BENEFITS AGREEMENT

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between
Mack Trucks, Inc.
and the
International Union,
United Automobile,
Aerospace and
Agricultural Implement
Workers of America
UAW and Its Locals
171, 677, 1247, 2301, 2420

November 15, 2023 – October 1, 2028

WAIVER

Section 1

During the negotiations resulting in this Benefits Agreement concerning the benefits and terms and conditions of employment of production, maintenance, and salaried employees, the Company and the Union each had the unlimited right and opportunity to make demands and proposals with respect to any subject matter as to which the National Labor Relations Act imposes an opportunity or obligation to bargain. Except as specifically set forth elsewhere in this Agreement, the Company expressly waives its right to require the Union to bargain collectively, and the Union expressly waives its right to require the Company to bargain collectively over all matters as to which the National Labor Relations Act provides an opportunity or imposes an obligation to bargain, whether or not: (1) such matters are specifically referred to or covered in this Agreement; (2) such matters were discussed between the Company and the Union during the negotiations that resulted in this Agreement; or (3) such matters were within the contemplation or knowledge of the Company or the Union at the time this Agreement was negotiated and executed.

Section 2

This Agreement contains the entire understanding, undertaking, and agreement of the Company and the Union, after exercise of the right and opportunity referred to in the first sentence of Section 1 above, and finally determines and settles all matters of collective bargaining between the parties for its term. Any changes to this Agreement or any changes to any other terms and conditions of employment not covered or contemplated by this Agreement during its term, whether by addition, waiver, deletion, amendment, or modification, must be reduced to writing and executed by the Company's Corporate Director, Employee and Labor Relations, the local Director of Human Resources, and the designated International and Local Union representatives to be enforceable.

Section 3

The waiver of any breach, term or condition of any of the provisions of this Agreement by either party does not constitute a precedent or past practice for any future waiver or enforcement of such breach.

Section 4

Unless specifically so provided in this Benefits Agreement to the contrary, past practices shall not be binding on either party.

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Appendix A

Mack Trucks, Inc.
Mack-UAW Pension Plan
For Employees Hired Before June 1, 2009

Summary Plan Description

January 1, 2024

To All Participants:

The Mack-UAW Pension Plan (the Plan) is designed to help ensure your financial security during retirement and to provide you with a source of income after you stop working. The Pension Plan covers employees who were hired before June 1, 2009.

The Mack-UAW Pension Plan provides for Normal, Early, Disability and Deferred Vested pension benefits. The Plan also provides benefits to eligible survivors of deceased participants.

This is your Summary Plan Description for the Pension Plan reflecting the agreement that is effective as of **November 15, 2023**, and as it applies to participants who terminate employment on or after **December 1, 2023 and commence payment on or after January 1, 2024**. If you terminated your employment before **December 1, 2023 or commenced payment before January 1, 2024**, the rules of the Plan document as in effect when you left will apply to you. If you need information about the Plan as in effect previously, please contact the Plan Administrator.

This Summary Plan Description provides you with information about your rights and benefits under the Plan in plain, easy-to-understand language. Because this is only an overview of the Plan, not all provisions of the Plan are discussed.

The Plan is maintained pursuant to a collective bargaining agreement between the Company and the International Union, UAW, Locals 171, 677, 1247, 2301 and 2420. You may obtain a copy of the collective bargaining agreement by writing to the Plan Administrator (see last page of this Summary for address). Additionally, the collective bargaining agreement is also available for examination by participants and beneficiaries at the office of the Plan Administrator and at the office of each Local.

The general explanation provided in this summary does not change, expand or otherwise interpret the terms of the Plan. The complete text of the official Plan document may be obtained from the Plan Administrator. If there are any differences, conflicts or inconsistencies between the information contained in this document and the official Plan document, the Plan document will always govern.

We encourage you to read this booklet carefully and share it with your family. If you have any questions about the Plan after reading this material, please contact your local Human Resources Department, Benefits Representative, or call **the Volvo Benefits Center (Retirement Services)** at 1-800-356-9240 or log into www.myplansconnect.com/volvo.

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Participation in the Plan

You are eligible to be an active participant in the Plan if:

- you are an active employee of Mack Trucks, Inc. or a UAW facility under the Mack Master Agreement (the "Company"); and
- you are represented by UAW Locals 171, 677, 1247, 2301, or 2420; and
- you were hired or rehired before June 1, 2009.

Earning Service

You can earn two types of service under the Plan: credited service and vesting service.

Credited Service

Your credited service is based on the hours of pay you receive from the Company in a calendar year and is used to calculate the benefits you will receive under the Plan.

To count as a full year of credited service, you must be paid for at least 1,700 hours.

You will receive proportionate credit (i.e., a partial year of credited service) to the nearest 1/10 of a year for years in which you receive pay for less than 1,700 hours. If you complete at least 1,615 hours during a calendar year, you will receive credit for a full year. For example, suppose you complete 1,620 hours during a year. You will receive 1,620/1,700 = .953 years, which would round to 1.0 year of credited service.

You may also receive credited service for periods during which you:

- are on an approved leave of absence for the purpose of permitting you to hold a position with the Local Union;
- are on an approved leave of absence for the purpose of permitting you to hold a position with the International Union;
- are in active service up to five years in the Armed Forces; or
- are on an approved leave of absence due to an occupational injury or illness and receiving Workers' Compensation.

In addition, if you have seniority as defined in the collective bargaining agreement, you may also be granted credit for time during which you are absent due to a layoff or a Company-approved sick leave, provided you have received pay from the Company for at least 170 hours of work in the year your layoff or sick leave begins.
To avoid duplication, pay for unused vacation does not count as credited service. However, pay for accrued vacation does count as credited service.

Pay for unused vacation or accrued vacation is recognized for the purpose of satisfying the 170-hours requirement described above.

Vesting Service

Your vesting service is equal to the number of years from your employment date to your severance date and is used to determine whether you are entitled to a benefit under the Plan. Years of service are calculated on the basis of completed months, with a completed month meaning the period of work from a particular day in a given month through the day preceding that day in the next month. An additional full month is awarded for any portion of a month beyond a completed month.

You also earn credit toward years of vesting service for periods during which you are absent from work on unpaid leave under the Family and Medical Leave Act of 1993 and for periods during which you are absent from work due to military service and you meet the requirements of the Uniformed Services Employment and Reemployment Rights Act.

You stop earning vesting service when your employment with the Company ends ("severance date"). However, you may continue to earn vesting service during:

- a Company-approved leave of absence for a period of up to two years;
- a layoff of up to two years, provided you don't refuse recall within that period; or
- a period of up to one year following your termination of employment from the Company, if you return to the Company within that year.

Transfers Into a Bargaining Unit or Creation of a New Bargaining Unit

If you become covered under the Plan because you are transferred into a covered bargaining unit or because you become a member of a newly formed bargaining unit, you may retain all of the credited and vesting service you had earned under any other Company retirement plan as of the time of transfer. To avoid duplication, the benefit payable from the Plan will be offset by the benefit payable under any other Company retirement plan.

Transfers Out of the Plan

If your coverage under this Plan ends because you are no longer represented by one of the UAW locals identified in the "Eligibility" section of this summary, you will retain the credited service that you had earned under this Plan and you will continue to earn vesting service as long as you are employed by the Company.

Breaks in Service

You will have a "break in service," if you cease working for the Company before accumulating five years of vesting service and thus before you become eligible for a Deferred Vested Pension. If you have a break in service, you may lose all of your years of credited service and vesting service. Depending upon the length of the break, the loss may be temporary and the previously accrued years of credited service and vesting service may be restored upon resumption of work with the Company. A longer break is

permanent, meaning that years of credited service and vesting service cannot be restored even if you later return to work with the Company.

For these purposes, your Severance Date is the date as recorded in the Company's records, on which you quit, retire, are discharged, or die, or, if earlier, the first anniversary of the first day of a period during which you remain absent from service with the Company and all Affiliated Companies (with or without pay) for any reason.

You shall incur a One-Year Period of Severance if your employment with the Company is severed and you remain out of the employment of the Company for the 12-month period ending on the day before the anniversary of your Severance Date.

If you sever your employment before accumulating five years of vesting service, you will permanently lose your years of credited service and years of vesting service if you are not reemployed by the Company before you incur five consecutive One-Year Periods of Severance.

If you sever your employment before accumulating five years of vesting service, you may nevertheless have your years of credited service and years of vesting service restored if you are re-employed by the Company before you incur five consecutive One-Year Periods of Severance, so long as you have earned one year of vesting service following your return to employment.

Notwithstanding the foregoing, an absence for one or more of the following reasons shall not be considered a severance from service: (a) layoff for a period not in excess of two years; (b) Company-approved leave of absence for a period not in excess of two years; (c) military service that meets the requirements for coverage under the Uniformed Services Employment and Reemployment Rights Act or such that the right to reemployment is protected by any other law; or (d) unpaid leave under the Family and Medical Leave Act of 1993. Additionally, if you are absent from work beyond the first anniversary of the first day on which you are absent by reason of pregnancy, childbirth or adoption, or for the purpose of the care for your child immediately after birth or adoption, the 12-consecutive-month period beginning on the first anniversary of the first day of such absence shall be neither a one-year period of severance nor a year of credited service or vesting service.

Qualifying for Benefits Under the Plan

You may qualify for any of three types of retirement under the Plan:

- Normal
- Early
- Disability

The Plan also provides a deferred vested pension if you break seniority after you have completed five years of vesting service but before you qualify for one of the three types of retirement shown above.

Normal Retirement

You are eligible to receive a Normal Retirement benefit if you retire at or after age 65 (the Plan's Normal Retirement Age) and you have earned at least five years of credited service.

Early Retirement

You are eligible for Early Retirement benefits if:

- You retire after earning at least 30 years of credited service (regardless of your age); or
- You retire between ages 60 and 65 and you have earned 10 or more years of credited service; or
- You retire between ages 55 and 62 and your age plus your years of credited service equal at least 85; or
- You retire after age 55 because your job is eliminated due to the sale, transfer or permanent discontinuance of a product line or business segment, provided that at least 20% of all bargaining unit employees in the plant, or 150 bargaining unit employees, are terminated as the direct result of that sale, transfer or discontinuance, and further provided that you would have met one of the eligibility conditions for early retirement described above if you had continued in employment for a period of time equal to your vesting service.

Disability Retirement

You may be eligible for Disability Retirement benefits if:

- you are totally and permanently disabled because of an illness or injury; and
- you are younger than age 65; and
- you have earned at least 10 years of credited service.

You are totally and permanently disabled if you have a permanent incapacity which results in your being unable to engage in any regular employment or occupation, by reason of any medically demonstrable physical or mental condition, with the Company at the plant or plants where you work, provided you are not engaged in paid regular employment (excluding employment or occupation which on the basis of medical advice

the Board of Administration determines to be for purposes of rehabilitation). You will not be considered to be totally and permanently disabled if your incapacity resulted from service in the armed forces of any country, provided, however, that this restriction shall not prevent you from being deemed to be totally and permanently disabled as described herein if you have accumulated at least five years of seniority after separation from service in the armed forces and before such incapacity occurs.

To qualify for Disability Retirement benefits, you will be required to submit to an independent medical examination by a doctor selected by the Board of Administration. In addition, you may be required to submit to periodic reexaminations up to twice a year at the Board's request to determine your continuing eligibility for benefits.

Deferred Vested Pension

If you incur a break in seniority before you qualify for one of the three types of retirement mentioned above and you have five or more years of vesting service, you qualify to receive an unreduced deferred vested pension when you reach age 65 or a reduced deferred vested pension when you reach age 60 (or if earlier, when the sum of your age, to the nearest one-tenth year, plus your credited service equals 85). If your benefit commences before age 65, it is reduced by 7.2% for each year (or .6% for each month) by which benefits begin before your 65th birthday.

Calculating Your Benefits

Your basic benefit from the Plan is called your Life Income benefit.

Normal Retirement

Your Normal Retirement Life Income benefit is determined as of the date you retire, and is calculated by multiplying your credited service times the Life Income benefit rate applicable to your retirement date.

The Life Income benefit rates are as follows:

Retirement Date	Life Income Benefit Rate
January 1, 2016 – December 31, 2016	$47.50
January 1, 2017 – December 31, 2019	$48.50
January 1, 2020 – December 31, 2023	$49.50
January 1, 2024 or later	**$53.50**

Benefit Escalation

Benefit Escalation does not apply to participants who retire during the life of this contract.

An Example of Your Normal Retirement Pension Benefit

Assume that you retired on **January 1, 2024** at age 65 with 20 years of credited service.

Your monthly Normal Retirement Benefit would be determined as follows:

Year	Monthly Pension
2024 and later	**$53.50** x 20 = $**1,070**

Early Retirement

Your Early Retirement Life Income benefit is also determined as of the date you retire and is calculated by multiplying your credited service times the Life Income benefit rate applicable to your retirement date times the reduction factor for early commencement.

The early retirement reduction factor is based on the following table:

	Early Retirement Factor	
Retirement Date	Under Age 60	60 and Over
January 1, **2024** or later*	**.9417**	1.000

***Applicable to employees who terminate from covered employment on or after December 1, 2023.**

If you retire on an Early Retirement Date, you may also be eligible for a Supplemental Allowance. Please see Page 19 for a description of the Supplemental Allowance.

An Example of Your Early Retirement Pension Benefit

Assume that you retire in **2024** at age 58 with 30 years of credited service.

You would be eligible for the supplemental allowance and your Early Retirement Benefit payable until age 62 and one month would be as follows:

Year	Monthly Pension
2024 and later, until age 62 and one month	$**2,500**

Your monthly Early Retirement Benefit payable after age 62 and one month would be determined as follows: $**53.50** x 30 x **.9417** = $**1,511**

In this example, because you attain age 62 and one month after January 1, 20**24**, your pension is calculated using a benefit level and early retirement factor of $**53.50** and **.9417**, respectively.

