age 72, or no later than April 1 of the year following the year in which you attain age 72. You should be aware that if your RMD is not taken until the following year, you will be required to take an additional RMD to cover the current year RMD. Since multiple RMDs in one calendar year could increase your tax liability, you should carefully consider the timing of your first RMD.

Example: *You reach age 72 in 2021. You can elect to receive your distribution by December 31, 2021, or by April 1, 2022. If you elect to receive your first RMD by April 1, 2022, you are still required to take an additional RMD by December 31, 2022.*

The default payment date is no later than December 31 in the year in which you attain age 72. If you do not notify the NESC that you would like to receive your first RMD payment by April 1 in the year following the year in which you attain age 72, the payment will be made by the default date. RMDs for the year are reduced by the amount of any withdrawals made earlier in the year that are not rolled over.

Ford Stock Fund Dividends

You have the option of receiving a distribution in cash or reinvesting the dividends attributable to your equivalent shares of Ford common stock based on the units held in the Ford Stock Fund. Effective with the dividend payable September 1, 2004, all dividend payments are immediately vested, regardless of the vesting status of the underlying Ford Stock Fund assets.

If you enrolled in the TESPHE before January 1, 2002, your proportionate share of any cash dividends will be handled in the same manner as they had been immediately prior to that date (either distributed to you in cash or reinvested in the Ford Stock Fund, depending on your instructions).

If you enrolled January 1, 2002, or after, your proportionate share of any quarterly cash dividends paid on the Ford Stock Fund will be reinvested in your account in the Ford Stock Fund in the Plan, unless you elect to have them distributed to you in cash.

You may change your dividend election any time on **myfordbenefits.com** or by calling the NESC at 1-800-248-4444.

The amount of any dividend not distributed in cash generally will be used by the trustee to acquire additional shares of Ford common stock. To the extent such dividends remain in the Plan, the number of units in your account will be increased to reflect the acquisition by the trustee of those additional shares.

Dividend distributions are not subject to the 10% early withdrawal penalty or the automatic 20% income tax withholding. They are considered taxable income subject to ordinary income tax rates and are not eligible for rollover to an IRA or another employer's eligible retirement plan.

Only units of the Ford Stock Fund in your Plan account by 4 p.m., ET, one day prior to the ex-dividend date, are eligible for the dividend payment. If you elect to have the dividends distributed, payment will be made as soon as practicable after receipt by the trustee of the dividend.

When You Die

Any vested assets in your account become payable when you die. If you die prior to termination of employment, any unvested Company contributions in your account will become fully vested.

Your assets will be distributed to your named beneficiary as soon as practicable after such beneficiary account is established following notification of your death. If you do not have a named beneficiary and are married, your assets will be distributed to a beneficiary account for your spouse. If you are not married, your assets will be distributed to your estate.

If your beneficiary is your surviving spouse, special rules apply:

- Your surviving spouse may retain his or her beneficiary account in the TESPHE. If you elected a distribution schedule that commenced before your death, your account will continue to be paid to your surviving spouse according to your schedule. At any time, your surviving spouse can elect a partial or full lump-sum distribution.
- If distribution has not commenced at the time of your death, your surviving spouse will be considered a participant for purposes of distribution under the TESPHE. Your surviving spouse will be deemed to attain age 72 on the date you would have attained 72.
- While your surviving spouse retains his or her beneficiary account in the TESPHE, he or she will be able to transfer among the investment options as any other participant. Your surviving spouse is also subject to the small account involuntary distribution rules.

It is important that you keep your beneficiary designation and address up to date. For information on beneficiaries, see the *Naming a Beneficiary* section.

Special Tax Notice

This document is based on a notice prepared by the IRS to advise you of the tax law affecting distributions and withdrawals from plans like the TESPHE.

This notice explains how you can continue to defer Federal income tax on your retirement savings in the TESPHE and contains important information you will need before you decide how to receive your TESPHE benefits. Regulatory changes affecting this notice may not be updated immediately. As a result, the information in this notice may not always be current. However, the NESC will send you the most recent notice prior to processing a distribution or withdrawal upon request.

This notice is provided to you because the payments you receive from the TESPHE may be eligible for rollover by you or, at your direction, by the Plan to an IRA or to an eligible employer retirement plan. It is intended to help you decide whether to do such a rollover. The notice is also available on **myfordbenefits.com** > *Other Resources > Plan Documents > Benefits Communications > Savings Plan > Notice of Rights,* or you can obtain a copy by contacting the NESC.

Rules that apply to most payments from a plan are described in the *Rollovers and Conversions* section.

An eligible employer plan is not legally required to accept a rollover, and it may not accept rollovers of certain types of distributions, such as after-tax amounts. Before you decide to roll over your payment to another employer plan, you should find out whether the plan accepts rollovers and, if so, the types of distributions it accepts as a rollover. You should also find out about any documents that are required to be completed before the receiving plan will accept a rollover.

If an employer plan accepts your rollover, the plan may restrict subsequent distributions of the rollover amount or may require your spouse’s consent for any subsequent distribution. A subsequent distribution from another employer plan or an IRA that accepts your rollover may also be subject to different tax treatment than distributions from the TESPHE. Check with the administrator of the other employer plan or the trustee of the IRA that is to receive your rollover prior to making the rollover.

If you have additional questions after reading this notice, contact the NESC at 1-800-248-4444.

Situations and Events Affecting TESPHE Benefits

Law and Regulation Changes

The TESPHE is subject to approval by the IRS and other regulatory agencies. As laws and regulations change, the Plan may require amendment as well. If changes affect your benefits, you will be notified.

Assignment of Benefits – Liens

Payments from the TESPHE are intended to be made to you, your eligible spouse or other beneficiary. Benefits under qualified retirement plans like the TESPHE generally may not be assigned or alienated except in accordance with a judgment, decree or order that is issued under State domestic relations law that relates to the provision of child support, alimony or marital property rights to a spouse, former spouse, child or other dependent of a Plan participant. Such an order must meet the requirements of a qualified domestic relations order (QDRO) as defined in Section 206(d) of ERISA and Internal Revenue Code Section 414(p), as determined by the Company. Benefits under TESPHE may not be pledged to secure loans, other than Plan loans, and are not subject to legal process or attachment for the payment of any claim except as described above.

Divorce or Legal Separation

If you are involved in a divorce or legal separation and require information concerning your qualified plan benefits, you should review your TESPHE quarterly statement or review your account on **myfordbenefits.com**. You may also request an account statement through the NESC at 1-800-248-4444.

If you need further information on QDROs, or to obtain a copy of the Plan's QDRO Approval Guidelines and Procedures, contact the NESC at 1-800-248-4444.

Submit your Domestic Relations Order (DRO) online for review or mail/fax to:

Qualified Order Center
P.O. Box 1590
Lincolnshire, IL 60069-1590
Fax: 1-847-883-9313 (draft orders only)

If the DRO is acceptable, you will be notified and the QDRO will be implemented according to its terms. Other forms of DROs may be acceptable if they comply with the legal requirements set forth in Section 206(d) of ERISA and Code Section 414(p), and can be administered in accordance with the guidelines of the TESPHE as determined by the Plan Administrator. Other forms of marital dissolution documents may be acceptable as DROs if they comply with the legal requirements set forth in Section 206(d) of ERISA and Code Section 414(p) and can be administered in accordance with the guidelines of the Plan as determined by the Plan Administrator.

Please submit any of the following documents online or mail/fax to:

Qualified Order Center
P.O. Box 1590
Lincolnshire, IL 60069-1590
Fax: 1-847-883-9313 (draft orders only)

- Domestic Relations Orders (original, true or court certified copies of original Orders filed in a court of competent jurisdiction)
- Proposed DROs
- Decrees of Divorce
- Judgments
- Property Settlement Agreements

Federal Garnishment

A Federal writ of garnishment against your TESPHE account may be obtained by the U.S. Government pursuant to the procedures authorized by the Federal Debt Collections Procedures Act of 1990 (FDCPA), 28 U.S.C., Sections 3001-3308, and the Mandatory Victims Restitution Act of 1996, 18 U.S.C. 3551. The Federal garnishment will attach a lien to your TESPHE account. Recovery of the Federal garnishment will begin once you are eligible to receive any distributions from your TESPHE account.

Plan End or Modification

The TESPHE is expected to continue in effect until the end of the 2019 Ford-UAW Collective Bargaining Agreement.

At that time, the TESPHE may be renewed automatically for successive one-year periods, unless Ford or the UAW makes a written request to modify the TESPHE at least 60 days before September 14, 2023, or any subsequent anniversary date. A request to terminate the TESPHE must be made within the same deadlines.

Subject to the 2019 Agreement, the Company Board of Directors may at any time change, suspend or terminate the TESPHE partially or completely. No change may reduce the value of your account, however, from what it was on the day before the change.

Your current account balance also is protected if the TESPHE is merged or consolidated with another plan, or if your account is transferred to another plan.

Immediately after the change, your account balance under the new plan would be at least equal to the balance under the TESPHE just before the change.

A change or suspension in the TESPHE may not change your right for the continued investment of your TESPHE account, your right to make approved withdrawals or your right to a final payout.

The Company may change, suspend or end the TESPHE for employees if the Tax-Efficient Savings Plan Committee finds that the laws of a State or country where they live make the TESPHE disproportionately expensive and inconvenient to administer. However, no change will be allowed that might use the Plan’s funds for any purpose other than providing benefits to you or your beneficiary or paying Plan expenses. Generally, account balances cannot be reduced, except for investment losses, even by a Plan amendment. If any material changes are made to the Plan in the future, you will be notified.

A change, suspension or termination will take effect no sooner than the date the Company notifies the trustee and participating companies. A retroactive change is allowed, however, if it is required to keep the TESPHE or the trust fund in compliance with legal requirements.

If the TESPHE is terminated, the Company may direct the trustee to pay out the assets in all accounts as of the termination date. Any Profit Sharing contribution to the Plan for 2023, however, will be administered as described in the TESPHE even if the TESPHE is terminated that year.

If the Plan is terminated, or if there is a partial termination affecting you, you will be immediately 100% vested in the value of your account representing Company contribution assets as of the date of termination. You are always vested in the contributions you make to the TESPHE.

Employment Status Changes

- **You transfer to salaried rolls or to a nonparticipating subsidiary.** Your contributions cease upon transfer. You may be eligible for a different plan.
- **You convert from Temporary Full-Time (TFT) status to Seniority Non-Skilled status.** You may be eligible for Company contributions. See the *Company Contributions for Certain Employees section.*

Employment Ends (e.g., retirement, quit, discharge)

- Your contributions and any Company contributions to the TESPHE cease at the time of your separation from the Company. You are always vested in contributions you make. Company contributions vest three years after your original hire date.
- You may not initiate any new loans.
- Generally, you must pay off any outstanding loans in full at the time of separation unless you elect to make loan payments using coupons or direct bank debit. However, under certain circumstances, loan repayment using coupons or direct bank debit is not an option. See *Loan Repayment* under the *Plan Loans* section for further information.
- You may leave your account balance in the TESPHE and continue to manage your account. Under certain circumstances, your account balance may be distributed to you automatically. For more details, see the *Distributions* section.
- You may initiate a partial, installment or total withdrawal of your vested account balance effective on any business day.

Family Status Changes

- **Marriage:** Your spouse is the beneficiary of your TESPHE unless you have another named beneficiary agreed to by your spouse. Refer to the *Naming a Beneficiary* section for more detailed information.
- **Divorce:** Refer to *Divorce or Legal Separation* under the *Situations and Events Affecting TESPHE Benefits* section.
- **Death of Your Spouse:** Your TESPHE assets will be paid to your estate if you have no named beneficiary. Refer to the *Naming a Beneficiary* section for more detailed information.

Leave of Absence

- Your contributions, any Company contributions and payroll deductions for loan repayments cease.
- You may continue to make loan payments on existing loans. If you are on a medical leave for more than 90 days, you will be removed from the active employment rolls. After the 90-day period, Ford will transmit your updated status to the NESC after which you will be suspended from making loan payments for up to one year. You may request coupons from the NESC to make loan payments. Acceptable forms of payment are cashier's or certified check, money order or direct debit from your bank account. See *Loan Repayment* under the *Plan Loans* section for more detailed information.
- Under certain circumstances, loan repayment using coupons or direct bank debit is not an option. For additional information, see *Loan Repayment* under the *Plan Loans* section.

- While you are on leave, you may initiate new loans, unless you have an outstanding defaulted loan balance. You must make loan repayments manually until you return to work.

Layoff

- Your contributions, any Company contributions, and payroll deductions for loan repayments cease.
- If you are on indefinite layoff (ILO), you will be suspended from making loan payments for up to one year. You may request coupons from the NESC to make loan payments. Acceptable forms of payment are: cashier's or certified check, money order or direct debit from your bank account. See *Loan Repayment* under the *Plan Loans* section for more detailed information. You may not initiate new loans while on ILO.
- Coupons are not sent to employees on a temporary layoff (TLO) nor can employees on TLO set up electronic payments. Regardless, you must continue to make your loan repayments to avoid loan delinquency. Acceptable forms of payment are: cashier's or certified check, or money order.
- Under certain circumstances, loan repayment using coupons or direct bank debit is not an option. For additional information, see *Loan Repayment* under the *Plan Loans* section.

Under any of the employment events described above that result in you not receiving a regular weekly paycheck from Ford, you may be required to continue to make loan repayments. If you fail to make your loan repayments under the terms of your loan agreement, a Loan Delinquency Notice (Notice) will be mailed to your address of record under the TESPHE. If you fail to remit the total delinquent payments by the due date and in the form of payment stated in the Notice, your loan will default.

Withdrawals While on Leave or Layoff

While you are on leave or layoff, you are subject to the same withdrawal provisions as an active employee (e.g., after-tax, hardship and age 59½ withdrawals). For additional information, see the *Withdrawals* section.

Return from Leave or Layoff

Generally, your contributions and payroll deduction for loan payments will resume automatically. The payment amount will be re-amortized if your payments had been suspended, and may be substantially higher. Always check your paystub to ensure deductions resume. Contact the NESC at 1-800-248-4444 immediately if loan repayments are not deducted from your paycheck.

Your status update is dependent on when Alight receives the information from Ford. If you elected to make loan repayments through direct bank debit while on leave or layoff, the time delay in updating your status could result in a loan repayment from both your bank account and your paycheck. Should this occur, all monies will remain in your TESPHE account unless the payments exceed the outstanding loan balance. Loan repayment amounts that exceed the outstanding loan balance will be returned to you.