An Example of Your Early Retirement Pension Benefit

Assume that you retire in **2024** at age 58 with 27 **(less than 30)** years of credited service.
You would be eligible for the supplemental allowance and your early retirement pension would be determined as follows:

Year	**Monthly Pension**
2024 and later, until age 62 and one month	27/30 x $**2,500** x 76% = $**1,710**

Your monthly Early Retirement Benefit payable after age 62 and one month would be determined as follows: $**53.50** x 27 x .**9417** = $**1,360**

In this example, because you attain age 62 and one month after January 1, **2024**, your pension is calculated using a benefit level and early retirement factor of $**53.50** and .**9417**, respectively.

Disability Retirement

If you qualify for Disability Retirement, you will receive an unreduced benefit determined in the same manner as the Normal Retirement benefit above.

In addition, if you begin receiving your disability benefit before you reach age 62 and one month (or become eligible to receive an unreduced Social Security benefit), your disability retirement benefit may be increased by an additional amount called the Temporary Benefit. The amount of your Temporary Benefit is determined by multiplying your credited service up to a maximum of 30 years times the current rate, $35.85. When

you reach age 62 and one month, or you become eligible to receive an unreduced Social Security benefit (if earlier) your Temporary Benefit will stop.

An Example of your Disability Retirement Benefit

Assume that you retire after qualifying for total and permanent disability in **2024**, at age 45 with 20 years of credited service. Your monthly Disability Retirement Benefit would be determined as follows:

Life Income benefit	=	$**53.50** x 20 =	$**1,070**
Temporary benefit	=	$35.85 x 20 =	717
Total			$**1,787**

When you reach age 62 and one month, your Temporary benefit will stop, and your pension will be $**1,070** per month.

Deferred Vested Pension

If you terminate employment with the Company and you qualify for a Deferred Vested pension, you may elect to begin receiving your benefit the first of any month following your 60th birthday (or, if earlier, the first day of the month following the month in which the sum of your age, to the nearer one-tenth year, plus your credited service, equals 85). The amount of your Deferred Vested pension is determined based on the date you broke seniority. If you break seniority, the benefit rate for each year of credited service is based on the benefit rates in the following table:

Date as of which Seniority is Broken	Life Income Benefit Rate
January 1, 2017 – December 31, 2019	$48.50
January 1, 2020 – December 31, **2023**	$49.50
January 1, **2024** or later*	$**53.50**

***Applicable to employees who commence benefits on or after January 1, 2024.**

Deferred Vested Pensions are payable as a life annuity only, subject to your spouse's Survivor Benefit rights. The Plan contains no provisions for lump-sum or disability payments of Deferred Vested Benefits. If you begin receiving payment of your Deferred Vested pension before you reach age 65, this benefit will be permanently reduced by 6/10ths of 1% for each month between your age at the commencement of payments and your 65th birthday.

If you break seniority prior to becoming eligible to retire, your pension will be determined using the Life Income benefit rate in effect when your seniority is broken.

An Example of Your Deferred Vested Pension

Assume that you terminate employment in **2024** at age 45 with 10 years of credited service.

Your monthly pension payable at age 65 would be determined as follows:

10 x $**53.50** = $**535**

Instead, you can elect to begin to receive your pension as early as age 60. In that case, your monthly pension would be determined as follows:

10 x $**53.50** x 64% = $**342**

Survivor Benefits

The Plan also provides benefits for your eligible survivors in the event of your death. These benefits may include a Regular Survivor benefit, a Pre-Retirement Survivor benefit, or Transition and Bridge Survivor Income benefits.

Regular Survivor Option

A Regular Survivor benefit is paid to your eligible spouse in the event of your death after retirement or if you die while still an active employee but after you become eligible for Normal or Early retirement.

Eligibility and Waiver

Your benefits automatically include the Regular Survivor Option if:

- you retire on Normal or Early retirement; or
- you retire on Total and Permanent disability and you are at least 55 years of age.

Your benefits are subject to the Regular Survivor Option that becomes effective on the later of: 1) the date you retire, or 2) the date you and your spouse have been married for one year.

If you retire on Total and Permanent disability, have less than 30 years of credited service, and are less than 55 years of age, the Regular Survivor Option will be effective on the later of:

- the first day of the month following your 55th birthday; or
- the date you and your spouse have been married for one year.

Your benefits under a Deferred Vested pension are subject to the Regular Survivor benefit on the later of:

- the date payment of your Deferred Vested pension begins; or
- the date you and your spouse have been married for one year.

If you do not wish for your spouse to receive Regular Survivor benefits, you may elect to waive the option by notifying the Board of Administration during the 180-day period preceding the date the option is due to take effect. In other words, if you do not want your pension to be reduced, as described below (because your spouse is more than 10 years younger than you), you can waive coverage during the 180-day period prior to your benefit commencement date. This notice must include your spouse's consent to this waiver, and your spouse's signature must be notarized unless witnessed by a Company representative.

In addition, your survivor option may be canceled in the event you lose your spouse through death or divorce. Cancellation will become effective on the first day of the month following the month that the Board of Administration receives proof of your spouse's death or your divorce.

Effect of the Monthly Survivor Benefit on Your Pension

If you have a monthly survivor benefit in effect, your Life Income benefit may be reduced to provide for continued benefits to your surviving spouse. If your spouse is more than 10 years younger than you, your Life Income benefit will be reduced by ½% for each year in excess of the 10 that your spouse is younger than you. For example, if your spouse is 12 years younger than you, your Life Income benefit will be reduced by 1% (½% x 2). The reduced amount of your pension is referred to as your Adjusted Life Income benefit.

Calculating Your Survivor Benefit

The benefit your surviving spouse will be eligible to receive is equal to 55% of your Adjusted Life Income benefit. You may also elect to provide a survivor benefit of 75% to your spouse. If you choose this option, your benefit will be reduced on an actuarially equivalent basis.

If You Die While Still Employed

In the event of your death while you are still employed but after you become eligible to retire under the Normal or Early retirement provisions of the Plan, your spouse will be eligible to receive a Survivor Pension benefit. This Survivor Pension benefit is equal to 55% of the Life Income benefit you would have received if you had retired and begun to receive benefits on the first day of the month preceding your death.

Pre-Retirement Survivor Option

Until you are eligible for coverage under the Regular Survivor Option, your spouse is automatically covered by the Pre-Retirement Survivor Option if you:

- are an active participant in the Plan; and
- have at least five years of Vesting Service; and
- have been married to your spouse for at least one year.

You are also covered by this option if you broke seniority after January 1, 1985 and have been found eligible for a deferred vested pension.

If you die while covered under the Pre-Retirement Survivor Option, your spouse will receive a benefit equal to 55% of the Life Income benefit you would have received if you had survived to your earliest possible retirement date. **Your spouse may elect** payment to begin on the first day of the month following the month you would have become eligible to retire.

If you do not wish to be covered by the Pre-Retirement Survivor Option, you may submit a waiver to the Board at any time before your coverage becomes effective. Your spouse must consent to your waiver in writing.

If you are divorced, you can elect to cancel your coverage without your spouse's consent by providing satisfactory proof of divorce to the Board of Administration.

Your coverage under the Pre-Retirement Survivor Option will automatically be canceled when you become eligible for coverage under the Regular Survivor Option.

Transition and Bridge Survivor Income Benefits

Transition and Bridge Survivor Income Benefits may be paid to your eligible survivors if you die 1) while actively employed, 2) while receiving a Total and Permanent Disability pension benefit, or 3) while on layoff and insured for Group Life Insurance. These benefits are designed to help your family adjust to the loss of your income.

Eligible survivors include:

- Your spouse, provided you were married for the one-year period immediately prior to your death;
- Your unmarried children who are:
  - under 21 years of age;

- between 21 and 25 years of age, legally residing with you and dependent on you; or

- over 25 years of age, totally and permanently disabled, legally residing with and dependent on you.

Children include your natural children, legally adopted children, and step-children residing with you at the time of your death.

In some cases, if there is no eligible spouse or children, benefits may also be paid to your parents or adoptive parents, provided they were dependent on you at the time of your death for at least 50% of their support.

Transition Benefits

Transition benefits will be paid to your eligible survivors beginning on the first day of the month following your death and continuing for a maximum of 24 months.

If only one survivor is entitled to benefits, and this survivor is not eligible for an unreduced Old Age, Survivor or Disability benefit under the Federal Social Security Act, the monthly Transition benefit will be $600.

If the survivor is eligible for an unreduced Old Age, Survivor, or Disability benefit under the Federal Social Security Act, the Transition benefit will be $325.

If more than one survivor is entitled to benefits, the applicable Transition benefit **for each will equal the amount which such survivor would have received as the sole survivor, multiplied by the ratio of one**, divided by the number of eligible survivors. For example, if an employee dies in **2024** and benefits are payable to two children, **one** of whom is eligible for **an unreduced Old Age, Survivor or Disability benefit under the Federal Social Security Act and the other is not, they** would receive **$162.50 ($325 divided by 2)** and $300.00 ($600 divided by 2), **respectively**.

Bridge Benefits

After the maximum period for Transition benefits, your surviving spouse may also be eligible to receive Bridge benefits. To qualify for Bridge benefits, your spouse must be:

- at least 45 years of age at the time of your death, or the sum of your spouse's age at the time of your death and your credited service equals at least 55; and
- unmarried at the time benefits begin; and
- ineligible to receive full Widow or Widower's benefits under Social Security; and
- ineligible to receive an Old Age, Survivor, or Disability benefit under Social Security.

The monthly Bridge benefit will be $600.

Bridge benefits will be payable to a surviving spouse until the earlier of:

- Age 62 and one month; or
- Remarriage.

If the Transition/Bridge benefit payment period extends beyond the date that benefits would begin under the Regular Survivor Option or the Pre-Retirement Survivor Option (as applicable), your spouse will receive the greater of the Transition/Bridge benefit or the Survivor benefit until the expiration of the Transition/Bridge benefit payment period.

Survivor Benefits for Retirees Receiving a Disability Retirement Benefit

If you die while in receipt of a Disability Retirement benefit, your spouse will receive Transition benefits and Bridge benefits (if applicable).

If you die before you have attained age 55, or if you retired before you had 30 years of credited service, your spouse will receive benefits under the Pre-Retirement Survivor Option (see page 17). If you die after age 55, or if you had 30 years of service when you retired, your spouse will receive benefits under the Regular Survivor Option (see page 15).

Lump Sum or Rollover

If the actuarial value of your spouse's benefits is less than $5,000, the administrator may pay such benefits in a single lump sum with your spouse's informed consent. In that case, your spouse may elect to receive payment in cash or as a direct rollover to an individual retirement account or other eligible retirement plan.

Other Benefits Provided by the Plan

Supplemental Allowance

If you retire under the early retirement provisions of the Plan before reaching age 62 and one month, you may be eligible to receive a Supplemental Allowance. The Supplemental Allowance is designed to provide a predetermined level of benefits until you become eligible for Social Security benefits. If you retire with 30 years of credited service, you receive the maximum Supplemental Allowance. If you retire with less than 30 years of credited service, you receive a proportionate amount. In addition, if you retire with less than 30 years of credited service, your benefit will be reduced for early commencement if your retirement precedes age 60.

If you **terminate on or after December 1, 2023** with 30 or more years of credited service **and commence benefits on or after January 1, 2024**, your maximum monthly benefit would be as follows:

Year	Maximum Monthly Benefit
2024 and later	$**2,500**

If you retire with less than 30 years of credited service, you will receive a proportionate amount. For example, if you had 20 years of credited service and you retired on **January 1, 2024** on or after age 60, your maximum monthly benefit would be 20/30 x $**2,500** or $**1,667**. If you retire before age 60, your maximum monthly benefit will be reduced by 1% for each month that your retirement date proceeds the first day of the month that you turn age 60. For example, if you retire at age 58 (24 months early) with 20 years of service, your monthly benefit will be reduced by 24% to $**1,267** ($**1,667** x 76%).

Part of this maximum amount will be provided by your Life Income benefit, and the balance will be your Supplemental Allowance.

Special Age 65 Benefit

The Special Age 65 benefit is intended to reimburse a retired employee or spouse for a portion of premium required for Medicare Part B coverage.
You are eligible to receive the Special Age 65 benefit if you are at least age 65 or you are enrolled for Medicare Part B coverage. Your spouse (or your surviving spouse in the event of your death) is also eligible to receive the Special Age 65 benefit if he or she is enrolled for Medicare Part B coverage. The benefit is not payable to you (or your spouse) if you retire with a Deferred Vested Pension (see page 11).

The monthly amount of the Special Age 65 benefit is the actual Medicare Part B premium, up to a maximum of $115.00.

Payment of the Special Age 65 benefit will begin on the earlier of:

- The first day of the month in which you, your spouse, or your surviving spouse turns age 65, or
- The date you, your spouse, or your surviving spouse enrolls in Medicare Part B coverage.

Please note that if you become eligible for Medicare Part B coverage before your 65th birthday, payment of the Special Age 65 Benefit will not begin until the first day of the month after you submit a copy of your Medicare card to the Board of Administration.

Effects Agreements

If you elected to participate in the retirement incentive program described in the Baltimore PDC Effects Agreement, you will be credited with additional years of credited service for purposes of determining your eligibility to retire under the Plan and for purposes of determining the amount of your pension benefit. The period for which additional years of credited service will be credited begins on the date of your layoff, and ends on the date you begin to receive pension benefits. If you meet two or more thresholds for early retirement, you can retire on either date and the plan provisions applicable to that retirement date apply. In addition, if you attain age 60 during the contract term (before October 1, 2019), your life income benefit will be calculated with no reduction for early commencement.

If you elected to participate in the retirement incentive program described in the Jacksonville PDC Effects Agreement, and you attain age 60 and retire before the end of the contract (October 1, 2019), your life income benefit will be calculated with no reduction for early commencement.

Payment of Benefits

Payment of your benefits will generally begin on the first day of the month that coincides with or follows the date you retire. However, if you work beyond age 70½, you can elect to begin to receive your pension as of the April 1 following the year in which you attain age 70½, even if you are still working for the Company.

If you were less than age 65 on May 1, 2012, and you work after your normal retirement age, your pension will be equal to the greater of (a) your accrued benefit as of May 1, 2012 actuarially increased from your normal retirement date to the date as of which your benefit commences to be paid and (b) your accrued benefit determined as of your benefit commencement date.

If you were at least age 65 on May 1, 2012, and you retire after that date, your pension will be equal to the greater of (a) your accrued benefit as of your normal retirement date actuarially increased from your normal retirement date to the date as of which your benefit commences to be paid and (b) your accrued benefit determined as of your benefit commencement date.

Applying for Benefits

To receive any benefit under the Plan, you must complete and return an application form. To obtain an application form, contact your local Human Resources Department, Local UAW Benefits Representative or **the Volvo Benefits Center (Retirement Services)** at 1-800-356-9240 no earlier than 180 days prior to the date you wish to commence benefits.

Claims Procedures

If your **application or other written claim** is denied, in whole or in part, you will receive written notification of the Board's decision within 90 days of the date the Board received your claim. In some cases, the Board may require more than 90 days to make a decision regarding your claim. In this case, the Board may take up to an additional 90 days, provided you are notified of the extension within the initial 90-day period together with an explanation of why more time is needed.

For claims involving disability determinations, the initial claim review period is 45 days, subject to a maximum of two extensions (both with advance notice) of up to 30 days each (i.e., the maximum extension is 60 days). The written notice of extension will advise you of:

- **the standards and criteria on which disability status is based;**
- **the outstanding issues preventing a decision;**
- **the time period in which you must submit required information to resolve such issues, if applicable (not less than 45 days); and**
- **the time period in which the Board must make its determination, except that such determination period will be tolled (i.e., extended by the number of days that elapse) during the period between a request for information and the date such information is provided.**

The notification of claim denial will include the specific reasons for the decision, reference to the specific Plan provisions on which the decision is based, a description of any additional information needed to complete the claim and why such information is necessary, and a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under §502(a) of ERISA following a denial on review under the appeals procedures below.

For adverse disability determinations, the notice of denial will also advise you of your right to request and receive (free of charge):

- **the identity of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination (without regard to whether such expert advice was relied upon by the Board);**
- **an explanation of any scientific or clinical judgment used in applying the Plan's terms to your medical circumstances;**
- **any policy, statement or guidance concerning your medical condition; and**

- **any rule, document, guideline, protocol, or other similar criterion if it was submitted to the Plan, considered by the Plan, or generated in the course of making the benefit determination.**

Appeal Procedures

If your claim for benefits is denied, in whole or in part, you may appeal the denial in writing within 60 days after you receive the denial. **In cases involving disability, however, the period to file is extended to 180 days after the date the claim is denied.** You or your representative have a right to review, upon request and free of charge, pertinent plan documents, records and other information and to submit a written statement, documents, records or other information in support of your claim. **A claimant who fails to submit an appeal request within the 60-day period (or 180-day period for disability determinations) will have no further right to appeal under these procedures nor to file an action for review by a court.**

The Board will conduct a full review of your claim and make a decision on the appeal within 60 days after they receive your written request for review.
In some cases, the Board may need more time to make a decision. In such a case, they may take an additional 60 days, provided you are notified of the extension within the initial 60-day period together with an explanation of why more time is needed.

For claims involving disability determinations, the appeal review period is reduced to 45 days (subject to an extension with advance written notice) not to exceed 90 days after the date the appeal is filed. The review of any appeal that involves disability determinations based on a medical judgment will be performed, without deference to the initial determination, by consulting with a qualified health care professional who: (a) has appropriate experience in the field of medicine involved; and (b) was neither consulted in connection with the initial denial nor a subordinate of any such individual.

The Board's decision regarding your appeal will be conveyed to you in writing. The Board's notice to you regarding its decision will include the specific reasons for the decision, reference to the specific Plan provisions on which the decision is based, a statement that you are entitled to receive, upon request and free of charge, pertinent Plan documents, records and other information, and a statement of your right to bring a civil action under §502(a) of ERISA.

Additional Plan Information

Limits on Benefits

The Internal Revenue Service has established certain limits on the amount of benefits employees may receive from the Plan. If your benefits are affected by these limitations, you will be notified by the Plan Administrator.

Benefits Payable to Minors and Individuals Declared Legally Incompetent

If the Board determines, after receiving appropriate proof, that the person to whom benefits under the Plan are payable is incapable of looking after their own affairs because of illness, injury, or minor status, payment may be made to the spouse, parent, child, brother, sister or legal guardian who is responsible for the person.

Vesting

No employee or other person will have any vested rights under the Plan, except rights, if any, that accrue on retirement or upon attaining eligibility for deferred vested or survivor benefits as described in the Plan.

Nonalienation of Benefits

In general, no one can take away your benefits under this Plan and you cannot give or sell them to someone else or use them as collateral for a loan. Also, your creditors cannot claim your benefits to satisfy your debts.

However, in the case of certain Qualified Domestic Relations Orders relating to provisions for child support, alimony, or marital property rights of your spouse, part or all of your benefits may be assigned to meet those obligations. If a court issues a Qualified Domestic Relations Order that applies to you, you will be notified by the Plan Administrator before any action is taken.

The Board of Administration has established procedures for determining whether an order constitutes a Qualified Domestic Relations Order. Participants and beneficiaries can obtain a copy of such procedure, without charge, from the Board of Administration.

Offsets For Payments Made Because of a Qualified Domestic Relations Order

The amount of monthly pension benefits otherwise payable to you at retirement will be reduced by the actuarially equivalent value of any past and future benefits paid to any other person under a Qualified Domestic Relations Order. If this reduction applies to you, you will be notified by the Plan Administrator.

Re-employment After Retirement

If you are re-employed by Mack Trucks after you retire, you will continue to receive your Life Income benefit, but not your Supplemental Allowance (if any). However, if you are employed by a Volvo company other than Mack trucks, you will continue to receive both your Life Income benefit and your Supplemental Allowance.

Deductions for Workers' Compensation

If you become eligible for Workers' Compensation benefits as a result of a claim filed more than two years after you retire or break seniority, a deduction will be made from your monthly benefit equal to the amount of payments you received under Workers' Compensation provided these benefits are attributable to premiums, assessments, taxes or other payments made by or at the expense of the Company.

Plan Costs and Funding

The entire cost of benefits under this Plan is paid by the Company. Contributions are actuarially determined and paid to a Trust Fund set up for this purpose. No contributions from employees are required or permitted.

Amendment or Termination of the Plan

The Company expects the Plan to continue, however the Company reserves the right to amend or terminate the Plan at any time with the mutual agreement of the Company and the Union. If any change to the Plan is required by the Internal Revenue Service for compliance with the Internal Revenue Code, the change may be made retroactively, if necessary.

Should the Plan terminate, the assets remaining in the Trust Fund after administrative expenses have been paid would be used to pay benefits according to priorities outlined in the Plan document.

The first priority would be to pay benefits to participants, beneficiaries, or surviving spouses who were already receiving benefits as of the three-year period ending on the date of plan termination, or who would have had a right to receive such benefits if the participant had retired before the plan termination.

The next priority would be to use any remaining assets in the Trust Fund to pay all other benefits guaranteed by the Pension Benefit Guaranty Corporation (see below). Then, payment of all other vested benefits under the Plan other than those that became vested because of the plan termination would be made. Finally, if any assets remained in the Trust, payment of any other eligible benefits under the Plan would be made.

Pension Benefit Guaranty Corporation

Your benefits under the Mack-UAW Pension 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 pension benefits. Most people 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 (1) normal retirement benefits, (2) disability benefits if you become disabled before the Plan terminates, and (3) certain benefits for your survivors.

The PBGC generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates; (2) some or all of benefit increases and new benefits based on Plan provisions that have been in place for fewer than 5 years at the time the Plan terminates; (3) benefits that are not vested because you have not worked long enough for the Company; (4) benefits for which you have not met all of the requirements at the time the Plan terminates; (5) certain early retirement provisions (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 (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.
Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending upon how much money your Plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees ask the Board of Administration or go to the PBGC's website, www.pbgc.gov or call toll-free at 1-800-400-7242 (TTY/TDD users may call the Federal relay service toll-free at 1-800-877-8339 and ask to be connected to 1-800-400-7242).

Your Rights Under ERISA

As a participant in the Mack-UAW Pension 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 participants of the Plan shall be entitled to:

- 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, and available at the Public disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Board of Administration, copies of all documents governing 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 Board of Administration may make a reasonable charge for copies.

- Receive a summary of the Plan's annual financial report. The Board of Administration is required by law to furnish each participant with a copy of this Annual Funding Notice.

Obtain a statement telling you whether you have a right to receive a pension 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 pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

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 your interest and that of 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 pension benefit or exercising your rights under ERISA.

If your claim for a pension 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 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 Board of Administration.

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 Board of Administration's decision or lack thereof concerning the qualified status of a domestic relations 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 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.

If you have any questions about your Plan, you should contact the Board of Administration. If you have any questions about this statement of your rights under ERISA **or to obtain certain publications about your rights and responsibilities under ERISA**, contact the Employee Benefits Security Administration, U.S. Department of Labor **by telephone at the toll free number 1-866-444-3272, electronically at www.askebsa.dol.gov, or by mail to** the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 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.

Administrative Information

This section provides you with information about how the Mack-UAW Pension Plan is administered.

Plan Name

Mack-UAW Pension Plan

Type of Plan

This Plan is a defined benefit pension plan designed to provide retirement benefits to eligible employees and their survivors.

Plan Number

004

Employer Identification Number

22-1582040

Plan Year

January 1 through December 31

Agent for Service of Legal Process

Corporate Secretary
c/o Mack Trucks, Inc.
8003 Piedmont Triad Pkwy
Greensboro, NC 27409
(Service may also be made upon the Plan Administrator or the Plan Trustee)

Plan Sponsor/Plan Administrator

Mack Trucks, Inc.
8003 Piedmont Triad Pkwy
Greensboro, NC 27409

Plan Trustee

JP Morgan Chase Bank
4 Chase MetroTech Center
Brooklyn, NY 11245

Board of Administration

The Plan is administered by the Mack-UAW Joint Board of Administration. One-half of the Board members are appointed by the Company and one-half of the Board members are appointed by the Union.

The Board of Administration is responsible for the day-to-day operation of the Plan. For example, the Board determines eligibility of employees to participate in the Plan, interprets Plan provisions and maintains records necessary for proper administration of the Plan. No member of the Board of Administration receives compensation for services on the Board.

The determination of the Board about any disputed question will be final and binding. Any claims for benefits or questions about the Plan should be addressed to the Board. You can contact the Board at the following address:

Volvo Benefits Center

Attn: Mack UAW Pension Board
PO Box 9622
Des Moines, IA 50306-0622

APPENDIX B

Mack Trucks, Inc.

Mack UAW Insurance Program

Summary Plan Description

The benefit coverage in effect on the date of execution of the Master Agreement, including the terms and conditions of coverage, the rules of initial eligibility, continuation of coverage and other general conditions of coverage contained in Appendix B dated November 15, 2023 or its replacement is your Summary Plan Description (SPD) for Welfare Benefits (Insurance Program) that replaces the original benefit agreement format and encompasses the terms of your agreement as well as required regulatory information.

November 15, 2023

APPENDIX B

INSURANCE PROGRAM

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APPENDIX B

INSURANCE PROGRAM

ARTICLE I

SECTION 1 Continuation of the Program

The Insurance Program which is attached as Appendix B to the Collective Bargaining Agreement between the parties dated June 1, 2009 (herein called the "2009 Insurance Program") shall be amended, effective as of **November 15, 2023** as described below, and maintained by the Company as amended for the duration of the Collective Bargaining Agreement of which Appendix B is a part.

SECTION 2 Continuation of Benefits

Provisions for payment of benefits under the 2009 Insurance Program will continue in accordance with the conditions, provisions, and limitations until October 1, 20**23**. On and after that date, benefits will be provided and paid by the Company under the amended 20**23** Insurance Program as describe below (hereinafter known as the "Program").

The Company shall arrange for group insurance coverage as here and after provided.

Such coverage will be arranged at the Company's sole discretion, in any manner or through any organization, including, but not limited to, a program or programs provided by an insurance carrier, by arrangement with a hospital plan corporation, professional health service corporation, or similar plan or organization; through a preferred provider arrangement; through a self-insured plan; or through a combination of any such methods. The terms and conditions of coverage, including those amendments made in these negotiations, are continued on the assumption that the current arrangement to deliver benefit is continued on the traditional fee for service basis for the term of the labor agreement. The Company will not exercise its option to select an alternate delivery system until the parties have reached mutual agreement on the terms and conditions including restrictions, limitations and definitions that would be applicable to any alternate delivery system.

The benefits provided under this Agreement as described in the following pages of this Appendix, as amended from time to time pursuant to the mutual agreement of the parties, will remain in effect during the term of this Agreement and will not be altered by the provisions of any agreement between the Company and any benefit program

provider. If there is a conflict between the language of this Agreement and that of any agreement between the Company and any benefit program provider, the language of this Agreement shall control.