Relocation and Address Changes

It is your responsibility to keep your address current. If you are an active employee (or on leave or layoff), be sure to change your address through your Plant Labor Relations Office. If you are separated from the Company, contact the NESC at 1-800-248-4444 with any address changes. Notices about the TESPHE will be sent to your address of record under the Plan. Verify that your address is correct on **myfordbenefits.com** or by calling the NESC at 1-800-248-4444.

Plan Administration and Committees

The TESPHE is sponsored by Ford Motor Company and the Company is the Plan Administrator. The Company has been designated "named fiduciary" pursuant to the requirements of ERISA, and has the power to control and manage the operation and administration of the TESPHE.

TESPHE Administration Committee

The TESPHE Administration Committee (Committee) consists of Company employees. Committee members and alternate members receive no additional compensation for Committee services as members or as alternate members. Except for non-delegable functions of the trustee, the Committee has full power and discretionary authorization to administer the TESPHE, interpret its provisions, and prescribe regulations and forms in connection with executing such duties. Decisions of the Committee are final, conclusive and binding and may be relied upon, unless arbitrary and capricious, by you, your beneficiaries, or the estate or legal representative thereof, the trustee and all other parties in interest. The Committee is also authorized to provide rules for the matters not provided for under the TESPHE. The Committee has no authority over matters expressly delegated to the Investment Process Oversight Committee or Investment Process Committee.

Written or telephone requests for information about the Plan should be directed to the NESC.

TESPHE Board of Appeals

The TESPHE Board of Appeals (Board) consists of Company and Union employees. Board members and alternate members receive no additional compensation for Board services as members or as alternate members. The Board has full power and discretionary authorization to interpret TESPHE provisions in deciding participant benefit appeals. Decisions of the Board are final, conclusive and binding and may be relied upon, unless arbitrary and capricious, by you, your beneficiaries, or the estate or legal representative thereof, the trustee and all other parties in interest. The Board has no authority over matters expressly delegated to the Investment Process Oversight Committee or Investment Process Committee.

Investment Process Oversight Committee (IPOC)

The IPOC created by the Company meets at least quarterly to review the investment options. The IPOC has sole power to add, delete or otherwise change investment options offered under the Plan as recommended by the IPC.

The IPOC will take action with respect to the Ford Stock Fund, State Street Global All Cap Equity NL Series Index Fund – Class A, Bond Index Fund NL and Interest Income Fund only to the extent required by ERISA.

The IPOC is responsible for maintaining the investment options under the TESPHE solely in the interest of the TESPHE participants and their beneficiaries.

Investment Process Committee (IPC)

The IPC created by the Company recommends an Investment Policy Statement (IPS), which includes investment process guidelines, to the IPOC for its approval. The guidelines include:

- The types of investment options to be offered in the TESPHE, with due regard to the risk and return characteristics of such options and the need to offer a reasonable array of such risk and return alternatives
- The individual investment options to be offered in the TESPHE consistent with the range of risk and return characteristics deemed appropriate
- Criteria for the selection of individual investment options for inclusion in the TESPHE
- Procedures for reviewing the performance of investment options offered in the TESPHE
- Criteria mandating the removal of investment options from the TESPHE

The IPC will review the IPS at least annually for continued appropriateness and recommends any changes to the IPOC. The IPC will meet at least quarterly to:

- Review the performance and fees of investment options pursuant to the criteria regarding the removal of investment options from the TESPHE
- Recommend the replacement/removal of existing options, or the addition of new options, to the IPOC

The IPC is responsible for maintaining the investment options in the TESPHE solely in the interest of participants and their beneficiaries. The IPC has no independent power to add, delete or otherwise change investment options offered in the TESPHE.

Additional Information

The TESPHE was established pursuant to the Collective Bargaining Agreement dated October 14, 1984, between the Company and the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW (the Union), and was approved by the Board of Directors of the Company on November 8, 1984. Contributions to the TESPHE commenced in March 1985.

The TESPHE was amended and continued pursuant to the Collective Bargaining Agreement effective November 18, 2019, between the Company and the Union.

Plan Filings

The following documents filed or to be filed with the Securities and Exchange Commission are incorporated by reference:

- The latest annual reports of the Company and the TESPHE filed pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 (the 1934 Act) which contain, either directly or by incorporation by reference, certified financial statements for the Company's latest fiscal year for which such statements have been filed
- All other reports filed pursuant to Section 13(a) or 15(d) of the 1934 Act since the end of the fiscal year covered by the annual reports referred to in the preceding paragraph
- The description of Ford common stock contained in Registration Statement No. 333-174150 filed by the Company under the Securities Act of 1933

All documents subsequently filed by the Company pursuant to Sections 13(a), 13(c), 14, and 15(d) of the 1934 Act, prior to the filing of a post-effective amendment which indicates that all securities offered have been sold or which deregisters all securities then remaining unsold, shall be deemed to be incorporated by reference in this material and to be a part hereof from the date of filing such documents.

The Company claims an exclusion from the definition of the term "commodity pool operator" under the Commodity Exchange Act for the Ford Motor Company Defined Contribution Master Trust, of which the TESPHE is a plan. Therefore, it is not subject to registration or regulation as a pool operator under the Commodity Exchange Act.

Participants may request, either in writing or orally, a copy of any and all of the information incorporated by reference in this section and any other documents required to be delivered to participants.

Exhibits to this information will not be included unless such exhibits are specifically incorporated by reference in the material this section incorporates. The Company will provide all such information without charge.

Requests for such information should be directed to the Company at:

Ford Motor Company
Investor Relations
WHQ Suite 1026
1 American Road
Dearborn, MI 48126-2798

Requests for TESPHE information should be directed to the Administration Committee at:

Ford Motor Company
Savings Plans Administration
WHQ Room 533
1 American Road
Dearborn, MI 48126-2798

Employee Stock Ownership Plan (ESOP)

A portion of the TESPHE is designated as an ESOP. The ESOP was established in the TESPHE effective January 1, 1989, and consists of all the shares of Ford common stock in the Plan. The trustee of the ESOP holds, invests, transfers and distributes shares of Ford common stock and all other assets in the ESOP in accordance with the Plan document.

Tax Consequences to the Company

Because of the TESPHE's qualified status under Code Section 401(a), the Company is currently entitled to deduct on its tax return the amounts that are contributed to the TESPHE on behalf of all employees, with the exception of Roth and after-tax contributions.

The Pension Benefit Guaranty Corporation (PBGC)

The TESPHE is a defined contribution pension plan. This means that your benefit depends on the amount of contributions made and the market value of the investment funds. No specific benefit amounts are guaranteed by the Plan. Therefore, Federal law does not provide for benefits under this Plan to be insured by the PBGC.

Trustee and Recordkeeper

The TESPHE is a defined contribution plan designed to comply with ERISA Section 404(c). Assets are held in a trust and therefore, are not available to the Company or the creditors of the Company. The money in the trust is set aside for the exclusive benefit of Plan participants and their beneficiaries.

The Company and State Street Bank and Trust Company (State Street) have entered into a trust agreement pursuant to which State Street acts as primary trustee under the TESPHE. The Company and State Street may jointly amend the trust agreement and the Company may change the trustee. The trustee has custody of the funds received and earnings thereon, and makes all purchases, sales and redemptions of securities in accordance with the provisions of the TESPHE.

Recordkeeping and administrative services are provided by Alight Solutions LLC.

The addresses for State Street and Alight are:

State Street Bank and Trust Company
Defined Contribution Services
2 Avenue de Lafayette
Boston, MA 02111

Alight Solutions LLC
Dept. 01700
P.O. Box 1590
Lincolnshire, IL 60069-1590

Claim and Appeal Procedure

Claim for Benefits

If you have a Claim for Benefits under the TESPHE, or if you believe that there has been an error in the administration of your TESPHE account or an error relating to deductions from your pay, profit sharing payment or other special pay that impacts your account, contact the NESC within twelve months of the error. The NESC will attempt to resolve your concerns informally. Otherwise, submit your claim to the NESC in writing to:

Claims and Appeals Management
Ford Motor Company
P.O. Box 1407
Lincolnshire, IL 60069-1407
Fax: 1-847-554-5104

Claim Denial Appeal Procedure

If the NESC denies a claim for benefits or participation in whole or in part, you will receive written notification within 90 days from the date the claim for benefits or participation is received. The notice will be deemed given upon mailing, full postage prepaid in the United States mail or on the date sent electronically to you.

Any denial of a claim will be in writing and include:

- The specific reason(s) for the denial
- A reference to the specific TESPHE provision(s) on which the denial is based, along with a copy of the Plan provision(s) or a statement that one will be furnished at no charge per your request
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary
- A description of the TESPHE's review procedures and the time limits applicable to such procedures, along with a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial for benefits on review

If the NESC determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the NESC expects to render the determination.

Board of Appeals Review

In the event that NESC denies a claim for benefits or participation, you may:

- Request a review by filing a written appeal to the Board of Appeals
- Review pertinent documents
- Submit written comments, documents, records and other information relating to the claim for benefits

The Board of Appeals must take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

You may send your written appeal to:

Claims and Appeals Management
Ford Motor Company
P.O. Box 1407
Lincolnshire, IL 60069-1407
Fax: 1-847-554-5104

You must request a review upon an appeal of the denial of the claim within 60 days after you receive the written notification of denial of the claim. It will be considered at the Board of Appeals' next regularly scheduled meeting. If it is filed within 30 days of the next meeting, a decision by the Board of Appeals shall be made by the date of the second meeting after receipt of your request for review.

Under special circumstances, an extension of time for processing may be required, in which case a decision shall be rendered by the date of the third meeting. If an extension is required because information is incomplete, the review period will be tolled from the date the notice was sent to the date information is received. In the event such an extension is needed, written notice of the extension will be provided to you prior to the commencement of the extension. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Board of Appeals expects to render the determination.

Written notice of a decision will be made not any later than five days after the Board of Appeals has made a decision. The notice will be deemed given upon mailing, full postage prepaid in the United States mail, or on the date sent electronically to you.

Any denial of an appeal will be in writing and include:

- The specific reason(s) for the denial of the appeal
- A specific reference to pertinent TESPHE provision(s) on which the denial is based, along with a copy of such TESPHE provision(s) or a statement that one will be furnished at no charge upon your request
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim
- A statement of your right to bring an action under Section 502(a) of ERISA within twenty-four months of the denial of the appeal

Claims and Appeals Timelines and COVID-19

During the COVID-19 Outbreak Period (as defined by Federal law and regulations), the deadlines for you to file claims, appeals and external review requests with the Plan have been modified. You will have until the earlier of (i) one year from the date you were eligible for the COVID relief or (ii) the time period from March 1, 2020 until 60 days after the end of the National Emergency.

For example, if you receive a claim denial letter dated July 10, 2020 and wish to appeal the denial, you will have until January 6, 2021 (180 days from the date of the claim denial) or the date that is 60 days following the end of the COVID-19 Outbreak Period, whichever is later, to submit your appeal.

Claim for Breach of Fiduciary Duty

The following procedure should be followed if you have a Claim for Breach of Fiduciary Duty under the TESPHE:

Any claim alleging breach of fiduciary duty must be in writing and directed to:

Ford Motor Company
Savings Plans Administration
WHQ Room 533
1 American Road
Dearborn, MI 48126-2798

The claim must:

- Specifically set forth the facts concerning the alleged breach
- Clearly identify the Plan fiduciary whom you allege has committed a fiduciary breach

- Cite the legal basis for the allegation of fiduciary breach and specifically set forth the remedy that you request on behalf of the TESPHE

Savings Plans Administration will review the claim and make a determination within 90 days from the date the claim is received. The notice will be deemed given upon mailing, full postage prepaid in the United States mail, or on the date provided electronically to you.

Any denial of a claim will be in writing and it will include:

- The specific reason(s) for the denial
- A reference to the specific Plan provision(s) on which the denial is based along with a copy of the Plan provision(s) or a statement that one will be furnished at no charge per your request
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- A description of the Plan's review procedures and the time limits applicable to such procedures, along with a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial for benefits on review

If Savings Plans Administration determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which Savings Plans Administration expects to render the determination.

At the discretion of Savings Plans Administration, the claim may be referred to the Committee or to General Counsel for review.

In the event that Savings Plans Administration denies a claim, you may:

- Request a review upon appeal by written application to the Committee
- Review pertinent Plan documents
- Submit issues and comments in writing

You must request a review upon appeal of the denial of the claim by Savings Plans Administration under this Plan within 60 days after receiving written notification of denial of the claim. The appeal will be considered at the Committee’s next regularly scheduled meeting. If the appeal is filed within 30 days of the next meeting, a decision by the Committee, as appropriate, shall be made by the second meeting after receipt of the request for review.

Under special circumstances, an extension of time for processing may be required, in which case a decision will be made by the date of the third meeting. If an extension is required because information is incomplete, the review period will be tolled from the date the notice was sent to the date the information is received. In the event such an extension is needed, written notice of the extension will be provided to you prior to the commencement of the extension.

In reviewing the claim, the Committee may retain experts or other independent advisors. In such event, an extension of time for processing may be required but a decision on the appeal will be made as soon as is reasonably practicable under the circumstances.

Written notice of the decision will be made to you not any later than five days after the decision has been made by the Committee. At the Committee's discretion, an appeal from a denial of the claim by Savings Plans Administration, or a referral of a claim directly to the Committee by Savings Plans Administration, may be referred to General Counsel for review.

When a claim for breach of fiduciary duty, or an appeal from a denial of a fiduciary duty claim is referred to General Counsel, that individual will have full authority and sole discretion to determine the manner in which to discharge his/her responsibility with respect to the review of the claim or the appeal. This includes, but is not limited to, retaining the responsibility to review the claim or appeal, appointing an independent fiduciary, seeking a declaratory judgment in Federal court, or seeking review of the claim or appeal by an existing or specially appointed committee of the Board of Directors.

General Counsel, or any person who is responsible for making the decision with respect to the claim or appeal as determined by General Counsel as described above (Appointee), may retain experts or other independent advisors in his/her sole discretion with respect to review of the claim or appeal. The claim or appeal will be reviewed on the basis of the written record submitted by you and the record developed by Savings Plans Administration, if any.

A decision will be made as soon as reasonably practicable under the circumstances. Written notice of the decision will be made to you no later than five days after the decision has been made. The notice will be deemed given upon mailing, full postage prepaid in the United States mail, or on the date sent electronically to you.

Any denial of an appeal will be in writing and will include:

- The specific reason(s) for the denial
- Specific reference to pertinent Plan provisions on which the denial is based, along with a copy of such Plan provisions or a statement that one will be furnished at no charge, upon your request
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, copies of, all documents, records, and other information relevant to your claim
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review

Savings Plans Administration, the Committee and General Counsel or the Appointees each severally will have full power and discretion under the TESPHE to consider participant fiduciary claims.