SECTION 3 Definitions

a) **Employee** means an individual who is actively at work within the bargaining unit on or after the effective date of this Agreement, or who, on or after the effective date of this agreement, is, pursuant to the terms and conditions of the Collective Bargaining Agreement and Local Supplements, on personal leave of absence or sick leave, maternity leave, vacation or is permanently and totally disabled, but excluding one who is on military leave, or leave of absence with the International Union, or leave of absence because of election to federal, state county or municipal office.

b) **Pension plan** means the Mack-UAW Pension Plan attached as Appendix A to the Collective Bargaining Agreement.

ARTICLE II

SECTION 1 Introduction to Coverage

Appendix B is a Summary Plan Description that explains the essential features and conditions of the group insurance benefits provided to you and your eligible dependents as of **November 15, 2023**, through the duration of the agreement. In general, the Plans cover active UAW employees of Mack Trucks, Inc. or any facility working under the Mack-UAW Master Agreement and their eligible dependents. This Appendix describes the details of the following programs:

- Life Insurance
- Accidental Death and Dismemberment Insurance
- Accident and Sickness Insurance
- Long Term Disability Insurance
- PPO Medical Coverage
- PPO Prescription Drug Coverage
- Vision Coverage
- Dental Coverage
- HMO Medical and Prescription Drug Coverage

SECTION 2 Eligibility and Commencement of Coverage

(a) Employee

If you were hired or rehired on or after January 1, 2014, and those previously hired who were not yet eligible for benefits, the coverages listed above will commence on the first day of third month immediately following your date of hire for both you and your eligible dependents, provided that if you are not actively at work when the coverage would otherwise take effect, coverage will not take effect until the day you return to full-time, active work. Human Resources (or the HR Service Center) will provide you the necessary enrollment forms.

When you enroll in Medical benefits (including waiver of coverage) you must do so within 31 days of your effective date of coverage. Your benefit election will remain in effect until you make a change. You may not make a change to your medical coverage election until the next annual enrollment period unless you have a life event change (see examples below). This is because you are making your required medical contributions on a pre-tax basis (before taxes) and the IRS requires us to follow certain regulations (Section 125).

Pre-tax contributions are taken from your pay before Federal, Social Security and (in some locations) State taxes are taken. Because your taxable income is reduced, you pay fewer taxes, and you never are required to pay tax on that income. This reduction in pay has no effect on the value of your life, accident, A&S and long term disability coverage or any other benefits based on pay.

Eligible dependents maybe added (or dropped) during your initial enrollment period, during annual enrollment or within 31 days of the life event change. Contact Businessolver at volvobenefits.com (company key is volvo) or call 1-833-929-1113 to request coverage changes.

Examples of life event changes include the following:

- Marriage, divorce, legal separation,
- Birth of a child, adoption, or placement for adoption,
- Death of a spouse or child,
- When your child is no longer an eligible dependent,
- You, your spouse or your child lose coverage under another benefit plan or that coverage is significantly changed (your spouse loses his/her job or is reduced to part-time status), or
- Your COBRA coverage continuation period ends from another employer.

If you do not enroll your new dependents within 31 days, you must wait until the next annual enrollment period to do so. You must also drop your ineligible dependents within 31 days to reduce your medical contributions.

(b) Eligible dependents include:

- The lawful spouse of an employee (including a spouse of a common-law marriage, as recognized by Pennsylvania Commonwealth Law with legal documentation provided), provided that the newly married spouse of a benefit-eligible employee will be eligible for coverage as of the date of marriage; and
- any child of the employee who is:
  - less than 26 years old regardless of dependency, marital or student status;
  - 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to the Plan within 31 days after the date the child ceases to qualify above. During the next two years the Plan may, from time to time, require proof of the continuation of such condition and dependence. After that, the Plan may require proof no more than once a year.
  - A child includes a legally adopted child. It also includes a stepchild or foster child. Any child under the age of 26 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Coverage upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption. If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.
  - A child under Qualified Medical Child Support Order (QMCSO). If a QMCSO is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Coverage. You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued. Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.
  - Special Enrollment Notice: if You are declining coverage for yourself or your eligible dependents because of other health insurance coverage, You may in the future be able to enroll yourself or your eligible dependents in health coverage, if You or Your Dependents lose eligibility for that other coverage (or

if the Employer stops contributing towards You or Your Dependents' other coverage) provided that you request enrollment within 31 days after You or Your Dependents' other coverage ends (or after the Employer stops contributing towards the other coverage).

- In addition, if You have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll yourself and Your Dependents. However, You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

- Eligible employees and dependents may also enroll under two additional circumstances:

    - The employee's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
    - The employee or dependent become eligible for a subsidy (state premium assistance).

  You or your dependents must request Special Enrollment within 60 days of loss of Medicaid/CHIP or of the eligibility determination.
- Sponsored dependents are only eligible for Medical/Drug coverage. Sponsored Dependents include blood relatives who depend on you for more than half of their financial support. They must qualify as your dependents or have been reported as dependents on your federal income tax return. Sponsored dependents can be other individuals who reside in your household and depend on your for more than half their financial support. The must qualify as your dependents or have been reported as dependents on your federal income tax return. You will be required to initially and periodically provide proof of dependent status.
  Sponsored Dependents must be enrolled for coverage within 90 days of first being eligible. If you do not, they must be enrolled for January 1. You must submit enrollment information one month prior to January 1 by contacting the HR Service Center at 1-800-344-8339.The Company will make available group medical and prescription drug coverage to sponsored dependents at the group rate cost**.** Required contributions for a sponsored dependent are made on an after-tax basis.

Coverage for a dependent **child** will continue through the last day of the month in which dependent **child reaches age 26**.

ARTICLE III

LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, ACCIDENT AND SICKNESS INSURANCE, AND LONG-TERM DISABILITY INSURANCE

SECTION 1 Group Life Insurance

Company-Paid Life Insurance

(a) The amount of group life insurance payable for death is as follows:

One and one-half (1.5) times base pay wage rate rounded to the next even dollar.

**Base pay wage rate is your contractual hourly rate of pay times 2,080 hours.*

(b) Acceleration for Terminal Illness

A disabled employee who has a terminal illness may receive on and after the effective date of his/her coverage, 50% or 100% of the employee's Group Life Insurance in 12 monthly installments (hereafter such installments are referred to as the "monthly installments") subject to the following:

1. Monthly installments shall begin on the later of:

- the first of the month following Prudential's receipt of proof of terminal illness, or
- six months from commencement of disability, or
- the month in which weekly Accident and Sickness Benefits or Long-Term Disability Benefits cease, or
- the date of signed application for such monthly installments.

No monthly installments shall be made to any person after the month in which age 65 is attained.

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, its medical staff or a qualified party selected by the insurer.

2. Upon the death of a disabled employee while such employee is receiving monthly installments, Group Life Insurance equal to the remaining monthly installments, if any or $500, whichever is greater, shall be paid to his beneficiary

in a lump sum. If at the time of death, a disabled employee has received 100% of the Group Life Insurance in monthly installments, $500 of Group Life Insurance shall be paid to such employee's beneficiary.

3. If a disabled employee returns to work, the full amount of such employee's Group Life Insurance in accordance with Section 1 (a) of this Article III will again be reinstated until such employee terminates employment. If a disabled employee has returned to work and again becomes disabled, such employee may not receive additional installments.

4. If a disabled employee recovers from total and permanent disability but does not return to work or is not eligible for insurance under any provisions of this Program, all of such employee's insurance terminates.

(c) Beneficiary

When you enroll for coverage (Group Life and Group AD&D), you must name a Beneficiary(ies) on the form furnished by the Company. You may change your Beneficiary at any time by completing another form. If there is more than one Beneficiary but the Beneficiary form does not specify their shares, the proceeds will be split evenly. If you do not have a named Beneficiary at the time of your death or your Beneficiaries have predeceased you, your life insurance amount will be paid to the first of the following: Your (a) surviving spouse; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

(d) Filing a claim

The amount of your coverage will be payable when the carrier receives written proof of death. Written proof of loss must be submitted within 90 days of the date of death. Your Beneficiary should contact the Volvo HR Service Center in Greensboro, NC at 1-800-344-8339, or by email at hrsc@volvo.com to file a claim.

(e) When your coverage ends

Your coverage will end when your employment ends, your membership in the covered class ends, or the group contract ends.

(f) Conversion Privilege

If you cease to be covered for life insurance because your employment ends or your coverage ends, you may be eligible to convert part or your entire insurance amount to an individual life insurance contact. Evidence of insurability is not required but you must convert your coverage and pay your first premium by the later of:

1. the thirty-first day after you cease to be insured; and
2. the fifteenth day after you have been given notice of conversion, but in no event later than the 92nd day after you cease to be insured under your group coverage.

Premiums under conversion are based on the carrier's rate as it applies to type and amount of coverage based on age and risk at the time of conversion.

(g) Recovery of overpayment
If payment has been paid in error, the insurance company reserves the right to recover the benefits paid.

(h) Cost of coverage
Mack pays the entire cost for your Group Life coverage.

Optional Life Insurance

If you have reached your Eligibility Date as defined in Article I, Section 2, are actively at work and work at least 30 hours per week, you may purchase optional term life insurance coverage for yourself, your spouse (if under age 70) and your eligible children.

(a) **When coverage begins**

Optional Life Insurance for you and your covered dependents will be effective on your Eligibility Date if you complete your required enrollment forms within the 31 days following your Eligibility Date. If you do not enroll within the first 31 days, you must wait until the next Annual Enrollment Period.

Your coverage will be effective provided you are actively at work on your Eligibility Date. If you are not actively at work on that date, your insurance coverage will begin when you return full-time to your duties.

Coverage for your eligible spouse and children will be effective provided they are:

- **not hospitalized or confined to home because of a physical or mental condition, and**
- **can engage in substantially all the normal activities of a healthy person of the same age for a period of at least 15 days in a row.**

(b) **Coverage Amounts**

You may purchase optional life insurance within 31 days of your Eligibility Date according to the following table:

	Amount	Rules
Employee	**1, 2 or 3 times pay**	**Annualized Basic Rate of Pay rounded to the next $500**
Spouse	**$25,000 increments**	**Maximum benefit is the greater of the total amount of your Basic and Optional Life or $300,000**
Dependent child	**$5,000 or $10,000**	**All dependent children are covered by the same amount you elect**

You may not elect Optional Life Insurance on a spouse who is also employed by Volvo or Mack and is eligible for his/her own Company-provided coverage. Dependent children may be covered for life insurance by one spouse, but not both.

Proof of Insurability (Non-medical Limits on Insurance Amounts)

The Optional and Dependent Life Insurance programs include a feature called your "Non-medical Limit". This means that a specific amount of insurance coverage will be available to you, regardless of your medical history, provided you accurately complete and submit an application within the required 31 days of your initial enrollment period. Optional Life elections during the initial enrollment period are limited to two times your annualized earnings up to $150,000. Dependent Life elections for your spouse are limited to $25,000. There is no Non-medical Limit for your dependent children. If you request coverage amounts that exceed the non-medical limit, you will be required to provide medical information to prove your insurability, including a medical examination. If necessary, medical examinations are paid for by the insurance carrier. Coverage amounts over the non-medical limit amount will be effective on the date the insurance company approves your coverage.

(c) **Cost**

You are responsible for paying the premiums for any Optional Life Insurance coverage you elect for you or your eligible dependents. Premiums are payable through payroll deductions.

If you become disabled and qualify for benefits under Accident and Sickness (A&S), Long Term Disability, or Workers' Compensation, your Optional Life Insurance may continue subject to your continuing your required premium payments to the earliest of the following: when you are no longer disabled, when you reach your Social Security Normal Retirement Age, upon your death, or when you reach your maximum benefit period under Long Term Disability.

(d) **Annual Enrollment Periods**

Each year during the Annual Enrollment period you may review your coverage and, subject to proof of insurability rules (evidence of good health), increase your optional coverage during the annual enrollment period. If you complete an annual enrollment application to enroll in coverage or increase your current coverage, you will be required to provide medical information to prove your insurability, including a medical examination. If necessary, medical examinations are paid for by the insurance carrier. Proof of insurability requirements are provided in your Annual Enrollment information and application forms. Increases in coverage that are subject to proof of insurability requirements are not effective until approval is received from the life insurance carrier. Required payroll deductions for any new coverage or increases will not begin until approval is received from the life insurance carrier.

Your coverage increase will be effective January 1, or if later, the date approved by the life insurance carrier as long as you are actively working as of the effective date. If you are not actively working as of that date, your coverage increase will begin when you return, full-time, to your duties.

If you do not complete an application during annual enrollment, your current coverage level, if any, will be continued.

Once the insurance company has approved your application for coverage or increased coverage, you will be provided a Confirmation Form, documenting your coverage amount for your records.

(e) **Benefit Reductions**

If you are still actively working at age 75 (or if you first become eligible for coverage at age 75) your coverage amount will begin reducing according to the following schedule:

When you Reach Age	Your Coverage Is Reduced by this Percentage
75	55%
80	65%
85	75%

NOTE: Your spouse's optional life coverage terminates at age 70. If your spouse is age 70 when you first become eligible for coverage, no coverage is available for your spouse.

(f) **When Coverage Ends**

You and your dependent's optional life insurance coverage will end on the date that:

- **the policy ends**
- **your employment terminates**
- **when your dependent is no longer eligible for dependent coverage**
- **you fail to make the required premium payment, or**
- **you are no longer an eligible employee.**

SECTION 2 Group Accidental Death and Dismemberment (AD&D) Insurance

Basic AD&D

The Company also provides AD&D Insurance benefits. To receive these benefits, your injury or death must be accidental. There are two types of benefits payable under AD&D. Death benefits are payable to your Beneficiary (see Article III, Section 1(c)). Dismemberment benefits are payable to you for certain accidental injuries.

(a) The amount of benefits payable under the plan is as follows, provided the loss occurs within one year from date of the accident:

Death Benefits (no time limit)	**Percentage of Life Insurance Amount**
Not job related	50%
Job related	100%
Dismemberment Benefits	
Sight of both eyes	100%
Loss of both hands or both feet	100%

Loss of any two: one foot, one hand, sight of one eye	100%
Loss of one hand, or one foot, or sight on one eye, or loss of speech	50%

If you have more than one loss due to the same accident you will be paid no more than your total amount of Life Insurance.

(b) A loss is not covered if it results from any of the following:

1. Suicide, or attempted suicide or self-inflicted injury
2. Sickness, or medical treatment of sickness
3. Any bacterial or viral infection
4. War or act of war, whether declared or not and includes armed resistance
5. Accident that occurs while serving on full-time active duty for more than 30 days in any armed forces
6. Commission of or attempt to commit an assault or a felony
7. Being under the influence of any narcotic unless administered or consumed on the advice of a Doctor

(c) Filing a claim

The amount of your coverage will be payable when the carrier receives written proof of loss. Written proof of loss must be submitted within 90 days of the date of your death or accident. You or your Beneficiary should contact the Volvo HR Service Center in Greensboro, NC at 1-800-344-8339, or by email at hrsc@volvo.com as soon as possible for help in filing a claim.

(d) When coverage ends

Your coverage will end when your employment ends; your membership in the covered class ends, the group contract ends, or the program is terminated.

(e) Recovery of overpayment

If payment has been paid in error, the insurance company reserves the right to recover the benefits paid.

(f) Conversion

Coverage under this program cannot be converted to an individual policy when coverage ends.

(g) Cost of coverage

Mack pays the entire cost for your **Basic** AD&D coverage.

Optional Accidental Death and Dismemberment Insurance

The Company provides an optional contributory accidental death and dismemberment insurance program at group rates for employees and their eligible dependents. Supplemental AD&D coverage begins as of your Eligibility Date if you are actively at work and you complete your enrollment form within 31 days of the date you are eligible for Basic AD&D. If you wait longer than 31 days, you will have to wait until the next Annual Enrollment Period. Please note that no one may be covered more than once under this Plan. If you are covered as an employee, you may not be covered as a spouse or dependent child. If you and your spouse both work for the Company, only one of you can cover your dependent children.

If you elect this coverage, you also may choose whom you want to cover. You can purchase coverage foryourself only, or — for an additional premium — you can also cover your spouse and dependent children. You may elect Supplemental AD&D insurance in $25,000 increments, in amounts ranging from $25,000to $300,000, for you and your covered dependents (separate coverage amounts apply for your spouse and children). The premiums you pay for Supplemental AD&D coverage depend on the amount of coverage you elect and whether or not you are covering your dependents.

In the event of your death or that of a covered family member from an accident, benefits will be payable provided death occurs within one year of the accident. You are covered for 100% of the amount you

elect. If you choose family coverage, their death benefit amount equals a percentage of the coverage amount you elect for yourself, as follows:

- **Your spouse's death benefit amount will be 50% of your coverage amount,**
- **Each of your dependent children's death benefit amounts will be 20% of your coverage amount,**
- **If you have no dependent children, your spouse's death benefit amount will equal 60% of yourcoverage amount.**

If you or your covered dependent dies as a result of a covered accident, you or your beneficiary will receive the AD&D death benefit amount as described above. Benefits are also payable for loss of sight, speech, hearing, or limbs provided the loss results from — and within 365 days of — a covered accident (See the Schedule of AD&D Benefits chart, listed above in Basic AD&D).

(a) Additional Provisions for Basic and Optional AD&D Seat Belt Benefits

Your Basic and Optional AD&D insurance pays an additional benefit if an injury results in a covered loss because a seat belt fails to protect you and your family. If you or your covered dependent die or are injured as a result of a covered accident while driving or riding in an automobile and it is determined you were wearing a properly fastened seat belt, the payable AD&D benefit amount will be increased by 10%, up to $10,000. (A properly secured child restraint as defined by state law also qualifies as a seat belt.)

The Seat Belt coverage does not cover any loss if the covered person who is operating the automobile is under the influence of intoxicants or narcotics.

Some of the terms used in the Coverage:

Automobile: A validly registered:

(1) Vehicle that may be legally driven with the standard issue class of motor vehicle driver's license and no additional class of license is necessary to operate this vehicle; or

(2) Four wheel, two axle private passenger motor vehicle

But automobile does not include: (1) a motor vehicle intended for off-road use; or (2) a motor vehicle being used without the owner's permission.

Losses not covered under this Additional Benefit: A Loss is not covered under this additional benefit if it results from driving or riding in any Automobile used in a race or a speed or endurance test, or for acrobatic or stunt driving, or for any illegal purpose.

(b) **Coma Benefits**

If, as a result of an injury, you or a covered dependent becomes comatose within 31 days of the accident and remains comatose for 30 days, the Basic and Supplemental AD&D plan will pay 1% of the coverage amount each month the covered individual remains in a coma.

Payment will cease if you die, recover from the coma, or when the total payment equals your total coverage amount. *Coma* means complete and continuous unconsciousness and the inability to respond to external or internal stimuli.

Common Disaster Benefit

If both you and your covered spouse lose your lives as a result of the same accident, your spouse's Optional AD&D benefit will be increased to 100% of yours. Both benefits combined cannot exceed $600,000.

When You Reach Age 75

If you continue to work after you reach age 75, your Basic and/or Optional AD&D coverages will bereduced by a percentage of the full amount for you and your covered spouse, as follows.

If you or your spouse are age…	Your AD&D benefits will be reduced to
75	45%
80	35%
85 or over	25%

***All reductions are based on percentages of the benefit payable before the end of the calendar year in which you reach age 75.**

Exceptions and Limitations

Benefits are payable for bodily injuries caused solely through violent, external, and accidental means. Themaximum payable benefits for any one accident shall not exceed the full amount of the Accidental Death and Dismemberment Insurance in force on the date of the accident.

Benefits for Basic and Optional AD&D are NOT payable for death or losses resulting from:

- **Suicide or attempted suicide, while sane or insane.**
- **Intentionally self-inflicted injuries, or any attempt to inflict such injuries.**
- **Sickness, whether the Loss results directly or indirectly from the sickness.**
- **Medical or surgical treatment of Sickness, whether the Loss results directly or indirectly from the treatment.**
- **Any bacterial or viral infection. But this does not include:**
    - **A pyogenic infection resulting from an accidental cut or wound; or**
    - **A bacterial infection resulting from accidental ingestion of a contaminated substance.**
- **War, or an act of war. War means declared or undeclared war, and includes resistance to armed aggression. Terrorism is not considered an act of war. Terrorism means the deliberate use of violence or the threat of violence against civilians to create an emotional response through the suffering of victims or to achieve military, political, religious or social objectives.**

- **An accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces. But this does not include Reserve or National Guard active duty for training.**
- **Commission of or attempt to commit an assault or felony.**
- **Travel or flight in any vehicle used for aerial navigation, if any of these apply:**
    - **The person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers.**
    - **The person is performing as a pilot or a crew member of any aircraft.**
    - **The person is riding as a passenger in an aircraft owned, operated, controlled or leased by or on behalf of the Contract Holder or any of its subsidiaries or affiliates. This does not apply to chartered aircraft. This includes getting in, out, on or off any such vehicle.**
- **Being under the influence of alcohol or alcohol intoxication, including but not limited to having a blood alcohol level above the limit for permissible operation of a motor vehicle in the jurisdiction where the Loss occurred, regardless of whether the person:**
    - **Was operating a motor vehicle; and**
    - **Was convicted of an alcohol related offense.**
- **Being under the influence of or taking any non-prescription drug, medication, narcotic, stimulant, hallucinogen, barbiturate, amphetamine, gas, fumes or inhalants, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by and administered in accordance with the advice of the insured's Doctor.**

SECTION 3 Group Accident and Sickness Benefits

The A&S program will pay you benefits if you become disabled while covered under the Plan. Effective for disabilities which commence on or after **November 15, 2023**, for employees hired or rehired prior to March 25, 2013, Group Accident and Sickness Benefits will be provided for eligible employees as follows:

(a) Benefit amount for employees with one or more year's seniority:
$**700.00** per week or 60% of base pay, whichever is greater.

The amount of benefit payment to eligible employees with less than one year of seniority who is not subject to the wage progression set forth below will be 75% of the scheduled amount set forth above.

The benefit amount for employees who are in wage progression pursuant to Article 16, Section 55 shall be equivalent to the wage progression level. For example, if an employee is at the 80% wage progression level, he shall receive 80% of the A&S benefit amount referenced above.

For Employees hired or rehired on or after March 25, 2013, any disabilities commencing after their effective date of coverage shall equal 60% of the weekly base wage rate, not subject to progression.

(b) Eligibility Requirements

To be eligible for benefits an employee must:

1. become wholly and continuously disabled while insured for Accident and Sickness Benefits, and
2. be unable to perform all duties of his occupation, and
3. be under the care of a physician licensed to practice medicine, and
4. furnish the Company with notice and satisfactory proof of disability.

(c) Commencement of Benefits

Benefits for an eligible employee shall begin with the first day of disability due to an accident and with the earlier of:

1. the eighth consecutive day of disability due to sickness, or
2. the first day of confinement in a legally constituted hospital, or
3. the first scheduled work day on or following the day surgery costing at least $25 is performed.

For a salaried employee, benefits shall be payable the first day following the last day on which Company-paid sick leave pursuant to the applicable Master Supplemental Agreement is paid to such employee by the Company.

(d) Duration of Benefits

Weekly benefits will be payable up to a maximum of 52 weeks for any one continuous period of disability. The existence at the same time of two or more causes of disability shall not be considered as creating more than one period

of disability. An otherwise eligible employee shall be eligible to receive Accident and Sickness Benefits for:

1. a period equal to such employee's length of service (from last date of hire) at commencement of disability, or
2. 52 weeks, whichever is less.

If at the date of expiration of such period you are confined in a hospital for the same disability or are receiving payments from the Company under any Worker's Compensation Law or any Occupational Disease Law or Act, benefits shall continue to be payable while you are so confined or continues to receive lost time benefits, but in no event not longer than 52 weeks.

(e) Fractional Part of a Week

Daily benefits shall be payable on the basis of a five-day workweek proration unless otherwise required by law.

(f) Successive Disabilities

Any two successive periods of disability separated by less than **three months** of active work on a full time basis will be considered one period of disability, except that any two disabilities due to different and unrelated causes separated by at least one day's return to work will be treated as separate disabilities. In the event of a pregnancy disability, such requirement of one day's return to work will not be required if another disability is due to a different and unrelated cause, but the total period for which benefits will be paid will not exceed 52 weeks.

(g) **Disability Payment Offsets**

Benefits payable for any period of disability will be reduced by any payments **received for Social Security Disability or** for time lost from work in that period to which the employee is entitled under any Worker's Compensation or Occupational Disease Law, including lump sum payments. No reduction will be made for payments for hospitalization or medical expense, or for disfigurements, or specific allowance for loss, or 100% loss of use of a member. No reduction will be made for permanent partial disability payments for an occupational illness or injury unrelated to the disability for which benefits under this Section 3 are payable.

In the event that Accident and Sickness Benefits are paid on the basis that an employee's period of disability is not compensable under **Social Security**

Disability or any Worker's Compensation or Occupational Disease Law, and subsequently, such period of disability is found to be compensable under **Social Security Disability or** Worker's Compensation or Occupational Disease Law, the employee will repay, in full, the amount duplicated by Accident and Sickness Benefit payments made for the same period. Repayment by the employee will be in one lump sum; however, if repayment cannot be made in one lump sum, satisfactory arrangements to repay the overpayment will be made.

(h) Holiday Pay

Accident and Sickness Benefits will not be paid for any day for which the employee is entitled to holiday pay.

(i) Waiver

An employee may irrevocably waive any right to receive Accident and Sickness Benefits with respect to any period of disability by completing a waiver form furnished by the Company for that purpose. No Accident and Sickness Benefits will be payable for any period of disability covered by such waiver.

(j) Unemployment Compensation

Benefits payable for any period of disability will be reduced by any Unemployment Compensation benefits paid for the same period. This reduction shall not apply to employees on a qualifying layoff.

(k) What is not covered

The A&S Program does not cover disabilities due to:

- War, or any act of war, whether declared or not,
- Taking part in commission of a felony, or
- Active military duty.

(l) How to file a Claim

If you have a claim for A&S benefits, please contact your local Human Resources Department or the HR Service Center in Greensboro (1-800-344-8339). They will help you file your claim.

(m) Verification of Disability

You will be required initially and periodically to furnish written proof of your disability satisfactory to the Company. Charges for the completion of any forms or statements by your Doctor will be your responsibility. You may also be required, as proof of your disability, to be examined by a Doctor designated by the Company at Company expense.

(n) When coverage ends

Your coverage will end when your employment ends; your membership in the covered class ends, the group contract ends, or the program is terminated.

(o) Recovery of overpayments

The Company reserves the right to recover benefits that were paid in error, duplicated in full or in part as the result of a compensable illness or injury under any Federal or state law, or determined not to be required.

(p) Conversion

A&S coverage cannot be converted to an individual policy when coverage ends.

SECTION 4 Reinstatement of Accident and Sickness Insurance During Layoff

(a) Eligibility Requirements

If you become disabled while on layoff, Accident and Sickness Insurance may be reinstated, subject to the following:

1. you become wholly and continuously disabled while on a qualifying layoff as defined in the MACK-UAW Supplemental Unemployment Benefit Plan (SUB Plan) and while insured for life insurance,
2. you are eligible for a Regular Benefit under the SUB Plan, and
3. you have applied for the benefit and have furnished the Company with satisfactory proof of disability.

Each week a benefit is claimed, you must:

1. be unable to perform all duties of your occupation,

2. be under a doctor's care, and
3. be eligible to receive a Regular Benefit under the SUB Plan.