Decisions

Decisions of the Board of Appeals, the Committee and General Counsel or the Appointees, as the case may be, are final, conclusive and binding and may be relied upon, unless arbitrary and capricious, by you, your beneficiaries, or the estate or legal representative thereof, the trustee and all other parties in interest.

Exhaustion Requirement and Claims Limitations

No legal actions may be brought by you, your dependent, beneficiary or the estate or legal representative for entitlement to benefits under the TESPHE or for breach of fiduciary duty until after the claims and appeal procedures have been exhausted.

Unless a different period of limitation is specifically provided under ERISA, any claim for benefits under the TESPHE must be brought no later than twelve months after the claim arises in order for the review authorities to conduct a timely and effective investigation of the claim. For matters not specifically addressed, no other actions may be brought against the TESPHE more than twenty-four months after the claims arise.

Your ERISA Rights

The TESPHE is designed to meet the requirements established by, and is subject to certain provisions of, ERISA, generally including reporting and disclosure, participation and vesting, fiduciary responsibility, and administration and enforcement provisions in Title I of ERISA. The TESPHE is also qualified under Code Sections 401(a) and 401(k). The TESPHE will be amended to be in compliance with any changes in the law or government regulations.

As a participant in the TESPHE, you are entitled to certain rights and protections under ERISA. Included are the right to receive certain Plan information and the right to file a lawsuit if you believe your rights have been violated.

Here is a listing of your rights under ERISA:

- You may visit Ford World Headquarters, and examine all Plan documents without charge. Contact the NESC at 1-800-248-4444 to determine where you must visit. You may review the TESPHE itself, the trust agreement for the TESPHE, the annual financial reports, the TESPHE summary plan description and all other official Plan documents.
- With reasonable written notice, copies of TESPHE documents will be made available for review at other locations.
- You may obtain copies of Plan documents by writing:

  Ford Motor Company
  Savings Plans Administration
  WHQ Room 533
  1 American Road
  Dearborn, MI 48126-2798

- The Company may make a reasonable charge for copies.
- You will receive a written summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish you with a copy of this summary annual report.
- You also may obtain a copy of the annual reports and other Plan documents at the U.S. Department of Labor's Public Disclosure Room at the Pension and Welfare Benefit Administration in Washington, D.C.
- You may not be discharged or discriminated against to prevent you from obtaining a benefit or for exercising your ERISA rights.

If your claim for a benefit is denied in whole or part:

- You will receive a written explanation from the Plan Administrator.
- You have the right to have your claim reviewed and reconsidered.

Besides creating rights for plan participants, ERISA also spells out certain duties for people who are responsible for operating the plan. These people are called “fiduciaries.” The fiduciaries of a plan have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA.

There are steps you can take to enforce your ERISA rights. For example:

- If you request materials from the TESPHE and don't receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials — unless the materials were not sent because of reasons beyond the control of the administrator.
- If your claim for benefits is denied in whole or in part after a final review, you may file suit in a State or Federal court.
- If the fiduciaries misuse the Plan's money or if you are discriminated against for asserting your ERISA rights, you may seek help from the U.S. Department of Labor or file suit in a Federal court. If you file a suit, the court will decide who should pay costs and legal fees. If you win your suit, the court may order the person you have sued to pay the costs and fees. If you lose your suit, or if the court decides your suit was frivolous, the court may order you to pay the costs and fees.

If you have any questions about the TESPHE, contact the NESC at 1-800-248-4444. If you have any questions about this statement or your rights under ERISA or need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

Basic TESPHE Information

Plan Name:	Ford Motor Company Tax-Efficient Savings Plan for Hourly Employees
Plan Sponsor:	Ford Motor Company Compensation and Benefits Office World Headquarters 1 American Road Dearborn, MI 48126-2798
Employer Identification Number:	38-0549190
Plan Number:	025
Type of Plan:	Defined Contribution Pension Plan (Code Sections 401(a) and 401(k) with a Cash or Deferred Arrangement (CODA), Employee Stock Ownership Plan (ESOP), ERISA Section 404(c))
Plan Administrator:	Ford Motor Company Compensation and Benefits Office World Headquarters 1 American Road Dearborn, MI 48126-2798 1-313-248-4444 or 1-800-248-4444
Type of Administration:	Services for the TESPHE are provided by: Ford Motor Company and State Street Bank and Trust Company (trustee) under a trust agreement and supplemental contracts; Alight Solutions LLC (third-party plan administrator) under contract
Trustee:	State Street Bank and Trust Company Defined Contribution Services 2 Avenue de Lafayette Boston, MA 02111
Agent for Service of Legal Process:	Ford Motor Company OGC – Secretary's Office World Headquarters 1 American Road Dearborn, MI 48126-2798 Alternatively, legal process may be served on the Plan trustee
Plan Funding:	Company and employee funded assets of the TESPHE are held in trust
Plan Year	January 1 through December 31

This Summary Plan Description contains an explanation of your Tax-Efficient Savings Plan for Hourly Employees (TESPHE) benefits based on documents, policies and negotiated collective bargaining agreements by which these benefits are provided. If there is any difference between this material and the TESPHE Plan documents or applicable negotiated agreements, the TESPHE Plan document and negotiated agreements always will govern.

The Company reserves the right to change, suspend, or terminate plans, subject to applicable collective bargaining agreements. Amendments also will be made to comply with applicable law. If changes are made, you will be notified.

Unless otherwise noted, transaction requests confirmed after 4:00 p.m. ET, or on weekends or holidays, will receive the next available closing prices.

The investment options available through the TESPHE reserve the right to modify or withdraw the exchange privilege.

Supplemental Unemployment Benefit (SUB)

UAW-Ford SUB Plan Summary Plan Description, November 2021

For UAW-Ford Represented:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees:** Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Supplemental Unemployment Benefit (SUB) Plan Overview

The Ford-UAW Supplemental Unemployment Benefit (SUB) Plan provides financial security during qualifying layoffs for eligible:

- **Legacy Employees**: Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees**: Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees**: Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

The Transition Assistance Plan (TAP) provides additional financial security after you have exhausted your benefits under the SUB plan.

If you are laid off from the Company and meet the eligibility requirements, you may be eligible for:

- **Regular Benefits**: Providing a weekly income for full weeks of layoff; Regular Benefits are a supplement to benefits provided under State Unemployment Systems
- **Transition Assistance Plan**: Providing a weekly income after you have exhausted your Regular Benefits under the SUB plan
- **Automatic Short Week Benefits**: Providing additional income in a short work week
- **Lump-sum Separation Payments**: Providing a lump-sum benefit if you are separated from the Company under certain circumstances

Note About Moving Allowance: The information for the Moving Allowance program can be found in the Collective Bargaining Agreement effective November 18, 2019.

Regular Benefits

If you are on layoff from a Ford-UAW Contract Unit, you may be eligible for Regular Benefits under the SUB plan

Eligibility

You may be eligible for Regular Benefits under the SUB Plan if you are an employee and:

- Have at least one year of Seniority as of the last day worked prior to the qualifying layoff
- Are on a qualifying layoff from a Contract Unit because of:
  - A reduction in force (including closing of a plant of operation)
  - A temporary layoff, or
  - Your inability to do work offered by the Company, even though you are able to perform other work in the plant that you would be entitled to if you had sufficient Seniority
- Have reported at a State employment office, if required by your State
- Have applied for Regular Benefits either in person or by mail, and
- Qualify for a Regular Benefit of at least $2

State Unemployment Compensation (UC) Benefits

In addition to the eligibility requirements described in the prior section, you must have received a State UC benefit, or be ineligible for one because you:

- Did not have a sufficient period of employment or earnings to qualify for State UC benefits
- Have exhausted your State UC benefits
- Worked or had earnings in the week that disqualified you for State UC benefits or Waiting Week Credit
- Were employed full time by an employer other than the Company and are not eligible for an Automatic Short Week Benefit
- Are serving a waiting week under the State UC System while you are laid off out of line of Seniority (with certain exceptions)
- Are serving:
  - A second waiting week within your State UC System benefit year
  - A waiting week that occurred within less than 52 weeks since your last waiting week, or
  - A waiting week immediately following a week for which you received a State UC benefit
- Refuse a Company offer of work that you have an option to refuse under the Collective Bargaining Agreement
- Are on layoff because you are unable to do your regular job, or other work offered by the Company, provided you are able to do other work in the plant that you would be entitled to if you had sufficient Seniority
- Have failed to claim a State UC benefit because pay from the Company would result in a State UC benefit of less than $2
- Are receiving pay for military service for a period following your release from active duty or were on short-term active duty of 30 days or less
- Are entitled to benefits for retirement or disability that would be payable while you are working full time
- Are on layoff for part of a week and have been denied a State UC benefit because for another part of the same week you were on a disciplinary layoff or layoff because of strike or other concerted action or received any statutory or Company Accident and Sickness benefit or Company retirement benefit

- Have been denied a State UC benefit and it would be contrary to the intent of the Plan to deny you a benefit
- Are otherwise qualified for Unemployment Compensation and SUB Regular Benefits, except for having failed to satisfy your State system reporting or certification requirements

The term "State Unemployment Compensation (UC) benefit" or "State system benefit" throughout this section includes certain allowances for training, Trade Readjustment Allowances and certain Workers' Compensation benefits.

If You Exhaust Your State Unemployment Compensation

Some special rules apply if you exhaust your State Unemployment Compensation and apply for Regular Benefits. In that instance, you must:

- Be able to work, be available for work and maintain an active registration for work with the State employment service,
- Do what a reasonable person would do to obtain work, and
- Apply for or accept suitable work that the State employment service or the Company informs you is available

If you have any questions regarding your State unemployment benefits, you must contact your State unemployment office.

Ineligibility

Certain circumstances affect your benefit eligibility under the Plan. You are not eligible for Regular Benefits if you:

- Are laid off:
  - For disciplinary reasons
  - Because of a strike, slowdown, work stoppage, picketing (whether or not by Ford-UAW employees) or concerted action — at a Company plant or plants — or any dispute of any kind involving Ford-UAW employees at a Company plant or elsewhere
  - Through your own fault
  - Because of any war or hostile action of a foreign power
  - Because of sabotage (including arson) or insurrection
  - Beyond the first two consecutive full weeks of layoff for which a Regular Benefit is payable in any period of layoff because of any act of God, or
  - Act of terrorism
- Refuse a Company offer of work that you cannot refuse under the Collective Bargaining Agreement
- Are in military service or on a military leave (other than short-term duty of 30 days or less)
- Are eligible for or claiming any statutory accident or sickness benefit, or other disability benefit (other than a disability benefit you would get even if working full time or a lost-time Workers' Compensation benefit while not disabled) or a Company retirement benefit (your eligibility for a regular early or normal retirement benefit if you are not yet receiving the benefit, however, will not disqualify you)
- Are receiving SUB payments from another employer or are eligible to receive them from another employer with whom you have more Seniority than you have with the Company
- Are receiving or are eligible to receive SUB payments under any other Ford SUB Plan, or
- Are eligible for an Automatic Short Week Benefit

Determination

Your SUB amount is determined by your weekly before-tax pay, certain other pay and State system benefits.

The Weekly Regular Benefits Calculation

Your weekly Regular Benefits are figured according to a formula:

74% of your Weekly Before-Tax Pay
- less $30.00 Work-Related Expense
- less any State system benefit, pay from the Company* excluding call-in pay, and earnings in excess of the greater of $10 or the maximum State unemployment amount you are eligible to receive or military pay in excess of $10.

The $30.00 reduction takes into account the work-related expenses you do not have when you are on layoff.

**80% of vacation pay received from the Company during Vacation Shutdown, under certain circumstances.*

Your weekly before-tax pay is based on your highest base hourly wage rate in the previous 13 weeks:

Base Hourly Wage				Regular SUB Benefit		
Under		$14.30				$423.28
$14.31	-	$14.50		$423.58	-	$429.20
$14.51	-	$14.70		$429.50	-	$435.12
$14.71	-	$14.90		$435.42	-	$441.04
$14.91	-	$15.10		$441.34	-	$446.96
$15.11	-	$15.30		$447.26	-	$452.88
$15.31	-	$15.50		$453.18	-	$458.80
$15.51	-	$15.70		$459.10	-	$464.72
$15.71	-	$15.90		$465.02	-	$470.64
$15.91	-	$16.10		$470.94	-	$476.56
$16.11	-	$16.30		$476.86	-	$482.48
$16.31	-	$16.50		$482.78	-	$488.40
$16.51	-	$16.70		$488.70	-	$494.32
$16.71	-	$16.90		$494.62	-	$500.24
$16.91	-	$17.10		$500.54	-	$506.16
$17.11	-	$17.30		$506.46	-	$512.08
$17.31	-	$17.50		$512.38	-	$518.00
$17.51	-	$17.70		$518.30	-	$523.92
$17.71	-	$17.90		$524.22	-	$529.84
$17.91	-	$18.10		$530.14	-	$535.76
$18.11	-	$18.30		$536.03	-	$541.68
$18.31	-	$18.50		$541.98	-	$547.60
$18.51	-	$18.70		$547.90	-	$553.52
$18.71	-	$18.90		$553.82	-	$559.44
$18.91	-	$19.10		$559.74	-	$565.36
$19.11	-	$19.30		$565.66	-	$571.28
$19.31	-	$19.50		$571.58	-	$577.20
$19.51	-	$19.70		$577.50	-	$583.12
$19.71	-	$19.90		$583.42	-	$589.04
$19.91	-	$20.10		$589.34	-	$594.96

Base Hourly Wage				Regular SUB Benefit		
$20.11	-	$20.30		$595.26	-	$600.88
$20.31	-	$20.50		$601.18	-	$606.80
$20.51	-	$20.70		$607.10	-	$612.72
$20.71	-	$20.90		$613.02	-	$618.64
$20.91	-	$21.10		$618.94	-	$624.56
$21.11	-	$21.30		$624.86	-	$630.48
$21.31	-	$21.50		$630.78	-	$636.40
$21.51	-	$21.70		$636.70	-	$642.32
$21.71	-	$21.90		$642.62	-	$648.24
$21.91	-	$22.10		$648.54	-	$654.16
$22.11	-	$22.30		$654.46	-	$660.08
$22.31	-	$22.50		$660.38	-	$666.00
$22.51	-	$22.70		$666.30	-	$671.92
$22.71	-	$22.90		$672.22	-	$677.84
$22.91	-	$23.10		$678.14	-	$683.76
$23.11	-	$23.30		$684.06	-	$689.68
$23.31	-	$23.50		$689.98	-	$695.60
$23.51	-	$23.70		$695.90	-	$701.52
$23.71	-	$23.90		$701.82	-	$707.44
$23.91	-	$24.10		$707.74	-	$713.36
$24.11	-	$24.30		$713.66	-	$719.28
$24.31	-	$24.50		$719.58	-	$725.20
$24.51	-	$24.70		$725.50	-	$731.12
$24.71	-	$24.90		$731.42	-	$737.04
$24.91	-	$25.10		$737.34	-	$742.96
$25.11	-	$25.30		$743.26	-	$748.88
$25.31	-	$25.50		$749.18	-	$754.80
$25.51	-	$25.70		$755.10	-	$760.72
$25.71	-	$25.90		$761.02	-	$766.64
$25.91	-	$26.10		$766.94	-	$772.56
$26.11	-	$26.30		$772.86	-	$778.48
$26.31	-	$26.50		$778.78	-	$784.40
$26.51	-	$26.70		$784.70	-	$790.32

Base Hourly Wage				Regular SUB Benefit		
$26.71	-	$26.90		$790.62	-	$796.24
$26.91	-	$27.10		$796.54	-	$802.16
$27.11	-	$27.30		$802.46	-	$808.08
$27.31	-	$27.50		$808.38	-	$814.00
$27.51	-	$27.70		$814.30	-	$819.92
$27.71	-	$27.90		$820.22	-	$825.84
$27.91	-	$28.10		$826.14	-	$831.76
$28.11	-	$28.30		$832.06	-	$837.68
$28.31	-	$28.50		$837.98	-	$843.60
$28.51	-	$28.70		$843.90	-	$849.52
$28.71	-	$28.90		$849.82	-	$855.44
$28.91	-	$29.10		$855.74	-	$861.36
$29.11	-	$29.30		$861.66	-	$867.28
$29.31	-	$29.50		$867.58	-	$873.20
$29.51	-	$29.70		$873.50	-	$879.12
$29.71	-	$29.90		$879.42	-	$885.04
$29.91	-	$30.10		$885.34	-	$890.96
$30.11	-	$30.30		$891.26	-	$896.88
$30.31	-	$30.50		$897.18	-	$902.80
$30.51	-	$30.70		$903.10	-	$908.72
$30.71	-	$30.90		$909.02	-	$914.64
$30.91	-	$31.10		$914.94	-	$920.56
$31.11	-	$31.30		$920.86	-	$926.48
$31.31	-	$31.50		$926.78	-	$932.40
$31.51	-	$31.70		$932.70	-	$938.32
$31.71	-	$31.90		$938.62	-	$944.24
$31.91	-	$32.10		$944.54	-	$950.16
$32.11	-	$32.30		$950.46	-	$956.08
$32.31	-	$32.50		$956.38	-	$962.00
$32.51	-	$32.70		$962.30	-	$967.92
$32.71	-	$32.90		$968.22	-	$973.84
$32.91	-	$33.10		$974.14	-	$979.76
$33.11	-	$33.30		$980.06	-	$985.68

Base Hourly Wage				Regular SUB Benefit		
$33.31	-	$33.50		$985.98	-	$991.60
$33.51	-	$33.70		$991.90	-	$997.52
$33.71	-	$33.90		$997.82	-	$1,003.44
$33.91	-	$34.10		$1,003.74	-	$1,009.36
$34.11	-	$34.30		$1,009.66	-	$1,015.28
$34.31	-	$34.50		$1,015.58	-	$1,021.20
$34.51	-	$34.70		$1,021.50	-	$1,027.12
$34.71	-	$34.90		$1,027.42	-	$1,033.04
$34.91	-	$35.10		$1,033.34	-	$1,038.96
$35.11	-	$35.30		$1,039.26	-	$1,044.88
$35.31	-	$35.50		$1,045.18	-	$1,050.80
$35.51	-	$35.70		$1,051.10	-	$1,056.72
$35.71	-	$35.90		$1,057.02	-	$1,062.64
$35.91	-	$36.10		$1,062.94	-	$1,068.56
$36.11	-	$36.30		$1,068.86	-	$1,074.48
$36.31	-	$36.50		$1,074.78	-	$1,080.40
$36.51	-	$36.70		$1,080.70	-	$1,086.32
$36.71	-	$36.90		$1,086.62	-	$1,092.24
$36.91	-	$37.10		$1,092.54	-	$1,098.16
$37.11	-	$37.30		$1,098.46	-	$1,104.08
$37.31	-	$37.50		$1,104.38	-	$1,110.00
$37.51	&	over		$1,110.30		

Maximum Benefit

In most instances, Regular Benefits are paid with no maximum. There is an exception, though. The maximum benefit is $200 if you refuse an offer of work by the Company (even though you had an option under the Collective Bargaining Agreement to refuse such work) if such a refusal:

- Results in your disqualification for State UC Benefits, or
- Occurs or such layoff continues after you have exhausted your State UC Benefits

The maximum will not apply, however, if you are a skilled Tool & Die, Maintenance and Construction or Power House employee and refuse an offer of work other than work in Tool Room Departments, Maintenance Departments and Power House Departments.

Reduced Benefit

The following provision will apply only in the event the terms of the 1987 SUB Plan are reactivated.

If you have less than 20 years of Seniority and the Credit Unit Cancellation Base (CUCB) is below $144.50, the Regular Benefit will be reduced by 20% but not to an amount less than $5. If you have less than 10 years of Seniority and the CUCB is below $44.50, a Regular Benefit will not be paid to you.

Benefit Overpayments

If for any reason you receive a benefit payment that should not have been paid or should have been paid in a lesser amount, the Plan provides for recovery of the overpayment amount. The overpayment will be recovered from future benefit payments or from regular paychecks.

Duration

The duration of SUB Regular Benefit payments is based on **your** number of years of seniority as of the day you are placed on a qualifying layoff.

1 year of seniority but less than 10 years	26 weeks
10 years but less than 20 years	39 weeks
20 years or more	52 weeks

Once you have exhausted your eligibility for SUB Regular Benefits, you may be eligible for Transition Assistance Plan (TAP) benefits.

Application

An electronic application will be automatically submitted for you if you receive a UC Benefit payment and work in a State where the automated SUB application process has been implemented (Michigan, Minnesota, Missouri, Kentucky and Ohio). Otherwise, you may apply for Regular Benefits in person or by mail. For instructions on how to apply by mail, contact the Company SUB office at the location where you work.

When to Apply

You may apply for State UC Benefits at any time; however, your Regular SUB is not payable until you apply and receive State UC Benefits. If you retroactively become eligible for State UC Benefits or your State UC Benefit amount is adjusted retroactively, which in turn affects your eligibility or benefit amount under this Plan, your Regular SUB may be affected. You must submit a new application form each week you claim a Regular Benefit, unless you live in a State where the SUB application has been automated.

However, once you are no longer eligible for State UC benefits, you must apply for SUB on a weekly basis. You will receive Regular Benefit payments in the same way in which you receive your regular pay.

Information to be Provided

The application form asks:

- The amount of any State UC and other benefits you have received. These include Workers Compensation Benefits, Retirement Plan Benefits, Trade Readjustment Allowances, benefits under any other SUB-type plans and State or Federal disability payments, and
- The amount of your earnings for each day in the week from any source other than the Company

You also must submit evidence that shows you:

- Have received a State UC Benefit,
- Are entitled to receive a State UC Benefit, or
- Are ineligible for a State UC Benefit for a reason under the Plan, described in the *Eligibility* section

Your Company SUB office can tell you what is considered qualifying evidence in your State.

Automatic Short Week Benefits

In certain circumstances, you may be eligible for Automatic Short Week Benefits.

Eligibility

You may be eligible for an Automatic Short Week Benefit if:

- You have at least one year of Seniority
- You work for the Company during the week, or:
  - You receive some jury duty pay, bereavement pay or military pay from the Company, or
  - You receive only holiday pay during the week from the Company and you received an Automatic Short Week Benefit or had 40 hours paid for or made available in the previous week.
- Because of layoff, the hours paid for or made available to you by the Company are less than 40, and
- Generally, you meet all of the eligibility requirements necessary to receive a Regular Benefit except you:
  - Need not have any Credit Units,* and
  - Need not have registered and reported to a State employment office.

**If the funding for the current SUB is exhausted, the 1987 SUB plan would be reinstated. A Credit Unit is provided under the 1987 SUB plan.*

Determination

Automatic Short Week Benefits are based on your straight-time pay and your hours worked.

Your Automatic Short Week Benefits are equal to:

80% of your straight-time pay (including any cost-of-living allowance) for each hour less than 40 not paid for or made available to you during the week.

In determining your hours made available for purposes of the Plan, there are two important points to keep in mind:

1. If, before a layoff during a week, notice of intent to work overtime has not been given to employees by the Company; overtime that is worked or available during that week but after the layoff and is not included in determining hours paid or made available during the week
2. Overtime hours that otherwise would be counted are not counted as hours made available if you are prohibited from working due to written restrictions imposed by your personal physician and agreed to by the plant physician

Example:

Suppose your straight-time hourly rate (including any cost-of-living allowance) is $29.84, you work 24 hours and you are on a qualifying layoff for the remaining 16 hours of the work week.

Your Automatic Short Week Benefit is computed as follows:

$29.84 hourly rate
x 80% short week percentage
$23.872 subtotal
x 16 hours laid off
$381.95 short week benefit amount

The $381.95 short week benefit amount when added to your regular pay of $716.16 will total $1,098.11 for the week.

This total is paid in one check. It is subject to all Federal, State and local income taxes and all other deductions normally taken from your pay.

Application

Generally, you do not need to apply for Automatic Short Week Benefits. However, if you believe you are entitled to an Automatic Short Week Benefit and do not receive it on the day it normally would be paid, you must submit a written application to the Company within 60 days of the day such benefit was payable. Also, submit a written application if the Automatic Short Week Benefit you receive is smaller than the amount you believe you are entitled to.

Transition Assistance Plan (TAP) Benefits

TAP benefits are payable to employees who are on an indefinite layoff and have exhausted their eligibility for SUB.

Duration

The duration of TAP benefit payments is based on **your** number of years of seniority as of the day you are placed on an indefinite layoff.

1 year of seniority but less than 10 years	26 weeks
10 years but less than 20 years	39 weeks
20 years or more	52 weeks

Once you have exhausted your eligibility for TAP benefits, you will no longer be eligible for any benefits under the SUB plan based on the 2019 CBA.

Determination

Your TAP benefits are determined by your weekly before-tax pay, certain other pay and State system benefits.

The Weekly TAP Benefits Calculation

Your weekly TAP Benefits are determined according to a formula:

50% of your weekly before-tax pay
- less any State system benefit, pay from the Company excluding call-in pay, vacation pay in-lieu or military pay in excess of $10.00

TAP Opt-out Benefit

Under certain circumstances, you may be eligible for a lump-sum TAP Opt-out Benefit.

As an alternative to receiving weekly TAP benefit payments, you may elect to opt-out of TAP benefits any time prior to, but no later than 30 days after, your TAP Benefits begin.

Your eligibility for TAP Opt-out Benefits is based on the following:

- Your Seniority as of your last day on the Active Employment Roll, and
- Your hourly rate.

Eligibility

You are eligible to receive a TAP Opt-out Benefit if you:

- Have at least one year of Seniority on the last day you are on the Active Employment Rolls of the Company,
- Have exhausted your SUB eligibility, and
- Do not refuse an offer of work by the Company (unless permitted by the Collective Bargaining Agreement) between layoff and the earliest date that you may apply.

The Payment Amount

The TAP Opt-out Benefit amount provides a lump-sum cash payment equivalent to the number of TAP benefit weeks payable to you, plus $10,000. By electing to opt-out of TAP benefits, you forfeit eligibility for weekly TAP benefit payments and all recall rights. **Selecting the TAP Opt-out option will terminate your employment.**

The gross (pre-tax) amount of the TAP Opt-out lump-sum cash payment is calculated at $10,000, plus the maximum TAP benefit for which you would otherwise be eligible (i.e., 50% of gross weekly wages, based on a 40-hour week, multiplied by your maximum TAP week eligibility). The lump-sum is subject to applicable taxes and any other amounts required to be deducted under applicable law or court order, and it will include deductions for any un-repaid overpayments under the SUB plan.

Lump-sum checks will be mailed to your address of record.

Separation Payments

Under certain circumstances, you may be eligible for a lump-sum Separation Payment under the SUB plan.

The Separation Payment amount depends on:

- Your Seniority as of your last day on the Active Employment Roll, and
- Your hourly rate.

Eligibility

You are eligible to receive a Separation Payment if you:

- Have at least one year of Seniority on the last day you are on the Active Employment Rolls of the Company
- Have been laid off for at least 12 continuous months (unless you are on a permanent layoff and appear to have no further employment opportunity with the Company) or have become totally and permanently disabled and are ineligible for a Company retirement benefit solely because you have less than 10 years of credited service
- Do not have a break in Seniority between the date of your layoff and the earliest date you can apply for a Separation Payment, and
- Do not refuse an offer of work by the Company (unless permitted by the Collective Bargaining Agreement) between layoff and the earliest date that you can apply.

Payment Amount

Your Separation Payment is based on your Base Hourly Rate plus any applicable cost-of-living allowance in effect on your last day worked and your years of Seniority. Your Seniority is translated into a specific number of hours of separation pay you will receive using the following table:

Years of seniority:	Hours of pay you receive:	Years of seniority:	Hours of pay you receive:
1 but less than 02	150	16 but less than 17	1,770
2 but less than 03	170	17 but less than 18	1,840
3 but less than 04	100	18 but less than 19	1,920
4 but less than 05	135	19 but less than 20	1,000
5 but less than 06	170	20 but less than 21	1,085
6 but less than 07	210	21 but less than 22	1,170
7 but less than 08	255	22 but less than 23	1,260
8 but less than 09	300	23 but less than 24	1,355
9 but less than 10	350	24 but less than 25	1,455
10 but less than 11	400	25 but less than 26	1,560
11 but less than 12	455	26 but less than 27	1,665
12 but less than 13	510	27 but less than 28	1,770
13 but less than 14	570	28 but less than 29	1,875
14 but less than 15	630	29 but less than 30	1,980
15 but less than 16	700	30 or more	2,080

In the event the provisions of the 1987 SUB Plan are reactivated, the following method of calculating the amount of a Separation Payment also will be available to employees who were at work on or after March 1, 1982:

The cash equivalent of your remaining Regular Benefits otherwise payable from the SUB Plan
plus
The cash equivalent of any insurance continuation coverage you are eligible to receive (unless eligible for insurance continuation due to retirement)
minus
The amount of any Regular Benefits received after your application for a Separation Payment was made

Under both methods, the amount you receive is reduced by:

- Any Moving Allowance you have received
- Any amounts that must be withheld by law or regulation, such as taxes
- SUB overpayments, and
- Any SUB payments you received for weeks after your last day worked.