(b) Payment of Benefits

Benefits start on the first day of a qualifying disability. No benefit shall be payable beyond the earlier of: (1) the time that the employee no longer satisfies the disability requirement; or (2) the employee is no longer eligible for regular SUB Benefits.

(c) Suspension or Reduction of Benefits

No benefit shall be payable for any week in which:

1. you receive an Accident and Sickness or Long-Term Disability Benefit under this program, or

2. you are not eligible for a Regular SUB benefit.

The benefit for any week (or day(s) in the event of a fractional part of a week) will be reduced by the amount of the Regular SUB Benefit you received for the same week (or day(s) in the event of a fractional part of a week) and any disability benefit you receive for the same week under a plan financed in whole or in part by another employer.

(d) Other

Except as specifically modified under Section 4, benefits will be governed by the applicable provisions of Section 3.

SECTION 5 Long-Term Disability Benefits

(a) Eligibility for Benefits

To be eligible for Long-Term Disability Benefits, you must:

1. be totally disabled and unable to engage in any regular employment or occupation by reason of any medically demonstrable physical or mental condition with the Company at the Plant or Plants where you work provided you are not engaged in regular employment for remuneration or profit (excluding employment or occupation which on the basis of medical evidence is determined to be for purposes of rehabilitation), and

2. have exhausted your Accident and Sickness Benefits as provided in Article III, Section 3, and
3. have not been continuously disabled for a period greater than the number of months of your seniority at commencement of your disability.

For an employee who waives receipt of Accident and Sickness Benefits, the time such employee would have otherwise exhausted such benefits shall be deemed the time such employee exhausts them for purposes of this Subsection.

(b) Amount of Benefit

For all employees, any disabilities commencing on or after October 2, 2016 will equal 60% of monthly basic wage rate, not subject to wage progression.

In addition, the long term disability benefit amounts described above in (b) are reduced by an amount equal to the monthly equivalent of the total of the following benefits for which you may be eligible:

a) all benefits under any retirement plan sponsored for Mack employees,
b) lost time benefits under Worker's Compensation laws or other laws providing benefits for occupational injury or disease, including lump-sum settlements, but excluding specific allowances for loss, or 100 percent loss of use, of a body member,
c) disability or old age insurance benefits to which the person is entitled (primary insurance amount) under the Federal Social Security Act or any future legislation providing similar benefits, except old age benefits reduced because of the age at which received, and
d) benefits under any state or federal law providing benefits for working time lost because of disability.

If you are awarded, including retroactively, any or all of the benefits identified above for any month or partial month for which long term disability benefits have been paid, you will repay, in full, the amount by which the sum of: (1) awards received above and (2) long term disability (LTD) benefits payments made to you, exceeds your LTD benefit payable for the same period. Increases to the benefits identified above received after LTD benefits begin are not included in calculation unless it is an adjustment to

the original payment. Your repayment will be in one lump sum; however, if repayment cannot be made in one lump sum, satisfactory arrangements to repay the overpayment will be made.

If your Social Security Disability Insurance Benefit Award results from a reconsideration or hearing before an administrative law judge, the amount of Long Term Disability Benefits to be repaid will be reduced by any attorney fees associated with the award provided you make such repayment within 30 days of the later of (i) the date you receive the award or (ii) the date you are notified of the amount to be repaid. This reduction applies only to attorney fees associated with a successful appeal of a denial of Social Security Disability Insurance Benefits and includes only that portion of the attorney's fee associated with the period of time the employee was entitled to receive LTD benefits. The reduction for attorney fees may not exceed 25 percent of the repayment due. Attorney fees for services prior to denial of the initial application for Social Security Disability Insurance Benefits will not reduce the amount of repayment due. In the event an employee is also a retiree who is also receiving or has received a Temporary Benefit under Article V, Section 2 or Section 3 of the Mack UAW Pension Plan, the amount of reduction outlined above will be in proportion to the total repayment due under both the Pension Plan and the LTD Plan. The combined reduction from both Plans may not exceed 25% of the repayment due or the actual attorney fees, if such fees are less than 25% of the repayment due.

3. In determining the amount by which Long-Term Disability Benefits are reduced:
   a) the monthly equivalent of benefits paid on a weekly basis shall be computed by multiplying the weekly benefit rate by 4.33, and
   b) lump-sum settlements under state Worker's Compensation laws shall result in reductions equal to the monthly equivalent of the amount of the Worker's Compensation benefit to which the employee would have been entitled under applicable law had there been no lump-sum payment, but not to exceed in total the amount of the settlement, and
   c) increases to additional benefits outlined above, subsequent to the first day for which Long-Term Disability Benefits are payable, are disregarded except that the amount of such increase is not disregarded if it represents an adjustment in the original determination of the amount of such benefit, and all LTD benefit reductions will begin with the later of the effective date of the award or the effective date of your LTD benefits.

4. The computation of your Long-Term Disability Benefit presumes your eligibility for Social Security Disability Insurance Benefits after you have been disabled for five months and Pension Plan disability retirement benefit (if you have 10 or more years of credited service). Amounts deducted from Long-Term Disability Benefits on this basis will be reinstated upon presentation of satisfactory evidence that these benefits were applied for and denied; provided, however, that a reduction in Long-Term Disability Benefits will be made in an amount equal to Social Security Disability Insurance Benefits that would have been payable except for your refusal to accept vocational rehabilitation services. You or a member of your family should contact the local Social Security Office to file a claim for Social Security benefits.

5. Benefits payable for less than a full calendar month shall be pro-rated on the basis of the ratio of calendar days of eligibility to total calendar days in the month.

6. The Company may require each applicant or recipient of Long-Term Disability Benefits to certify or furnish verification of the amounts of his income from sources listed in Subsection (b) 2 of this Section 5. The amount of any Long-Term Disability Benefit payments in excess of the amount that should have been paid, after reduction for such other benefits, may be deducted from future Long-Term Disability Benefits.

(c) Commencement and Duration of Benefits

1. Long-Term Disability Benefits are payable to you following your approval and will commence the day following your last day of weekly Accident and Sickness Benefits, including weeks in which such Accident and Sickness Benefits were partially or wholly offset because of receipt of a Worker's Compensation benefit. LTD benefits are paid monthly as long as you have not been continuously disabled for a period longer than the number of months of your seniority.

2. The maximum period for Long-Term Disability Benefits is the number of full months of seniority, at the commencement of your disability, which exceeds the maximum number of weeks for which you were eligible to receive Accident and Sickness Benefits. The maximum period for salaried employees is reduced by the number of months (or fractional months) that you receive Company-paid sick pay pursuant to the provisions of the applicable Local Supplemental Agreement. No benefits are payable to

you beyond your date of death, the end of the month in which you attain age 65, or if you no longer satisfy the disability requirement.

If you become disabled when you are age 60 or older you will be entitled to receive benefits for up to sixty (60) months (less the period of weekly Accident and Sickness benefits and salary continuation if any) but not after age 70. If you become disabled when you are age 70 or older, you will be entitled to benefits for up to three months.

If your return to work with the Company is not effective to qualify you for a new period of Accident and Sickness Benefits (ineffective return to work) or if you engage in some gainful occupation or employment other than one for which you are reasonably qualified by education, training or experience, your satisfaction of the disability requirement does not end, but your Long-Term Disability Benefit will be suspended for the period of the ineffective return to work or the period you engage in the occupation or employment.

3. When determining your maximum period for monthly Long-Term Disability Benefits, any month in which your benefit is partially or wholly off-set by benefit payments from sources listed in Subsection (b) 2 above, or suspended under Subsection (c) 2 above, is counted as a full month. Fractions of the first and last month are counted as fractions of a month.

4. The cumulative total number of months during any previous periods of Long-Term Disability Benefits, regardless of whether for the same or related disabling condition, will reduce the maximum number of monthly benefit payments for which you are otherwise eligible if you again become eligible for Long-Term Disability Benefits.

(d) Rehabilitation

If you work under a recognized vocational rehabilitation program, you will be considered disabled for LTD coverage. However, your benefits will be suspended for the period you work.

(e) Proof of Disability

You will be required, initially and periodically, to furnish written proof of your disability satisfactory to the Company. Charges for completion of any forms or statements by your Doctor will be your responsibility. The Company may require you, as a condition of eligibility, to submit to examination by a

designated physician at Company expense for the purpose of determining your initial or continuing disability.

(f) Exclusions

No benefit shall be payable to an employee for any period of disability resulting from service in the armed forces of any country, unless such employee has been in employment with the Company at least 10 years after separation from such service. In addition, the LTD plan does not cover disabilities due to war, or any act of war, whether declared or not; taking part in the commission of a felony or active military service.

(g) Waiver

You may waive irrevocably any right to receive Long Term Disability Benefits with respect to any period of disability by completing a waiver form furnished by the Company for that purpose. No Long Term Disability Benefits will be paid for any period of disability covered by the waiver.

(h) Medicare Enrollees

Effective on and after January 1, 1985, an employee receiving Long-Term Disability Benefits, regardless of when the employee last ceased active work, who is enrolled in Medicare Part B coverage which is available under the Federal Social Security Act, will while so enrolled receive the actual Medicare Part B premium up to a maximum of $115 per month; to be effective the first day of the month following the month in which the Company is notified that the employee has enrolled for such coverage, unless the employee is receiving under the Pension Plan the same amount for the same purpose. Payment of the applicable amount provided under this Subsection (h) will be made concurrent with a monthly Long Term Disability Benefit payment and for the same period of disability.

(i) Successive Disabilities

Any two successive periods of disability, due to the same or related cause or causes, separated by less than 30 consecutive calendar days of active full-time work, will be considered a continuation of the previous period of disability.

(j) How to file a claim

Please contact your local Human Resources Department or the HR Service Center at 1-800-344-8339.

(k) When Coverage Ends

1. Your LTD coverage will end on the earliest of the following dates:
   - The date the Plan or the LTD Insurance Program is terminated
   - The date your employment terminates, you retire, or you are laid off
   - The date you no longer belong to a class of employee who are eligible for this coverage, and
   - The date which you cease to be eligible for coverage.

(l) Recovery of Overpayments

If payment has been made under the LTD Plan but is determined to have been paid in error, duplicated in total or in part as result of a compensable illness or injury under any of the sources described under the LTD benefit reduction section, or not to have been required, Mack or the Claims Administrator has the right to recover the benefit paid. Repayment must be in one lump sum; however, if repayment cannot be made in one lump sum, satisfactory arrangement to repay the overpayment will be made.

(m) Conversion

Coverage under the LTD program cannot be converted to an individual policy when coverage ends.

SECTION 6 Continuation of Coverages

(a) Sick Leave

During the period you are on sick leave and unable to work at your customary job or other available work, the Company will continue your **Company-Paid** Group Life, **Basic** Accidental Death and Dismemberment, Accident and Sickness, Long-Term Disability and Survivor Income (as described in Appendix A) coverages, if in effect, without employee contribution for the period equal to your seniority as of the date sick leave commences.

(Accident and Sickness Insurance or Long Term Disability Insurance terminates when maximum duration of benefits is reached).

(b) Leave of Absence (Other Than Sick Leave)

During the period you are on an approved leave of absence, including vacations pursuant to the terms of the applicable collective bargaining agreement, other than leave with the International Union, leave because of

election to federal, state, county or municipal office, or military leave, the Company will continue your insurance under the Program without contributions.

(c) Layoff

Subject to any applicable federal or state law, if you are laid off, the Group Life Insurance and Accidental Death and Dismemberment Insurance in force at the time of such layoff, will continue without cost to you through the last day of the calendar month following the month in which you are laid off. If a returning veteran, who would be entitled to reinstatement under the Master Bargaining Agreement if the employee had sufficient seniority, is not reinstated and is placed on layoff, such Employee's Group Life and Accidental Death and Dismemberment insurance coverages will be in effect at no expense to the returning veteran for the balance of the month in which the employee is placed on layoff. In addition, Group Life Insurance and Accidental Death and Dismemberment Insurance shall continue to be provided for laid off employees, without cost, during a layoff which meets the conditions of Article I, Section 3 of the SUB Plan, including those employees laid off under any predetermined bumping system which may limit job selection for bumping purposes and those employees taking a voluntary layoff under any local supplemental agreement, for each full calendar month of layoff, (for which the employee receives no pay from the Company) for a period determined in accordance with the Seniority table below. The day the employee reports for work will be deemed to be the employee's last day worked prior to layoff (as of the date placed on layoff in the case of a returning veteran), but only for purposes of determining the period of continuation and eligibility for Company contributions for such coverages.

Year(s) of Seniority on Last Day Worked Prior to Layoff	**Maximum Number of Months for Which Coverage Will Be Provided Without Cost to Employees**
Less than 1	0
1 but less than 4	6

4 but less than 5	8
5 but less than 6	10
6 and Over	12

If you remain on layoff beyond the period for which such insurances are continued at Company expense, you may continue the Group Life Insurance and Accidental Death and Dismemberment Insurance for up to an additional 12 consecutive months of layoff by paying in advance to the Company the monthly premiums of $.50 per $1,000 life insurance in force.

If you are laid off and have less than one year of Seniority, you may continue the Group Life Insurance and Accidental Death and Dismemberment Insurance in force for up to 12 months following the last full month the Company continues such insurances at no cost during your layoff (if there is no break in your Seniority) by paying to the Company in advance the monthly premium for such insurances and benefits of $.50 per $1,000 of life insurance in force.

The Company will furnish you with a written statement at the time of your lay-off that will include the following information:

1. number of months of continued insurances and benefits at no cost to you including one full calendar month following the month in which layoff occurred, and
2. month and year that premium payment must be made to continue insurance and benefits in effect.