To Receive a Separation Payment

To receive a Separation Payment, you must apply within 24 months (36 months if you have at least 10 years of Seniority and you were at work on or after March 1, 1982) after your layoff or disability period begins. An exception is made, however, if you become totally and permanently disabled and are not eligible for a disability retirement benefit because you do not have 10 years of credited service and are receiving an Extended Disability Benefit under Section 13 of the Life and Disability Insurance Program. If this is the case, you may apply for a Separation Payment on or before the 30th day following the last month you were eligible to receive an Extended Disability Benefit.

Effect on Seniority

If you accept a Separation Payment, you:

- Agree that such payment is a lump-sum payment allocable to an inactive period ("Allocation Period") during which no other pay or benefits or rights of employment shall apply
- Will cease to be an Employee and your Seniority will be deemed to have been broken as of the date your application for such Separation Payment was received by the Company ("Termination Date") for all purposes
- Will not be able to receive a special early retirement under any Company retirement plan
- Will not be permitted to retire under any Company retirement plan during the Allocation Period following the Termination Date, and
- Cannot grow into retirement if ineligible as of the break in Seniority (but without prejudice to any right to a deferred vested benefit).

The Allocation Period in weeks shall equal your Separation Payment divided by one-half the unreduced SUB Regular Benefit you received, or would have received, for the current period of layoff.

If you return the Separation Payment draft within 30 days of the date of the draft, your Seniority will be reinstated. If you are later rehired by the Company, you cannot refund the payment and your Seniority cannot be reinstated.

If you are eligible for an immediate pension benefit under the Ford-UAW Retirement Plan, at the time of your break in service (due to receipt of a SUB Separation Payment), you will, upon completion of the Allocation Period and application for a pension benefit, become eligible for post-retirement health care and life insurance on the same basis as other retirees. For purposes of applying the terms of the Ford-UAW Retirement Plan, you will not be treated as a deferred vested retiree by reason of your receipt of a SUB Separation Payment.

In the Event of Rehire

In the event that you are rehired by the Company within three years from the date of a prior separation from the Company, you may later become entitled to receive a second Separation Payment that would take into account the earlier Separation Payment.

How the SUB Plan is Financed

Payment of benefits will be paid through regular payroll by Ford Motor Company.

How the SUB Plan Works

This section of your handbook has described how the SUB Plan works and how some circumstances might affect your benefits.

Appeal Procedures

If you believe you have been improperly denied a Benefit or Separation Payment, or receive a Benefit or Separation Payment that is smaller in amount than that to which you believe you are entitled, you may file an appeal. Such an appeal must be in writing and must be filed with your local SUB office within 30 days following date of mailing of the payment, notice of denial or suspension of SUB or a Separation Payment or within 30 days of payment of an Automatic Short Week Benefit that is smaller in amount than that to which you believe you are entitled.

A local SUB Plan Committee has been established for each Company location. There are two members representing the UAW and two members representing the Company who will consider your appeal. If the local Committee denies the appeal, there is no further appeal.

If the local Committee does not resolve the issue, a further appeal may be made at the request of the employee to the Ford-UAW Board of Administration for SUB. This Board includes three Company members and three UAW members. The Plan provides for an impartial chairman. There is no appeal from the Board's decision.

If the Plan Terminates

If the Plan terminates, all assets remaining in the SUB Fund will be used to pay Plan Benefits to eligible employees for one year, unless the assets are exhausted sooner.

Plan provisions that provide for additional Company contributions to the SUB Fund when the CUCB falls below certain levels will not apply if the Plan terminates. After the end of the first year after Plan termination, the Company and the UAW will negotiate a program that will specify how any assets remaining in the Fund will be allocated.

Deductions that May Reduce Benefits

Tax withholding is based on your current exemption status on record with the Company.

If you wish to change your exemption status while you are receiving SUB/TAP benefits, you must submit an updated Form W-4 to your work location.

Your SUB/TAP benefits will also be reduced by the amount of any applicable court order directing the Company to withhold from your wages or benefits. Court orders for dependent support, bankruptcy, tax levies, garnishment, etc. that are on file with payroll services will be withheld from your SUB/TAP benefits.

Profit Sharing Plan

UAW-Ford Profit Sharing Plan Summary Plan Description, November 2021

For UAW-Ford Represented:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Profit Sharing Plan Overview

Profit Sharing is one of your well-earned rewards. It reflects the importance of your hard work contributing to Ford's success, and is a result of negotiations with the UAW.

The Profit Sharing Plan is designed to reward your efforts that result in Ford's profitability. Through the Plan:

- Each year that Ford's North American pre-tax profits, as stated in its Annual (10K) Report, exceed $1.25 billion, Ford will set aside a portion of these profits.
- The money allocated for Profit Sharing is divided among the Plan participants.
- Each Plan participant receives a portion of these profits, called a "Profit Share."
- Your Profit Share is based on your eligible compensated hours for the year and can be:
  - Paid by direct deposit or check
  - Put in the Tax-Efficient Savings Plan for Hourly Employees (TESPHE)
  - Deposited in your Ford Interest Advantage Account, or
  - A combination of these.

It's your choice.

If you decide to have the Company contribute all or a part of your share to the TESPHE, the provisions on investments, transfers, withdrawals, etc., that cover other TESPHE contributions will apply.

Plan Participation

Eligibility

You're eligible for Profit Sharing if you:

- Were hired on or before December 31 of the Plan year (the Plan year is the same as a calendar year)
- Are a full-time hourly employee of Ford Motor Company, and
- Are employed in a Unit to which this Plan is applicable.

Your eligibility is not affected if, during the Plan year:

- You are on layoff or approved leave
- You retire or separate from service at age 55 or older with 10 or more years of service from your most recent Ford service date, or at any age with 30 or more years of service from your most recent Ford service date, or
- Your employment terminates because the Company sells the operation where you work.

Beneficiaries of eligible employees who die during the Plan year also are eligible for Profit Sharing.

You Are Not Eligible If:

- Your employment terminated during the Plan year (without being reinstated) for reasons other than retirement, separation from service at age 55 or older with 10 or more years of service from your most recent Ford service date or at any age with 30 or more years of service from your most recent Ford service date, death or sale of an operation
- You are a Temporary Part-time or Temporary Full-time employee

Amount Determination

Each year that Company profits are generated, Ford will make Profit Sharing payments*, *as long as Ford's North American pre-tax profits exceed $1.25 billion for the Plan year.

The Profit Sharing amount is calculated based on North America profits on a pre-tax basis excluding special reconciling items that management reports to its shareholders. The formula generates an amount equal to $1 for every $1 million of North America pre-tax profit, not to exceed $12,000, for each eligible employee that is compensated for 1,850 hours or more within a given Plan year.

Individuals compensated less than 1,850 hours will generate a prorated contribution to Profit Sharing. The total Profit Sharing amount will then be distributed to individual participants based upon their individual compensated hours and the total compensated hours of all participants.

Here is an example of how the formula works in practice:

Step 1:

The first step is to identify Full-Year Automotive Sector North America Pre-tax Profits, excluding Special Items. This amount — frequently referred to more simply as "Automotive Sector North America Pre-tax Results" — is disclosed in Ford's Earnings Release announcement and in the annual Form 10-K filed with the U.S. Securities and Exchange Commission (SEC). In the following example, a hypothetical amount of $5 billion will be used.

Step 2:

Calculate the Amount of the Profit Sharing Fund. Example:

Participants with greater than or equal to the Maximum Compensated Hours		**Participants with less than the Maximum Compensated Hours**
30,000 Participants with >=1,850 X $5000* = $150,000,000		10,000 Participants with <1,850 X $5000* X 1,000 Avg Hrs / 1,850 = $27,027,027
Total Plan Year Profit Sharing Fund = $177,027,027		

**$5,000 (million) is a hypothetical figure intended to represent the FNA EBIT reported on the SEC Form 10-K. $5,000 (million) is the same thing as $5 billion. The reason that $5,000 million is used in the example (instead of $5 billion) is because the formula generates an amount equal to $1 for every $1 million of North America pre-tax profit (not to exceed $12,000).*

Note: The "Maximum Compensated Hours" refers only to the compilation of the total Profit Sharing Fund, not the calculation for the individual Profit Share amount (see Step 3).

When you receive your distribution, your pay stub will show how your individual Profit Share was calculated. Keep in mind that the actual Profit Sharing amount will change from year to year, and so will your eligible compensated hours. Also, this amount will be subject to withholding of applicable Federal, State and local income taxes, FICA taxes (including Social Security and Medicare) and deductions for Union dues.

Your Profit Share

Your share of the Total Profit Share is based on your eligible Compensated Hours.

Your Eligible Compensated Hours

Once the Profit Sharing amount is determined, your Profit Share then can be calculated. Your Profit Share depends on your eligible Compensated Hours and the total Compensated Hours of all participants. To determine your individual Profit Share, the Total Profit Share Amount is divided by the Total Compensated Hours for all participants in the Plan. Then this Amount Per Compensated Hours is multiplied by your individual Compensated Hours.

Step 3:

Calculate the Participant Profit Share Amounts. Example:

Total Plan Year Profit Sharing Fund	Total Compensated Hours	Profit Share Per Compensated Hour
=	=	=
$177,027,027	80,000,000	$2.212837

Name	**Compensated Hours**	**Profit Share Amount**
John	2000	$4,425
Kelly	1850	$4,093
Sam	900	$1,991

Eligible Compensated Hours

Eligible Compensated Hours include hours that an eligible employee receives pay within the Plan year for:

- Base Pay
- Overtime (with each hour paid at premium rates to be counted as one hour)
- Vacation
- Holiday
- Bereavement
- Apprentice Training
- Jury Duty
- Short-term Military Duty (up to the employee's weekly base schedule)
- Family Day
- Call-in

Eligible employees may receive credit for hours while on medical leave while receiving Workers' Compensation.

If you are on a qualified local Union leave, you will be credited with up to 40 Compensated Hours per week. In addition, if you are on a qualified military leave, you will be credited with up to 40 Compensated Hours per week. Local Union leave and qualified military leave are not to exceed 1,850 hours for the Plan year.

Compensated Hours will **not** include:

- Shift Premium
- Seven-day Premium
- Incentive Pay
- Moving Allowance
- Supplemental Unemployment Benefit (SUB) Payments Under the SUB Plan
- Transition Assistance Plan (including automatic short work week benefits)
- Sickness and Accident Benefits
- Extended Disability Benefits

Date of Participation

If you meet the Plan's eligibility requirements during the year, your Profit Share will be based on your eligible Compensated Hours.

Generally, your "date of participation" is your date of hire as a full-time employee, or the first day of the first full pay period beginning on, or after, the date on which you become a full-time employee. If you're eligible but are laid off or on approved leave at the beginning of the year and then return to work, your share will be based on your eligible Compensated Hours after you return to work.

How to Receive Your Share

How your Profit Share is paid to you is your decision. If you have an existing bonus election on **myfordbenefits.com**, your Profit Share payment will utilize that election. To verify if you have made a bonus election, go to **myfordbenefits.com** > *MY SAVINGS* > *Confirmation History* > *Bonus Contribution Rate* or contact the National Employee Services Center (NESC) at 1-800-248-4444.

Your options include:

- Receive all cash (direct deposit or check)
- Have the Company contribute your share on your behalf to the Tax-Efficient Savings Plan for Hourly Employees (TESPHE)
- Have the Company direct your share to your Ford Interest Advantage Account, or
- Elect a combination of these options.

Because tax issues can be complicated, you may want to talk with a tax advisor for more information before making your Profit Share decision.

Any Profit Sharing payment for the Plan year will be made by March 15 of the following year, unless otherwise specified under Volume III, Section III, page 88.

Choosing Cash

If you decide to take all or part of your share in cash, you'll receive direct deposit or a check for the net amount from Ford. Keep in mind that this is your Profit Share based on profits from the previous year. Profit Shares you receive by cash are considered taxable income, so Ford will withhold amounts for applicable Federal, State and local income taxes and FICA taxes.

Choosing TESPHE

If you prefer and you are eligible to contribute to the TESPHE, you can direct the Company to contribute all or part of your Profit Share, in 1% increments, to the TESPHE as a pre-tax or Roth contribution.

For pre-tax, any amount contributed to the TESPHE is not subject to Federal income taxes until you receive a distribution in the future. (The same may be true for State and local income taxes, depending on where you live and work.) For Roth, any amount contributed to the TESPHE is subject to Federal, State and local income taxes. However, future eligible Roth distributions are tax-free. For both options, the investment earnings on the amount you save are not taxed while they remain in the TESPHE.

Profit Sharing is subject to FICA taxes even if you elect to have the Company contribute your Profit Share to the TESPHE. If you have part of your Profit Share contributed to the TESPHE, FICA taxes and any required State and local income taxes on the portion contributed to the TESPHE will be withheld from your remaining cash payment, or from your next regular paycheck if necessary.

Any Profit Share contributed to the TESPHE will be based on your bonus contribution election on file. If you do not have a bonus contribution election on file, your Profit Share will be paid to you 100% in cash.

Any Profit Share contributed to the TESPHE will be invested according to your investment elections on file for pre-tax and/or Roth contributions. If you do not have an investment election on file, your contributions will be invested in the default investment option, presently a BlackRock LifePath® Index NL Fund based on your age. You may then transfer your contributions to other investment options, subject to any restrictions imposed by the investment option.

In general, the savings in your TESPHE account may be distributed upon your request when you retire or leave the Company. If you want to withdraw tax-efficient savings before you leave the Company or retire, you must be at least age 59½ or prove financial hardship under the tax laws in effect.

For more information on the TESPHE, see that section of this handbook.

Choosing Ford Interest Advantage (FIA) Account

You may authorize the Company to direct all or a portion of your Profit Share to your Ford Interest Advantage Account if you have an account open under that program and are investing in it through payroll deduction. Profit Share directed to your Ford Interest Advantage Account is considered taxable income, so Ford will withhold amounts for applicable Federal, State and local income taxes and FICA taxes. For FIA contact information, see the *FIA* section in this handbook.

Union Dues

Any required Union dues also will be deducted from your Profit Share, whether you take your Profit Share by check, have it contributed to the TESPHE, have it directed to your Ford Interest Advantage Account, or a combination of these. If you take all or part of your Profit Share by check, the necessary Union dues will be deducted from your cash payment. If you have the Company contribute all of your Profit Share to the TESPHE, Union dues on the full amount of your Profit Share will be deducted from your next paycheck. If you have all or part invested in your Ford Interest Advantage Account, the necessary Union dues will be deducted from any portion received in cash or, to the extent necessary, from the amount contributed to your Ford Interest Advantage Account.