(d) Termination After Age 60 (Excluding Retirement)

If you are terminated after attaining age 60 with at least five years of credited service under the Pension Plan, you may continue the full amount of your Group Life and Accidental Death and Dismemberment Insurance in force at termination (as provided in Section 1(a) and Section 2 of this Article III) until you attain age 65. To continue your coverage, you must pay in advance a monthly insurance contributions of $.50 for each $1,000 of life insurance in force

(e) While a Grievance is Pending

If you are terminated and have a grievance pending to protest loss of Seniority resulting from discharge, failure to report, over-staying leave or disciplinary layoff, you may continue the full amount of such Group Life and Accidental Death and Dismemberment Insurance as provided in Section 1(a) and Section 2 of this Article III until such grievance is resolved. To do so, you must pay in advance a monthly insurance contribution of $.50 per $1,000 of Group Life Insurance in force. If you are reinstated, or the disciplinary layoff is reduced, the Company will reimburse you for the insurance contributions which the Company otherwise would have paid.

(f) Return to Active Employment

If your active employment ceases for any reason, but there was no break in your Seniority, then upon your return to active employment all insurance coverage commences immediately.

(g) Recall While Disabled

If you are recalled from layoff and are physically unable to return to work because of a disabling illness or injury incurred during your period of layoff, you will be deemed eligible for benefits under the Insurance Program, provided that you furnish the Company with proof satisfactory to the Company's physician of your bona fide illness or injury. You will not be entitled to such benefits if you are eligible to receive comparable benefits under any insurance program provided by another employer.

(h) Termination of Insurance

Except as provided for in this Article III and subject to the conversion privileges under the Group Life Insurance policy, on the date you cease active work for the Company or cease being a member of a bargaining unit, all of your insurance under the program will be canceled.

SECTION 7 Company Obligation

The Company will pay the full cost of all insurance provided in this Article III, less the amounts of contributions required to be paid under Section 6 of this Article III.

SECTION 8 Definitions

"*Accident*" means an accidental bodily injury that results from sudden, unexpected, and wholly external means.

"Claims Administrator" means a third party which has entered into an agreement with the Company to provide services necessary to administer the benefits stipulated under the Plan.

"Company-Paid Sick Leave" means the continuation of pay for absence due to illness or injury subject to the limitations described in the respective labor agreements.

"Physician" means a doctor of medicine, a doctor of osteopathy, a doctor of dental surgery and a doctor of podiatry legally licensed to practice within the scope of that license.

ARTICLE IV

PPO – PPO Prescription Drug - Dental – Vision Plans - HMO

Article IV provides you with a description of your Medical PPO, PPO Prescription Drug, Dental, Vision and HMO (if applicable) benefits. You should familiarize yourself with the Plans' main provisions. A thorough understanding of your coverage will enable you to use your benefits wisely. If you have any questions, please contact the Claims Administrator's Customer Service Department for specific benefit plan information.

SECTION 1 Anthem PPO

Anthem Blue Cross and Blue Shield, or "Anthem" has been designated by Mack to provide administrative services for the Medical PPO, such as claims processing, care management, and other services, and to arrange for a network of health care providers whose services are covered by the Plan.

Important: This is not an insured benefit Plan. The benefits described are funded by Mack who is responsible for their payment. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Verification of Benefits

Verification of benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Member Services with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 8:00 p.m. eastern time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. CALL THE MEMBER SERVICES NUMBER ON YOUR IDENTIFICATION CARD or see the section titled Health Care Management for Precertification rules.

Identity Protection Services

Identity protection services are available with Your Employer's Anthem health plans. To learn more about these services, please visit www.anthem.com/resources.

(a) Table of Contents

(b) Members Rights and Responsibilities

As a Member You have rights and responsibilities when receiving health care. As Your health care partner, the Claims Administrator wants to make sure Your rights are respected while providing Your health benefits. That means giving You access to the Claims Administrator's network health care Providers and the information You need to make the best decisions for Your health. As a Member, You should also take an active role in Your care.

You have the right to:

- Speak freely and privately with Your doctors and other health providers about all health care options and treatment needed for Your condition no matter what the cost or whether it is covered under Your Plan.
- Work with Your doctors in making choices about Your health care.
- Be treated with respect and dignity.
- Expect the Claims Administrator to keep Your personal health information private by following the Claims Administrator's privacy policies, and state and Federal laws.
- Get the information You need to help make sure You get the most from Your health plan, and share Your feedback. This includes information on:
  - The Claims Administrator's company and services
  - The Claims Administrator network of health care Providers
  - Your rights and responsibilities
  - The rules of Your health Plan
  - The way Your health Plan works
- Make a complaint or file an appeal about:
  - Your health Plan and any care You receive
  - Any Covered Service or benefit decision that Your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care You may get in the future. This includes asking Your Doctor to tell You how that may affect Your health now and in the future.

- Get the most up-to-date information from a health care Provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health Plan rules and policies.
- Although it is not required, it is highly recommended that you choose a Network Primary Care Physician (doctor), also called a PCP, to coordinate your care.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care you're getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care Providers.
- Give the Claims Administrator, Your Doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health Plan. This may include information about other health insurance benefits You have along with Your coverage with the Plan.
- Inform Member Services if You have any changes to Your name, address or family members covered under Your Plan.

If You would like more information, have comments, or would like to contact the Claims Administrator, please go to anthem.com and select Customer Support>Contact Us. Or call the Member Services number on Your Identification Card.

The Claims Administrator wants to provide high quality customer service to our Members. Benefits and coverage for services given under the Plan are governed by the Employer's Plan.

How to Obtain Language Assistance
Anthem is committed to communicating with our Members about their health plan, regardless of their language. Anthem employs a language line interpretation service for use by all of our Member Services Call Centers. Simply call the Member Services phone number on the back of Your Identification Card and a representative will be able to assist You. Translation of written materials about Your benefits can also be requested by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

(c) Schedule of Benefits

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Member's Plan. See the Definitions and Claims Payment sections for more information. Under certain circumstances, if the Claims Administrator pays the healthcare Provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

Schedule of Benefits - Effective 01/01/2024	**Network**	**Out-of-Network**
Calendar Year Deductible		
Individual	$350	**$2,000**
Family	$700	**$4,000**
Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.		
All Covered Services are subject to the Deductible unless otherwise specified in this booklet.		
Your Plan has an embedded Deductible which means: • If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You. • If You also cover Dependents (other family members) under this Plan, both the "Individual" and the "Family" amounts apply. The "Family" Deductible amounts can be satisfied by any combination of family members, but You could satisfy Your own "Individual" Deductible amount before the "Family" amount is met. You will never have to satisfy more than Your own "Individual" Deductible amount. If You meet Your "Individual" Deductible amount, Your other family member's claims will still accumulate towards their own "Individual" Deductible and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Deductible or the entire "Family" Deductible is met.		

Schedule of Benefits - Effective 01/01/2024	Network	Out-of-Network
Amounts satisfied toward the Network calendar year Deductible will be applied toward the Out-of-Network calendar year Deductible and amounts satisfied toward the Out-of-Network calendar year Deductible will be applied toward the Network calendar year Deductible.		
Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)		
Plan Pays	80%	70%
Member Pays	20%	30%
All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out of Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.		
Out-of-Pocket Maximum Per Calendar Year Includes Coinsurance, Copayments and the calendar year Deductible. Does NOT include Prescription Drug benefits, precertification penalties, services deemed not Medically Necessary by medical management and/or Anthem, charges in excess of the Maximum Allowed Amount and Non-Covered Services.		
Individual	$750	**$4,000**
Family	$1,500	**$8,000**
Your Plan has an embedded Out-of-Pocket which means: • If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You. • If You also cover Dependents (other family members) under this Plan, both the "Individual" and "Family" amounts apply. The "Family" Out-of-Pocket amounts can be satisfied by any combination of family members, but You could satisfy Your own "Individual" Out-of-Pocket amount before the "Family" amount is met. You will never have to satisfy more than Your own 'Individual" Out-of-Pocket amount. If You meet Your "Individual" amount, other family member's claims will still accumulate towards their own "Individual" Out-of-Pocket and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Out-of-Pocket or the entire 'Family" Out-of-Pocket is met.		
Amounts satisfied toward the Network Out-of-Pocket Maximum will be applied toward the Out-of-Network Out-of-Pocket Maximum and amounts satisfied toward the Out-of-Network Out-of-Pocket Maximum will be applied to Network Out-of-Pocket Maximums.		

Schedule of Benefits - Effective 01/01/2024	Network	Out-of-Network
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, services are subject to the applicable Deductible and Coinsurance.		
Allergy Care Testing and Treatment	20%	30%
Member responsibility per office visit for Network services is the Copayment or the actual charge, whichever is less.		
Behavioral Health/Substance Abuse Care Hospital Inpatient Services	0% per visit	30%
Outpatient Services • Copayment applies to visits/consults only. Other services (including IOP and PHP) are subject to deductible and coinsurance	$10	30%
Physician Services (In person and/or virtual) • Online visits are covered and mirror the professional office Behavioral Health visit benefit	$10	30%
Applied Behavioral Analysis Note: Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with federal law.	0%	30%
Clinical Trials See Clinical Trials under Benefits section for further information.	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Dental, Oral Surgery and TMJ Services Accidental Injury to natural teeth (treatment must be completed within **12** months of the Injury) Oral Surgery/TMJ - Subject to Medical Necessity – excludes appliances and orthodontic treatment	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received

Schedule of Benefits - Effective 01/01/2024	Network	Out-of-Network
Diagnostic Physician's Services		
Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:		
Primary Care Physician Copayment	$20	30%
Specialist Physician Copayment	$40	30%
Diagnostic X-ray and Lab – office or independent lab	20%	30%
Any service billed with a diagnosis of rabies is covered at 100%, not subject to Deductible, Network or Out-of-Network		
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, services are subject to the applicable Deductible and Coinsurance.		
Diabetic Supply Diabetic supplies covered by the prescription drug plan are not covered under the PPO (lancets, syringes, insulin). Diabetic supplies not covered by Rx plan are covered under PPO.	20%	20%
Emergency Room, Urgent Care, and Ambulance Services		
Emergency room for an Emergency Medical Condition **(Deductible does not apply.)** (Copayment waived if admitted or if referred by your doctor)	**$150**	**$150** **(See note below)**
Use of the emergency room for non-Emergency Medical Conditions	20%	30%
Urgent Care clinic visit for an Emergency Medical Condition	$40	30%
Ambulance Services (when Medically Necessary)	Covered in full	Covered in full

Schedule of Benefits - Effective 01/01/2024	Network	Out-of-Network
Land / Air		
Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.		
➢ **Eye Care (non-routine)**		
• Office visit – medical eye care exams (treatment of disease or Injury to the eye)		
➢ Primary Care Physician	**$20**	**30%**
Specialist Physician	**$40**	**30%**
Hearing Care (routine)		
Hearing Exam (once every 36 months)	**$60 Maximum**	**$60 Maximum**
➢ Hearing Aid (repair or purchase)	**100% up to $1,600/yr.**	**100% up to $1,600/yr.**
Hearing Care – Non-Routine		
Office visit – Audiometric exam/hearing evaluation test		
Primary Care Physician Copayment/Coinsurance	$20	30%
Specialist Physician Copayment/Coinsurance	$40	30%
• **Note: Copayment only apply to certain services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, services are subject to the applicable Deductible and Coinsurance.**	**Covered at 100% (not subject to the Deductible)**	**Covered at 100% (not subject to the Deductible)**

Schedule of Benefits - Effective 01/01/2024	Network	Out-of-Network
Hearing devices/hearing aids • Limited to $1,600 per calendar year, combined Network and Out-of-Network (Includes hearing aid accessories and repairs when Medically Necessary) • Hearing aid exams are covered subject to Deductible and 80% coinsurance for Network and Out-of-Network. Limited to 1 every 36 months with a $60 maximum, combined Network and Out-of-Network.	**Covered at 100% (not subject to the Deductible)**	**Covered at 100% (not subject to the Deductible)**
Home Health Care Including Private Duty Nursing benefit	**20%**	**30%**
Hospice Care Services	**Covered in Full**	**Covered in Full**
Hospital Inpatient Services – Precertification Required	**20%**	**30%**
Room and board (Semiprivate or ICU/CCU)	**20%**	**30%**
Hospital services and supplies (x-ray, lab, anesthesia, surgery (Precertification required), etc.) Inpatient Physical Medical Rehab – limited to 30 days per calendar year, combined Network and Out-of-Network	**20%**	**30%**
Pre-Admission testing	**20%**	**30%**
► Physician Services:		
► Surgeon	**20%**	**30%**
► Anesthesiologist	**20%**	**30%**
► Radiologist	**20%**	**30%**
► Pathologist	**20%**	**30%**
Note: *Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits (Coinsurance) when providing Inpatient services. **If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges**.		
Inpatient Care	**20%**	**30%**

Schedule of Benefits - Effective 01/01/2024	Network	Out-of-Network
Inpatient Therapies (e.g., chemo, radiation, dialysis, infusion, physical, occupational, respiratory, speech and vision)	**20%**	**30%**
Maternity Care & Other Reproductive Services		
Physician's office:	**$20**	**30%**
Global care (includes pre-and post-natal, delivery) – Copayment (first visit):		
Primary Care Physician (includes obstetrician and gynecologist) Copayment/Coinsurance	**$20**	**30%**
Specialist Physician Copayment/Coinsurance	**$40**	**30%**
Midwife (Precertification required)	**$40**	**30%**
Physician Hospital/Birthing Center Services (Precertification required)	**20%**	**30%**
Physician's services	**20%**	**30%**
Newborn nursery services (well baby care)	**20%**	**30%**
Circumcision	**20%**	**30%**
Note: Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified		
Infertility Services		