Circumstances That Might Affect Your Profit Share

You should be aware of some circumstances that might affect your benefits from the Profit Sharing Plan.

Naming a Beneficiary

If you die while you are eligible for Profit Sharing, the Profit Share you have earned will go to the person or persons who are your beneficiaries. Your beneficiary is the person who receives payment of the Company's Group Life Insurance benefit. You may designate a different beneficiary for this Plan, however, if you wish.

If all or part of your Profit Share was contributed to the TESPHE and you die, your TESPHE account (including the amount contributed from your Profit Share) will go to your TESPHE beneficiary.

You may submit beneficiary designation(s) for your Profit Share by going to **myfordbenefits.com** > *Your Profile* > *Beneficiaries* > *Profit Sharing Plan.* You may change or revoke your beneficiary designations at any time.

Assignment of Benefits

In most cases, benefits from the Plan cannot be assigned. If you become divorced or separated, or if your Profit Share is garnished, certain court orders could require that part of your Profit Share be paid to someone else — your former spouse or children, for example. This could apply to benefits paid to you as well as to any beneficiary.

If the Plan Administrator determines that the court order qualifies, payments will be made according to the order.

Prior Year Payments

If you do not receive a Profit Share because you are terminated during the year for discharge, failure to report or overstaying a leave, and your seniority is reinstated in a later Plan year through the grievance procedure, you will receive your Profit Share after your service is reinstated. The amount will be based on your eligible Compensated Hours received for the prior Plan year and the Profit Share Per Compensated Hour amount for that Plan year.

If you receive a retroactive Worker's Compensation payment for a prior year for which you were eligible for a Profit Share, you may be eligible to receive a Profit Share payment based on the time period covered by the retroactive payment.

Incapacitation

If you or your beneficiary are incompetent, incapacitated or have not yet reached the age of majority, the Company may make payment to an appropriate individual and fully discharge its liability. This individual may be a relative by blood or marriage or any other individual or institution appearing to have assumed custody of you or your beneficiary.

Amount Discrepancies and Disagreements

If you disagree with the Company regarding your eligibility for Profit Sharing or the amount of your Profit Share, you should contact your payroll coordinator at your regular working location.

If Your Profit Share Is Underpaid

If an error is made when calculating your Profit Share and you were underpaid more than $25, the Company will pay the difference within 60 days after determining the error.

If Your Profit Share Is Overpaid

If your Profit Share is overpaid, you will receive a written notice of the amount that you should repay to the Company. If you do not repay this amount, the Company will deduct it from any monies payable in the form of wages or benefits payable under the Collective Bargaining Agreement. If necessary, your Profit Share for the next year will be reduced.

Repayment is not required if:

- The total amount of overpayment is $25 or less, or
- You are not given notice of the overpayment within 120 days after the overpayment was made.

Transfers

If you're transferred to the salaried payroll during the year, you'll receive a Profit Share from this Plan based on your eligible Compensated Hours earned while you participated in this Plan. Your eligibility and earnings as a salaried employee will be covered under the salaried Annual Incentive Compensation Plan (AICP).

Plan Modification

The 2019 Collective Bargaining Agreement between Ford Motor Company and the UAW authorizes the Profit Sharing Plan through the 2023 Plan year. At that time the terms of this Plan are subject to renegotiation.

The Company has the authority to control and manage the operation and administration of this Plan. The Company also has the authority to interpret Plan provisions, except as otherwise specifically provided in the 2019 Agreement.

Any disagreement between the Company and the UAW over the interpretation of the terms of this Plan as provided in the 2019 Agreement may be submitted to a mutually acceptable, impartial person for resolution at the request of either party. If the Company and the UAW cannot agree on an acceptable, impartial person, the Umpire under the Agreement will make the appointment. The impartial person's decision will be limited to Profit Share amounts allocated or distributed during the year the decision is made and subsequent Plan years, and will be binding on the UAW, its members, the participants and the Company.

Legal Services Benefit

UAW-FCA-Ford-General Motors Legal Services Plan, November 2021

For UAW-Ford Represented:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees**: Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees:** Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Legal Services Benefit Overview

The UAW-FCA-Ford-General Motors Legal Services Plan is responsible for providing legal services benefits to eligible active workers, former employees/retirees, and their spouses or surviving spouses as described in the plan's Summary Plan Description (SPD).

Covered Office Work Benefit

The Plan provides a covered office work benefit for certain specified legal services at no cost to the covered participant, which are summarized below.

- Wills and trusts
- Purchase or sale and other non-contested issues regarding residential property
- Uncontested family matters
- Powers of attorney
- Deeds
- Credit reporting matters
- Contracts for goods or services not involving litigation
- Residential leases
- Name changes
- Birth or marriage certificates
- Minor traffic matters or questions
- Social Security questions
- Medicare and Medicaid questions

Full Legal Services for Social Security Disability Matters

The plan also provides full services for Social Security Disability matters, including representation at the hearing, for eligible active and former workers.

Low-Cost Referrals for Litigation and Other Non-Office Work Matters

Low-cost referrals (paid by the eligible member) are made to private attorneys who have signed a contract with the Plan to represent eligible members at reduced rates. Referrals are provided for personal litigation matters, including probate, guardianships, contested domestic matters, residential real estate litigation, consumer litigation and bankruptcy.

Questions

To open a case, call the Plan at 1-800-482-7700 or email clientcomments@uawlsp.com. A case intake employee will ask you for information about your legal matter and answer your eligibility and coverage questions.

Regular office hours are Monday through Friday from 9 a.m. to 5 p.m. ET.

Dependent Care Assistance Plan (DCAP)

UAW-Ford DCAP Summary Plan Description, November 2021

For UAW-Ford Represented:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Dependent Care Assistance Plan (DCAP) Overview

The Dependent Care Assistance Plan (DCAP) helps you stretch your budget by letting you set aside tax-free dollars to pay for the cost of dependent care and elder care expenses for qualified dependents.

You may use the DCAP to reimburse yourself for eligible child care or elder care expenses you have during the year. You use the money you contribute to this account to pay yourself back for services you receive from providers such as nursery schools and licensed day care centers.

Ford offers you tax-savings opportunities through the DCAP. You designate a specified amount of your wages, up to $5,000 annually ($2,500 for a married person filing separately), from your pay on a pre-tax basis for eligible child care or elder care expenses you have during the year. You determine the amount of before-tax dollars to contribute from your paycheck to a DCAP.

Then you may use that money during the plan year to reimburse yourself for eligible dependent care expenses. You pay for your eligible expenses yourself and submit your paid receipts and claims documentation (i.e., signed claim form and itemized bill) for reimbursement.

The DCAP has a number of advantages. It helps you save and pay for anticipated expenses. It also lets you set aside money on a before-tax basis. That means dollars are contributed from your paycheck to the DCAP before taxes are taken out. Money is never taxed — not even when you take a reimbursement. This reduces your taxable income.

Participation and Eligibility

You may choose not to participate in the DCAP.

Participation in the DCAP is optional. You may enroll if this plan meets the needs of you and your qualified dependents.

Eligibility

Ford employees are eligible to participate in the DCAP. You may use the DCAP to reimburse yourself for eligible dependent care expenses for your qualified dependents.

Your dependents must meet the definition of qualified dependents for you to be reimbursed for their eligible dependent and elder care expenses.

Qualified Dependents

You may cover certain expenses for the care of your qualified dependents through the DCAP. To be eligible, a qualified dependent must be:

- A child, under age 13, who:
  - Lives with you more than half of the tax year, and
  - Does not provide more than half of his or her own support.

  or
- A relative of any age who:
  - Is mentally or physically unable to care for himself or herself,
  - Lives with you more than half of the taxable year, and
  - Does not have an annual gross income exceeding the exemption amount as defined by the IRS ($4,200 for 2020).

In addition, special eligibility rules apply to dependents for whom you claim expenses under the DCAP. See *Rules* later in this section for complete details.

Enrollment

To participate in DCAP, you must enroll during the Annual Enrollment period. You may enroll each plan year, and make new elections for each plan year, during the Annual Enrollment period held in the months of November and December. Once you have enrolled and made elections for a plan year, you cannot change your elections during the plan year unless you have a qualifying "change in status" (such as marriage, divorce, spouse's death, a change in your spouse's employment, the birth, adoption, or death of a child, etc.).

Cost

To participate in the DCAP, you must make weekly contributions from your paycheck throughout the plan year to your account.

You may not make lump-sum contributions. You contribute dollars to the DCAP on a before-tax basis.

When Participation is Effective

- If elected during the Annual Enrollment period, participation becomes effective on January 1 and continues through December 31.
- If elected during the plan year (for example, in the case of a new hire or rehire), participation becomes effective when you become eligible for health care or on the 90th day following your date of hire or rehire.
- If elected as a result of a "change in status," as soon as practicable after the "change in status," the Plan Administrator will advise you when your contributions will start based on the timing of your notification of the "change in status."

Basic Information

Dependent Care Assistance Plan (DCAP) is like a checking account. You deposit before-tax payroll deductions, and then use the account to pay yourself back for certain expenses.

Spending Accounts

The DCAP lets you set aside dollars that you can use throughout the plan year to reimburse yourself for eligible elder care and dependent care expenses. These accounts have special tax advantages; the money you set aside in them is never taxed, so your dollars go further to help you pay for eligible expenses.

Using Spending Accounts

- Estimate your expenses — estimate in advance how much your eligible expenses will be for the plan year
- Decide how much you want to contribute — you can deposit from $50 to $5,000 ($2,500 for married individuals filing separately) into your account during each plan year; some limits apply however (these are explained later); your contributions will be deducted in equal amounts from each paycheck throughout the plan year
- File a claim — when you have eligible expenses, pay for them as you normally would; then submit your paid receipts and claim documentation (i.e., itemized bill) — along with a signed claim form to HealthEquity/WageWorks, the Plan Administrator
- Receive your reimbursement — any reimbursements you receive from the DCAP will be tax free, meaning they won't be taxed when you receive them

Tax Advantages

The money you deposit in the DCAP is never taxed — not when it goes into your account and not when you receive reimbursement for an eligible expense. Here are the taxes you save:

- Federal income taxes
- Social Security taxes
- State and local income taxes (in most cases)

When you save on taxes, your dollars go further to help you pay for the cost of eligible elder care or dependent care expenses, as the following example shows. Suppose you contribute $1,000 to the DCAP and are in the 22% tax bracket. You could save $220 in Federal income taxes and $76 in Social Security (FICA) taxes for a total of $296.

Your savings could be even greater when you add State and local tax savings.

Possible Tax Savings

Total Amount Contributed to Spending Accounts	Estimated Annual Federal Income and Social Security Tax Savings		
	22% bracket	24% bracket	32% bracket
$ 100	$ 29	$ 32	$ 40
$ 250	$ 74	$ 79	$ 99
$ 500	$ 148	$ 158	$ 198
$1,000	$ 297	$ 317	$ 397
$2,500	$ 741	$ 791	$ 991
$5,000	$1,483	$1,583	$1,983

These are estimates. Your actual savings will depend on your income and filing status. These estimates are based on Federal income and Social Security taxes only. Your State and local taxes also may be reduced. Figures are based on 2019 tax rates. This example is based on an employee's wages only.

Before-tax contributions reduce the amount of your pay that is subject to Social Security taxes. If your earnings are less than the Social Security wage base, you'll pay lower Social Security taxes and may receive a smaller Social Security benefit when you retire. However, the tax advantages generally offset any slight reduction in Social Security benefits.

If you have any questions about taxes and how you could be affected, contact your personal tax advisor.

Rules

Because the Dependent Care Assistance Plan (DCAP) offers special tax advantages, certain rules apply to using the account.

These rules are:

- In general, you may not change the amount you contribute to your account during the plan year; however, if you have a "change in status," you may change the amount you contribute to your account.
- You can be reimbursed from the accounts only for services provided during the plan year — from January 1 through December 31; if you join the plan mid-year because you are a new hire or rehire, you can file claims only for services provided after you become a plan participant and your account is active.
- Other limitations for receiving reimbursements from the DCAP may apply if you end your employment during the plan year.
- **Under IRS rules, if you don't use all of the money in your account during the plan year, you must forfeit the excess; you have until March 31 to file claims for services received during the plan year ending the prior December 31; claims postmarked after March 31 cannot be accepted.**

Note: The Consolidated Appropriations Act of 2021 (CAA) allows participants a temporary exception to roll over all unused amounts in their DCAP from 2020 to 2021 and from 2021 to 2022.

Maximum Contribution Limits

Because of IRS rules, your maximum contribution to the DCAP may be limited. If you're married and:

- File your personal income taxes separately from your spouse, your annual contribution to the DCAP is limited to $2,500 (instead of $5,000)
- File a joint income tax return and your spouse also contributes to a Dependent Care Assistance Plan, the combined limit for the family is $5,000 per calendar year
- Your spouse is disabled or a full-time student, special limits apply; check with the Internal Revenue Service at 1-800-829-3676, consult IRS Publication 503 and talk to your tax advisor.

In any event, you may not contribute more than 50% of your earnings or 100% of those of your spouse, whichever is less.

If you are not married, your maximum contribution is $5,000 annually.

Eligible Expenses

The IRS requires that dependent care expenses meet certain criteria to be eligible for reimbursement from a DCAP.

Working or Looking for Work

To be work related, a dependent must receive care when:

- You're at work or searching for work, and
- If you're married, your spouse must be:
  - At work, or
  - Searching for work, or
  - In school as a full-time student, or
  - Mentally or physically disabled and unable to provide the care

Services may be provided either inside or outside your home by a licensed day care or elder care center, babysitter or companion, including relatives, but excluding your dependent children under age 19 and relatives you claim as exemptions on your Federal income tax return. The caregiver will be required to claim the income they receive from you on their own taxes.

Whether your expenses allow you to work or look for work depends on the facts. For example, the cost of a babysitter while you and your spouse go out to eat is not normally a work-related expense. Expenses are not considered work related merely because you incurred them while you were working. They must enable you to be gainfully employed. For example, you are not gainfully employed if you do unpaid volunteer work or volunteer work for a nominal salary.

Partial Work Year

If you work for only part of the year, you must figure your expenses only for the periods worked.

Payments While Out Sick

Amounts you pay for child and dependent care while you are off work because of illness do not count as work-related expenses.

Deductible Expenses

The following is a summary of dependent care expenses that generally would be deductible on your Federal income tax return and, therefore, are reimbursable through the DCAP. It's important to note that you can't claim a deduction on your tax return for expenses reimbursed through the DCAP. See IRS Publication 503 for an explanation of eligible and ineligible expenses. This publication changes annually, and some of the expenses listed below may not be reimbursable in future years. You can obtain a copy of the current complete list at your local IRS office, by calling the IRS toll free at 1-800-829-3676, or by viewing their website at irs.gov.

Care of Qualifying Person

To be work related, your expenses must be to provide care for a qualifying person. You don't have to choose the least expensive way of providing the care.

Expenses for household services qualify if part of the service is for the care of qualifying persons. See the "Household Services" explanation.

Expenses are for the care of a qualifying person only if their main purpose is the person's well-being and protection.

Expenses for care do not include amounts you pay for food, clothing and entertainment. However, if these amounts are incident to, and cannot be separated from, the cost of caring for the qualifying person, you can count the total cost.

Schooling

You can count the total cost of sending your child to school if:

- Your child is in a grade level below kindergarten, and
- The amount you pay for schooling is incident to, and cannot be separated from, the cost of care.

You can use the total cost of schooling before first grade only if the cost of schooling cannot be separated from the cost of the child's care. If your child is in the first grade or higher, or if the cost of schooling can be separated, you must take the total cost and separate the cost of care and the cost of schooling. You can count only the cost of care in figuring your contributions.

Example 1: You take your three-year-old child to a nursery school that provides lunch and educational activities as a part of its pre-school child care service. You can count the total cost in figuring your contributions.

Example 2**:** Your five-year-old child goes to kindergarten in the morning. In the afternoon, she attends an after-school day care program at the same school. Your total cost for sending her to the school is $3,000, of which $1,800 is for the after-school program. Only the $1,800 qualifies for figuring your contributions.

Example 3: You place your ten-year-old child in a boarding school so you can work full time. Only the part of the boarding school expense that is for the care of your child is a work-related expense. You cannot count any part of the amount you pay the school for your child's education.

Care Outside Home

You can count the cost of care provided outside your home if the care is for your dependent under age 13, or any other qualifying person who regularly spends at least eight hours each day in your household. Note:

- Dependent care center — you can count care provided outside your home by a dependent care center if the center complies with all applicable State and local regulations: a dependent care center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment or grant for providing services for any of those persons, even if the center is not run for profit.
- Camp — the cost of sending your child to an overnight camp is not considered a work-related expense.

Transportation

The cost of getting a qualifying person from your home to the care location and back or from the care location to school and back is not considered a work-related expense. This includes the cost of bus, subway, taxi or private car. Also, if you pay the transportation cost for the care provider to come to your home, you cannot count this cost as a work-related expense.

Household Services

Expenses you pay for household services meet the work-related expense test if they are at least partly for the well-being and protection of a qualifying person.

Household services are ordinary and usual services done in and around your home that are necessary to run your home. They include the services of a housekeeper, maid or cook. However, they do not include the services of a chauffeur, bartender or gardener.

Expenses Partly Work Related

If part of an expense is work related (for either household service or the care of a qualifying person) and part is for other purposes, you have to separate the expense. To figure the amount that may be reimbursed, count only the part that's work related. However, you do not have to separate the expense if only a small part is for other purposes.

Example: You pay a housekeeper to care for your nine-year-old and 15-year-old children so you can work. The housekeeper spends most of the time doing normal household work and spends 30 minutes a day driving you to and from work. You can treat the entire expense of the housekeeper as work related because the time spent driving is minimal. You do not have to separate the expenses between the two children because the household expense is partly for the care of your nine-year-old child, who is a qualifying person.

Housekeeper Meals and Lodging

If you have expenses for food that your housekeeper eats in your home, count these as work-related expenses. If you have extra expenses for your housekeeper's lodging, count these as work-related expenses also.

Example: You move to an apartment with an extra bedroom for a housekeeper. You can count the extra rent and utility expenses for this bedroom as work related. If your housekeeper moves into an existing bedroom in your home, you can count the extra utility expenses as work related.

Taxes Paid on Wages

The taxes you pay on wages for qualifying child and dependent care services are work-related expenses.

Ineligible Expenses

Certain expenses may not be reimbursed through a DCAP. Be careful not to include these expenses when you determine your contribution amount:

- Expenses you incur while away from work due to illness, leave or vacation
- Payments to a person who could be claimed as a dependent on your tax return or your spouse's tax return
- Payments to your child or stepchild who is under age 19 at the end of the taxable year
- Tuition for kindergarten
- Caregiver's transportation expenses
- Expenses claimed under the Federal Child and Dependent Care Tax Credit
- Expenses incurred before or after your participation in the account
- Expenses for overnight camp
- Health care expenses for dependents
- Child support or family maintenance payments
- Dependent care expenses that exceed the earned income of the lower-paid spouse

Coordination with Federal Tax Credit

You can also save taxes on dependent care expenses by claiming a tax credit on your Federal income tax return. Both the tax credit and the DCAP are intended to offer you tax savings. You may not use both for the same expense. However, you may use the account for some expenses and the tax credit for other expenses, subject to the limits described below. The better method for you depends on your income, the number of dependents you have and other factors.

Every dollar reimbursed through your DCAP reduces, dollar-for-dollar, your maximum eligible expenses under the Federal tax credit. That maximum is $3,000 a year if you have one qualifying dependent and $6,000 a year if you have two or more qualifying dependents. So, if you have one qualifying dependent and you contribute $3,000 or more to a DCAP, you wouldn't be able to use the tax credit for any other eligible expenses.

Consult a professional tax advisor or refer to IRS publication 503 for a complete discussion of the tax credit. To order a copy, call the IRS toll free at 1-800-829-3676.

Reimbursement

You must submit a claim form for reimbursement of dependent care expenses.

If you make contributions to a DCAP, funds will be deducted from each paycheck. Your contributions will be credited to an account set up in your name by the Plan Administrator.

When you incur an eligible expense, you can submit a claim online at **www.HealthEquity.com/WageWorks**, using the mobile app EZ Receipts or by completing a claim form and send it with your paid receipt to:

Claims Administrator
P.O. Box 14053
Lexington, KY 40511
Fax: (877) 353-9236

Claims are processed and reimbursement checks or direct deposits are issued as they are processed throughout the month. You will receive an Explanation of Benefits (EOB) statement and a new claim form with each reimbursement check.

Claims

When you have eligible dependent care expenses, simply fill out a claim form. You must furnish proof of payment for the services provided, such as a signed receipt. Additionally, you can have your provider acknowledge the services by signing the claim form.

If your claim exceeds your present account balance, you will receive a reimbursement only for the amount presently in your account. The remaining amount will be pended and automatically resubmitted for payment when your next payroll deduction is credited to your account. Assuming more contributions are credited to your account, you will receive another reimbursement check.

Claim Submission

You can request a reimbursement for dependent care expenses at any time. There's no minimum amount. Just request a reimbursement by submitting online at **HealthEquity.com/WageWorks** or completing a claim form and faxing or mailing it. Dependent care expenses are paid to you on a reimbursement basis. With the claim form, you must submit proof that the expense has already been paid, such as a signed receipt.

HealthEquity/WageWorks administers dependent care claims. Your reimbursement will be processed if you do the following:

- Use the HealthEquity/WageWorks claim form, complete the Employee's Statement and sign and date the form; or, use the electronic form available at **myfordbenefits.com**
- If not indicated on your receipts, be sure to add the name of the person for whom the services were rendered
- Provide a telephone number where HealthEquity/WageWorks may contact you for additional information, if needed
- Finally, if you have a question about dependent care expenses or procedures, simply call HealthEquity/WageWorks for assistance

If you submit a properly completed claim form to HealthEquity/WageWorks, you'll be reimbursed within two weeks after your claim form is received.

Only services rendered during the plan year are eligible for reimbursement. The plan year begins January 1 and ends on the following December 31.

You have until March 31 to submit claims for reimbursement of dependent care expenses incurred during the prior plan year. Claims postmarked after March 31 cannot be accepted. Under IRS rules, any unspent dollars remaining in your account after that date will be forfeited.

Account Statements

You can download a statement on the HealthEquity/WageWorks website. Go to **myfordbenefits.com > My Coverage > View My DCAP/HRA Details**. The statement shows contributions, payments made and account balances. In addition, each time you receive a reimbursement, you will receive a summary of year-to-date activity and a blank claim form.

Situations Affecting Participation

Some situations could affect your participation in the Dependent Care Assistance Plan (DCAP), as summarized here:

- You are not eligible for reimbursements of expenses that were incurred during a period that you were not at work (i.e., illness, vacation, leaves of absence, etc.).
- Generally, if you're married, both you and your spouse must be at work in order to receive eligible dependent care reimbursements.
- If you are on unpaid leave of absence, you're not eligible to continue participation in the DCAP while on leave, nor would you receive any reimbursement for eligible work-related expenses during the period of your leave.
- If you return from your unpaid leave of absence within the same plan year, your spending account payroll deductions resume.
- If you return from your unpaid leave of absence in a different plan year, you may make a new spending account election after you return to work.
- Your participation in the DCAP ends with your termination and cannot be continued; you may be reimbursed up to the balance in your account for expenses incurred prior to termination.

For More Information

If you have questions about the DCAP, call the NESC at 1-800-248-4444. Normal business hours are from 9 a.m. to 9 p.m. ET, Monday–Friday except for New York Stock Exchange holidays.

Ford Interest Advantage

For UAW-Ford Represented:

- **Legacy Employees**: Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees**: Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees**: Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Ford Interest Advantage Overview

Ford Interest Advantage (FIA) is a U.S. program available to employees, retirees and other persons who have a registered permanent address in the United States. It allows investment in demand notes issued by Ford Motor Credit Company, LLC. The program is offered through prospectus only and requires a $1,000 minimum investment to enroll. It is administered by the agent bank, The Northern Trust Company located in Chicago, Illinois.

Interest Rates

Current interest rate information is available on our website and is updated weekly. Pricing supplements are filed with the SEC that discloses the current interest rates on the Notes.

How to Enroll

Visit the FIA website at **ford.com/finance/investor-center/ford-interest-advantage** and click on ‘‘Enrollment Package.’’ Please read the prospectus. You have three enrollment options from which to choose:

- Apply online and submit your initial $1,000 investment using an electronic transfer from your bank account
- Print a copy of the enrollment form. Complete, sign and mail to the Agent Bank with an initial investment check for $1,000
- Contact the investor service line at 1-800-462-2614 and request an enrollment package. Complete, sign and mail to the Agent bank with an initial investment check for $1,000

Investments and Redemptions

Investments can be made by check and/or wire transfer. Employees are eligible to invest through payroll deduction. Interest is earned daily and automatically reinvested monthly. Funds may be redeemed at any time. All investors have free check writing privileges ($250 minimum).

Disclosure

The Notes issued under the Ford Interest Advantage Program are unsecured debt obligations of Ford Motor Credit Company LLC. They are not insured by the Federal Deposit Insurance Corporation, they are not guaranteed by Ford Motor Credit Company, and they do not constitute a bank account. Ford Interest Advantage is not a money market mutual fund. As investments in the debt of one company (Ford Credit), the Notes do not meet the diversification or investment quality standards for money market funds set forth in the Investment Company Act of 1940.

The Notes available through Ford Interest Advantage are issued by Ford Motor Credit Company and are offered only in the United States. The FIA website does not constitute an offer to sell or a solicitation to invest in the Notes in any jurisdiction in which such offer or solicitation is not authorized, or to any person to whom it is unlawful to make such offer or solicitation in any such jurisdiction. U.S citizens and resident aliens with U.S. Taxpayer ID (e.g., Social Security Number) may apply.

Ford Credit has filed a registration statement (including a prospectus) with the Securities and Exchange Commission relating to the offering of Ford Interest Advantage Notes. Before you invest, you should read the prospectus in the Registration Statement and the other documents Ford Credit has filed with the SEC for more complete information about Ford Credit and the Ford Interest Advantage Note program. The documents may be obtained free of charge through EDGAR on the SEC website. Alternatively, Ford Credit will send you a prospectus upon request by calling 1-800-462-2614.

Administrative, Employee Retirement Income Security Act (ERISA) and Family Medical Leave Act (FMLA) Information

UAW-Ford Administrative, ERISA and FMLA Information Summary Plan Description, November 2021

For UAW-Ford Represented:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees**: Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

Administrative, ERISA and FMLA Information Overview

Information regarding your employee benefit Plans is filed with the Federal government and must meet certain administrative requirements under government regulations. This section contains administrative details regarding the Plans.

Covered Employees

Unless specifically noted, this book describes benefit programs for Legacy UAW-represented hourly employees of Ford Motor Company who were:

- **Legacy Employees:** Hired or rehired prior to November 19, 2007
- **Skilled Trades Employees:** Hired or rehired prior to October 24, 2011
- **"New" Skilled Trades Employees:** Hired after October 24, 2011 and prior to November 18, 2019
- **New Traditional Employees:** Former "Entry Level" Employees who transitioned to "New Traditional" status in 2015

You can obtain a copy of the Collective Bargaining Agreement (CBA) by writing to the Plan Administrator. You also can review a copy of the CBA at your work location.

Plan Administrators

The Plan Administrator for all your benefit Plans, with the exception of the Legal Services Plan, is:

Ford Motor Company
One American Road
Dearborn, MI 48126

The third-party administrator and point of contact for all your benefit Plans, as well as recordkeeper of the Tax-Efficient Savings Plan for Hourly Employees (TESPHE) is:

Regular Mail	**National Employee Services Center** Dept. 01700 P.O. Box 1590 Lincolnshire, IL 60069-1590 1-800-248-4444
Express Mail	**National Employee Services Center** Dept. 01700 4 Overlook Point, Ste. 4OB Lincolnshire, IL 60069 1-800-248-4444

For information on the Supplemental Unemployment Benefit (SUB) Plan, contact your local hourly personnel office.

Plan Sponsor

Ford Motor Company is the Plan Sponsor of all your Plans.

Employer Identification Number

The Federal government has assigned Ford Motor Company an employer identification number for tax purposes. It is EIN 38-0549190.

Agent for Service of Legal Process

Legal process may be served upon the Plan Administrator or the Agent for Service of Legal Process:

Secretary
Ford Motor Company
One American Road
Dearborn, MI 48126

For SUB, legal process also can be served upon the Trustee of the Plan:

Secretary
Ford Motor Company
One American Road
Dearborn, MI 48126

For the Retirement Plan, legal process also can be served upon the Trustee of the Plan:

The Northern Trust Company
Ford Motor Company Retirement Plan
50 S. LaSalle Street
Chicago, IL 60675
1-312-630-6000

For TESPHE, legal process also can be served upon the Trustee of the Plan:

State Street Bank and Trust Company
Ford Motor Company Defined Contribution Services
2 Avenue de Lafayette
Boston, MA 02111
1-617-786-3000

Plan Year

The Plan Year for all plans is January 1 through December 31.

Plan Termination

Ford Motor Company intends for your Plans to continue indefinitely. No changes may be made until the expiration of the 2019 Collective Bargaining Agreement, except as required by law or as mutually agreed between Ford Motor Company and the UAW. The 2019 Collective Bargaining Agreement expires on September 14, 2023.

If the Retirement Plan should terminate, the Pension Benefit Guaranty Corporation (PBGC), a government-owned corporation guaranteeing certain pension benefits, would protect all or a portion of your benefit. See the *Retirement Plan* section of your handbook for more details.

Further, each section of your handbook has details describing what would happen if a particular Plan should end.

Plan Filing and Funding

The Employee Retirement Income Security Act of 1974, as amended (ERISA), requires that additional administrative information about your benefits be provided. A table with more information follows.

Summary of Administrative Information

UAW Hospital-Surgical-Medical-Dental-Drug-Vision (H-S-M-D-D-V) Program for Hourly Employees (Plan Number 520)				Administrative Services for Health Care are Provided by the Following Organizations:	
Plan Name:	**Type of Plan:**	**Cost Paid By:**	**Trustee:**	**If You Work In:**	**Benefits Administered or Insured Through:**
National PPO (BCBS) Hospital-Surgical-Medical-Hearing coverage	Welfare Plan providing Hospital-Surgical-Medical benefits	Benefits are paid by the Company. The Company pays fees to carriers and other organizations for administrative services and claims processing.	None	All States and the District of Columbia	Blue Cross Blue Shield of Michigan (BCBSM) Ford Hourly Service Center P.O. Box 312089 Detroit, MI 48231-2089 1-800-482-5146
Prescription Drug coverage for National PPO (BCBS)	Welfare Plan providing Prescription Drug benefits	Benefits are paid by the Company. The Company pays fees to carriers for administrative services and claims processing.	None	All States and the District of Columbia	Blue Cross Blue Shield of Michigan (BCBSM) Ford Hourly Service Center P.O. Box 312089 Detroit, MI 48231-2089 1-800-482-5146 Express Scripts P.O. Box 2096 Lee's Summit, MO 64063-7096 1-800-778-0735

UAW Hospital-Surgical-Medical-Dental-Drug-Vision (H-S-M-D-D-V) Program for Hourly Employees (Plan Number 520)				Administrative Services for Health Care are Provided by the Following Organizations:	
Plan Name:	**Type of Plan:**	**Cost Paid By:**	**Trustee:**	**If You Work In:**	**Benefits Administered or Insured Through:**
HMOs, PPOs & DHMOs: Alternative Hospital-Surgical-Medical Prescription Drug or Dental coverages*	Welfare Plan providing Hospital-Surgical-Medical Prescription Drug or Dental benefits	Depending upon the plan, the Company (i) pays the benefit and fees to carriers for administrative services and claims processing, or (ii) pays a premium to the carrier to fully insure the benefit.	None	Various States	Various alternative plans (HMOs, PPOs & DHMOs)
Traditional Dental coverage	Welfare Plan providing Dental benefits	Benefits are paid by the Company. The Company pays fees to carriers for administrative services and claims processing.	None	All 50 States including Puerto Rico and the District of Columbia	Delta Dental PPO Customer Service Department P.O. Box 9089 Farmington Hills, MI 48333-9089 1-844-223-8520

** Some HMO/PPO plans may include Vision and Hearing Aid coverages — varies by plan.*

UAW Hospital-Surgical-Medical-Dental-Drug-Vision (H-S-M-D-D-V) Program for Hourly Employees (Plan Number 520)				Administrative Services for Health Care are Provided by the Following Organizations:	
Plan Name:	**Type of Plan:**	**Cost Paid By:**	**Trustee:**	**If You Work In:**	**Benefits Administered or Insured Through:**
Vision Care coverage*	Welfare Plan providing Vision Care benefits	The Company pays a monthly premium to the carrier to fully insure the benefit. The carrier pays the claims.	None	All States and the District of Columbia, unless provided by your HMO	SVS, Inc. Ford/UAW Vision Care Program P.O. Box 464 Mt. Clemens, MI 48046-0464 1-800-225-3095
Outpatient Physical Therapy for National PPO Plan (BCBS) and Blue Preferred Plus PPO	Welfare Plan providing Outpatient Physical Therapy benefits	Benefits are paid by the Company. The Company pays fees to carriers for administrative services and claims processing.	None	Michigan	TheraMatrix Physical Therapy Network P.O. Box 321036 Detroit, MI 48232 1-888-638-8786

** Some HMO/PPO plans may include Vision and Hearing Aid coverages — varies by plan.*

Group Life and Disability Insurance Program (Plan Number 521)				
Plan Name:	**Type of Plan:**	**Cost Paid By:**	**Trustee:**	**Benefits Administered or Insured Through:**
Basic Life Insurance, Accidental Death and Dismemberment Insurance, Safety Belt User and Survivor Income Benefits	Welfare Plan providing life insurance	The Company pays premiums to the carrier in amounts reflecting the number and amount of claims paid.	None	Basic Life Insurance, Accidental Death and Dismemberment Insurance, Safety Belt User and Survivor Income Benefits are provided by: Group Policy 17-GCC <u>On or after January 1, 2021:</u> MetLife P.O. Box 6100 Scranton, PA 18505-6100 1-800-638-6420 <u>Prior to December 31, 2020:</u> UNICARE Life and Health Insurance Company P.O. Box 2090 Dearborn, MI 48123-2090 1-800-843-8184
Accident and Sickness Benefits and Extended Disability Benefits	Welfare Plan providing disability benefits	Benefits are paid by the Company either directly or through a trust fund established by the Company. Accident & Sickness benefits for New York and New Jersey are paid by a carrier.	None	Accident and Sickness Benefits (except New York and New Jersey) and Extended Disability Benefits are paid by Ford Motor Company. Claims are processed by: UniCare Life & Health Insurance Company P.O. Box 4479 Dearborn, MI 48126 1-800-572-1581 Accident and Sickness Benefits for employees in New York and New Jersey, are insured by UniCare Life & Health Insurance Company (Group Policy 17-GCC)

Group Life and Disability Insurance Program (Plan Number 521)				
Plan Name:	**Type of Plan:**	**Cost Paid By:**	**Trustee:**	**Benefits Administered or Insured Through:**
Optional Life & Accident Insurance Program • Optional Group Life Insurance Benefit • Dependent Group Life Insurance Benefit • Optional Accident Insurance Benefits	Welfare benefits offering: • Life insurance • Life insurance for your dependents • Accident insurance for you and your dependents	Participating employees	None	<u>On or after January 1, 2021:</u> MetLife P.O. Box 14406 Lexington, KY 40512-4406 1-833-552-FORD <u>Prior to December 31, 2020:</u> UniCare Life & Health Insurance Company P.O. Box 2090 Dearborn, MI 48123-2090 1-800-843-8184

Optional Long-Term Disability Insurance (Plan Number 524)				
Plan Name:	**Type of Plan:**	**Cost Paid By:**	**Trustee:**	**Benefits Administered or Insured Through:**
Optional Long-Term Disability (OLTD) (for eligible employees)	Welfare Plan offering additional employee paid disability insurance	Participating employees	None	UniCare Life & Health Insurance Company P.O. Box 2090 Dearborn, MI 48123-2090 1-800-843-8184

Other Benefits					
Plan Name:	**Plan Number:**	**Type of Plan:**	**Cost Paid By:**	**Trustee:**	**Benefits Administered or Insured Through:**
Supplemental Unemployment Benefit (SUB) Plan	503	Welfare Plan providing supplemental income benefits to eligible employees for certain periods in the event of a qualifying layoff	Ford Motor Company pays full cost of the Plan up to the limits of the Plan	None as of July 1, 2017	Plan Administrator: Ford Motor Company Compensation & Benefits Office One American Road Dearborn, MI 48126 313-594-2747 Ford transfers assets to the SUB Trust Fund [weekly] sufficient to pay benefits and administrative costs of the Plan.
Ford Motor Company-UAW Retirement Plan	001	Pension Plan providing defined benefits (a defined benefit plan) for eligible Legacy and Skilled Trades Employees	Ford Motor Company makes contributions to the Pension Fund to fund the normal and amortized past-service cost, as determined by an independent actuary — based on ERISA and the Retirement Agreement	The Northern Trust Company 50 S. LaSalle Street Chicago, IL 60675 1-312-630-6000	Plan Administrator: Ford Motor Company Third-party administrator: Alight Solutions LLC Dept. 01700 P.O. Box 1590 Lincolnshire, IL 60069-1590 1-800-248-4444

Other Benefits					
Plan Name:	**Plan Number:**	**Type of Plan:**	**Cost Paid By:**	**Trustee:**	**Benefits Administered or Insured Through:**
Ford Motor Company Tax-Efficient Savings Plan for Hourly Employees (TESPHE)	025	Defined Contribution Plan	Generally, Ford Motor Company pays Plan administrative expenses. For eligible employees who elect a wage reduction or contribution from 1% to 50% of pay and/or those who elect to deposit their eligible bonuses, the Company will contribute those funds to a trust fund.	State Street Bank and Trust Company Defined Contribution Services 2 Avenue de Lafayette Boston, MA 02111	Alight Solutions LLC Dept. 01700 P.O. Box 1590 Lincolnshire, IL 60069-1590 1-800-248-4444
Ford Motor Company Profit Sharing Plan for Hourly Employees in the United States	N/A	Unfunded arrangement for employee profit sharing; not an ERISA plan	Ford Motor Company makes payments under the Profit Sharing Plan when profits are generated	None	National Employee Services Center (NESC) Dept. 01700 P.O. Box 1590 Lincolnshire, IL 60069-1590 1-800-248-4444
Dependent Care Assistance Plan (DCAP)	N/A	Wage reduction program to provide pre-tax savings on the cost of eligible dependent care expenses	Participating employees	None	WageWorks P.O. Box 14053 Lexington, KY 40511 1-800-248-4444

Employee Retirement Income Security Act of 1974 (ERISA)

You have certain rights under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA Rights

As a participant in any of the ERISA plan descriptions in this Employee Handbook, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Included are the right to receive certain Plan information and the right to file a lawsuit if you believe your rights have been violated.

Here is a listing of your rights under ERISA:

Receiving Information About Your Plan and Benefits

- Examine, without charge, at the NESC and at other specified locations, such as worksites or union halls (as applicable), and in some cases Ford World headquarters, all documents governing the plan, including insurance contracts and collective bargaining agreements (as applicable), and copies of the latest annual report (Form 5500 Series), filed by the plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all plan documents and other plan information upon written request to the NESC (the Company may make a reasonable charge for the copies). Write to the NESC at:

  National Employee Services Center
  Dept. 01700
  P.O. Box 1590
  Lincolnshire, IL 60069-1590
  1-800-248-4444
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each plan participant with a copy of this summary annual report.
- Obtain an annual statement telling you whether you have a right to receive a benefit from the Retirement Plan at normal retirement age (age 65) and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to have a right to such a benefit. This statement must be requested in writing. The plan must provide the statement free of charge.
- You also have a right to a statement of your benefits under TESPHE. Your TESPHE account statement is prepared quarterly. If you elected to receive your statement online, you will receive a notification that the statement is available. Otherwise, one will be provided in the mail. If you elect to receive your quarterly statements online, a statement covering the entire year will be mailed to you annually.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
- For additional information, see COBRA in the Other Non-Ford Group Health Care Plan Information section of this handbook.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plans. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for any benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you may take to enforce the above rights. For instance:

- If you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a State or Federal court.
- In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.
- If the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.
- The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Plan Assistance

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

If you have any questions about your plans, you should contact the NESC by mail at:

National Employee Services Center
Dept. 01700
P.O. Box 1590
Lincolnshire, IL 60069-1590

Or you may call 1-800-248-4444.

Family Medical Leave Act of 1993 (FMLA)

Your Rights

Your FMLA entitlement is governed by Federal and State law.

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or childbirth;
- To care for the employee's child after birth, or placement for adoption or foster care (this leave must conclude within 12 months of birth or placement);
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

The Company will continue to use, initially, a calendar year as the 12-month period of the leave entitlement.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative child care, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is the employee’s spouse, son, daughter, parent or next of kin; who is a current member of the Armed Forces, including a member of the National Guard or Reserves; who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon timely return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Paid Leave for Unpaid Leave

Employees may choose to use accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Responsibilities

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30-days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member has a serious medical condition that requires the employee's care or assistance, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the notice of employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers also must inform employees if leave will be designated as FMLA-protected, the date the FMLA coverage began, the anticipated end date of the FMLA coverage, or, if the leave is expected to exceed the employee's FMLA entitlement, the amount of leave that will be covered by the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement that provides greater family or medical leave rights.

Determination

The Company is responsible for determining if your leave will be considered an FMLA leave, based on information you provide. Generally, leave cannot be credited as FMLA leave after the leave has ended. Failure to provide timely notice of the need for FMLA coverage may result in FMLA coverage being delayed or denied.

In some instances, FMLA leaves may be concurrent with Personal or Medical Leaves of Absence.

Under the 2019 Collective Bargaining Agreement, qualifying FMLA time that is comparable under the Accident and Sickness Insurance provisions of the Group Life and Disability Insurance Program will not be counted against your 12-week FMLA entitlement unless you elect to have it so counted. You will continue to have all your FMLA rights for qualifying leave without regard to whether you elect to have the leave count against your 12-week entitlement.

Vacations and FMLA Leaves

Absence from work due to a Family and Medical Leave Act leave to care for a family member identified above, with a serious health condition, or due to the birth of an employee's child or the placement of a child with the employee for adoption or foster care, will not be counted in computing the 35 days of absence for purposes of vacation eligibility.

Health Care Coverage Continuation

The Company will continue health care coverage for you, your spouse and your eligible dependents while you are on FMLA leave if such coverage was provided by the Company before the FMLA leave began.

Such coverage will be on the same terms as if you had continued to work. You also may be entitled to continue health care coverage for other dependents at your own expense while on FMLA leave (such as Sponsored Dependent coverage). However, the Company may recover premiums paid to maintain your health care coverage if you fail to return to work from FMLA leave for a reason other than the continuation of a serious health condition or circumstances beyond your control.

Future FMLA Procedural Changes

The Company may change the above procedures to reflect relevant changes in the law. However, any changes will not reduce leave provided by the Collective Bargaining Agreement.

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