Schedule of Benefits - Effective 01/01/2024	Network	Out-of-Network
Anthem's WINFertility Program offers fertility support – inclusive family-building solutions delivered with support and care. To learn more contact Anthem at the number on your medical ID card. **Two Retrieval Cycle Maximum; Elective Cryopreservation Storage 1 year; Surrogacy Education only; Dependent Children are Excluded** **Infertility Services have a Separate Lifetime Maximum. Treatment for underlying medical conditions are covered under medical.** **Full Coverage Diagnostic Services and Treatment** **Covered Services include but are not limited to: List treatment options selected - in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT.)**	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
Sterilization Services (Precertification required for Inpatient procedures)		
Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section in Benefits for further details.	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
Vasectomy	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
• **Medical Supplies and Equipment**		
• **Medical Supplies**	**20%**	**20%**
Durable Medical Equipment	**20%**	**20%**
• **Orthotics**	**20%**	**30%**
• Foot and Shoe		

Schedule of Benefits - Effective 01/01/2024	Network	Out-of-Network
Prosthetic Appliances (external) Wigs/Toupees limited to 1 per benefit period, subject to Medical Necessity	**20%**	**30%**
Nutritional Counseling for Diabetes	**20%**	**30%**
Outpatient Hospital/Facility Services		
Outpatient Facility	**20%**	**30%**
Lab and x-ray services	**20%**	**30%**
Outpatient Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	**20%**	**30%**
Physician Services (Home and Office Visits)		
➢ Primary Care Physician	**$20**	**30%**
➢ Specialist Physician	**$40**	**30%**
➢ Office Surgery	**20%**	**30%**
➢ Prescription Injectables/Prescription Drugs Dispensed in the Physician's Office	**20%**	**30%**
Preventive Services	Covered at 100% (not subject to Deductible)	30%
Private Duty Nursing	**20%**	**30%**
Skilled Nursing Facility	**20%**	**30%**
Surgical Services	**20%**	**30%**
Gastric Bypass/Obesity Surgery When Medically Necessary. Precertification Required	**20%**	**30%**
Therapy Services (Outpatient)		
Physical Therapy	**20%**	**30%**

Schedule of Benefits - Effective 01/01/2024	Network	Out-of-Network
Occupational Therapy	**20%**	**30%**
Speech Therapy	**20%**	**30%**
Cardiac Rehabilitation	**20%**	**30%**
Chiropractic Care	**20%**	**30%**
Radiation Therapy	**20%**	**30%**
Chemotherapy	**20%**	**30%**
Respiratory Therapy	**20%**	**30%**
Vision Therapy	Not Covered	Not Covered

Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.

Benefits for Physical Therapy are limited to 90 visits per calendar year, combined Network and Out-of-Network.

Benefits for Occupational Therapy are limited to 30 visits per calendar year, combined Network and Out-of-Network.

Benefits for Speech Therapy are limited to 30 visits per calendar year, combined Network and Out-of-Network.

Benefits for Manipulation Therapy are limited to 20 visits per calendar year, combined Network and Out-of-Network.

Transplants		
Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, including Medically Necessary preparatory myeloablative therapy. **The Center of Excellence requirements do not apply to** Cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. **Note:** Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims	**Center of Excellence/Network Transplant Provider**	**Out-of-Network Transplant Provider**

Schedule of Benefits - Effective 01/01/2024	Network	Out-of-Network
Administrator to determine which Hospitals are Network Transplant Providers. (When calling Customer Service, ask to be connected with the Transplant Case Manager for further information.)		
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Customer Service number on Your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)	Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Schedule of Benefits - Effective 01/01/2024	Network	Out-of-Network
Covered Transplant Procedure during the Transplant Benefit Period	20% Covered at 100% when using a BDCT Facility	Not Covered
Care coordinated through a Network Transplant Provider/ Center of Excellence – not subject to Deductible When performed by Out-of-Network Transplant Provider (subject to Deductible, does not apply to the Out of Pocket Maximum). **You are responsible for any charges from the Out-of-Network Transplant Provider which exceeds the Maximum Allowed Amount.**		
Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient)	20% Covered at 100% when using a BDCT Facility	Not Covered
Includes unrelated donor search up to $30,000 per Transplant.		
Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement)	20% Covered at 100% when using a BDCT Facility	Not Covered
Eligible Travel and Lodging	20% Covered at 100% when using a BDCT Facility	Not Covered
Limited to $10,000 per Transplant maximum combined Network and Out-of-Network **subject to Claims Administrator's approval.**		
All Other Covered Transplant Services	20% Covered at 100% when using a BDCT Facility	Not Covered

(d) Total Health and Wellness Solutions

1. Quick Care Options

Quick Care Options helps to raise Your awareness about appropriate alternatives to hospital emergency rooms (ERs). When You need care right away, retail health clinics and urgent care centers can offer appropriate care for less cost—and leave the ER available for actual emergencies. Quick Care Options educates You on the availability of ER alternatives for non-urgent diagnoses and provides a provider finder website to support searches for ER alternatives.

2. Complex Care

The Complex Care program reaches out to You if You are at risk for frequent and high levels of medical care in order to offer support and assistance in managing Your health care needs. Complex Care empowers You for self-care of Your condition(s), while encouraging positive health behavior changes through ongoing interventions. Complex Care nurses will work with You and Your physician to offer:

- Personalized attention, goal planning, health and lifestyle coaching.
- Strategies to promote self-management skills and medication adherence.
- Resources to answer health-related questions for specific treatments.
- Access to other essential health care management programs.
- Coordination of care between multiple providers and services.

The program helps You effectively manage Your health to achieve improved health status and quality of life, as well as decreased use of acute medical services.

3. Condition Care Programs

Condition Care programs help maximize Your health status, improve health outcomes and control health care expenses associated with the following prevalent conditions:

- Asthma (pediatric and adult).
- Diabetes (pediatric and adult).
- Heart failure (HF).
- Coronary artery disease (CAD).
- Chronic obstructive pulmonary disease (COPD).

You will receive:

- 24/7 phone access to a nurse coach who can answer your questions and give you up-to-date information about your condition.
- A health review and follow-up calls if you need them.
- Tips on prevention and lifestyle choices to help you improve your quality of life.

4. Future Moms

The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early prenatal interventions, risk assessments and education. The program includes special management emphasis for expectant mothers at highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches, supported by pharmacists, registered dietitians, social workers and medical directors. You will receive:

- 24/7 phone access to a nurse coach who can talk with you about your pregnancy and answer your questions.
- *Your Pregnancy Week by Week*, a book to show you what changes you can expect for you and your baby over the next nine months.
- Useful tools to help you, your doctor and your Future Moms nurse coach track your pregnancy and spot possible risks.

5. 24/7 Nurse Line

You may have emergencies or questions for nurses around-the-clock. 24/7 Nurse Line provides You with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, You can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 Nurse Line features:

- A skilled clinical team – RN license (BSN preferred) that helps Members assess systems, understand medical conditions, ensure Members receive the right care in the right setting and refer You to programs and tools appropriate to Your condition.

- Bilingual RNs, language line and hearing impaired services.
- Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics.
- Proactive callbacks within 24 to 48 hours for Members referred to 911 emergency services, poison control and pediatric Members with needs identified as either emergent or urgent.
- Referrals to relevant community resources.

6. My Health Advantage

My Health Advantage is a free service that helps keep You and Your bank account healthier. Here's how it works: the Claims Administrator reviews Your incoming health claims to see if we can save You any money. The Claims Administrator can check to see what medications You're taking and alert Your doctor if we spot a potential drug interaction. The Claims Administrator also keeps track of Your routine tests and checkups, reminding You to make these appointments by mailing You My Health Notes. My Health Notes summarize Your recent claims. From time to time, The Claims Administrator offers tips to save You money on prescription drugs and other health care supplies.

7. AIM Imaging Cost & Quality Program

Volvo has selected this innovative Imaging Cost & Quality Program for Anthem Blue Cross Blue Shield members through AIM Specialty Health. This Program provides You with access to important information about imaging services You might need. The Program is not a benefit under your health benefit plan.

If You need an MRI or a CT scan, it's important to know that costs can vary quite a bit depending on where You go to receive the service. Sometimes the differences are significant – anywhere from $300 to $3000 – but a higher price doesn't guarantee higher quality. If your benefit plan requires You to pay a portion of this cost (like a deductible or coinsurance) where You go can make a very big difference to your wallet.

That's where the AIM Imaging Cost & Quality Program comes in – AIM does the research for You and makes it available to help You find the ***right*** location for your MRI or CT scan. Here's how the Program works:

- Your doctor lets Anthem know You will have one of these procedures.

- Anthem will check to see if the Provider who will perform the procedure offers a low cost for the service.
- If not, Anthem will call You to give You other choices nearby.
- You choose the Provider that best meets Your needs, whether it's the one Your doctor suggested or one Anthem tells You about. It's completely up to You.

The AIM Imaging Cost & Quality Program gives You the opportunity to reduce your health care expenses (and those of your employer) by selecting high quality, lower cost providers or locations. No matter which provider You choose, there is no effect on your health care benefits. We are bringing this Program to You to give You information that helps You to make informed choices about where to go when You need care.

(e) Eligibility

1. Coverage for the Employee

   This Benefit Booklet describes the benefits an Employee may receive under this health care Plan. The Employee is also called a Subscriber.

2. Coverage for the Employee's Dependents

   If the Employee is covered by this Plan, the Employee may enroll his or her eligible Dependents. Covered Dependents are also called Members.

   Please see ARTICLE II, Section 2, for detailed information regarding Eligibility for your benefits.

3. Special Enrollment Periods

   If an Employee or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Employee or Dependent must request Special Enrollment within 31 days of a qualifying event.

   Special Enrollment is available for eligible individuals who:

   - Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.

   - Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.

- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes About Special Enrollment:

- Individuals enrolled during special enrollment periods are **not** Late Enrollees.
- Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

4. Medicaid and CHIP Special Enrollment/Special Enrollees

   Eligible Employees and Dependents may also enroll under two additional circumstances:

   - the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
   - the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

   The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

(f) How Your Plan Works

Note: Capitalized terms such as Covered Services, Medical Necessity, and Out-of-Pocket Maximum are defined in the "Definitions" Section.

1. Introduction

   Your health Plan is a Preferred Provider Organization (PPO) which is a comprehensive Plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

   Providers are compensated using a variety of payment arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

   All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied**.**

2. Network Services

When You use a Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. The Plan has the final authority to decide the Medical Necessity of the service.

Network Providers include Primary Care Physicians/Providers (PCPs), Specialists (Specialty Care Physicians/Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for You. Referrals are never needed to visit a Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them You are an Anthem Member,
- Have Your Member Identification Card handy. The Doctor's office may ask You for Your group or Member ID number.
- Tell them the reason for Your visit.

When You go to the office, be sure to bring Your Member Identification Card with You.

For services from Network Providers:

A. You will not need to file claims. Network Providers will file claims for Covered Services for You. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by Your Network Provider(s) for any Non-Covered Services You get or when You have not followed the terms of this Benefit Booklet.

B. Precertification will be done by the Network Provider. (See the **Health Care Management – Precertification** section for further details.)

Please read the **Claims Payment** section for additional information on Authorized Services.

3. After Hours Care

If You need care after normal business hours, Your doctor may have several options for You. You should call Your doctor's office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If You have an Emergency, call 911 or go to the nearest Emergency Room.

4. Out-of-Network Services

   When You do not use a Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Benefit Booklet.

   For services from an Out-of-Network Provider:

   - the Out-of-Network Provider can charge You the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
   - You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
   - You will have to pay for services that are not Medically Necessary;
   - You will have to pay for Non-Covered Services;
   - You may have to file claims; and
   - You must make sure any necessary Precertification is done. (Please see **Health Care Management – Precertification** for more details.)

5. How to Find a Provider in the Network

   There are three ways You can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

   - See Your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and facilities that participate in this Plan's Network.
   - Call Customer Service to ask for a list of doctors and Providers that participate in this Plan's Network, based on specialty and geographic area.
   - Check with Your doctor or Provider.

   If You need details about a Provider's license or training, or help choosing a doctor who is right for You, call the Customer Service number on the back of Your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

6. The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates in a program called "BlueCard." This program lets You get Covered Services at the Network cost-share when You are traveling out of state and need health care, as long as You use a BlueCard Provider. All You have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send Your claims to the Claims Administrator.

If You are out of state and an Emergency or urgent situation arises, You should get care right away.

In a non-Emergency situation, You can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Please refer to **Inter-Plan Arrangements** in the **Claims Payment** section for more information on BlueCard.

7. **Blue Cross Blue Shield Global Core® Program**

If You plan to travel outside the United States, call Member Services to find out Your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health Identification Card with You.

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

If You need inpatient hospital care, You or someone on Your behalf, should contact the Claims Administrator for preauthorization. Keep in mind, if You need Emergency medical care, go to the nearest hospital. There is no need to call before You receive care.

Please refer to the **Health Care Management – Precertification** section in this Booklet for further information. You can learn how to get preauthorization when You need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core®

In most cases, when You arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When You need Blue Cross Blue Shield Global Core® claim forms You can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

8. Copayment

   Certain Network services may be subject to a Copayment amount which is a flat-dollar amount You will be charged at the time services are rendered.

   Copayments are the responsibility of the Member. Any Copayment amounts required are shown in the **Schedule of Benefits**. Unless otherwise indicated, services which are not specifically identified in this Benefit Booklet as being subject to a Copayment are subject to the **calendar year Deductible** and payable at the **percentage payable** in the **Schedule of Benefits**.

9. Calendar Year Deductible

   Before the Plan begins to pay benefits (except certain benefits which are subject to Copayment instead of Deductible), You must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the **Schedule of Benefits**. Deductible requirements are stated in the **Schedule of Benefits.**

(g) Health Care Management - Precertification

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Benefit Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or

place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care or higher cost setting/place of care.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. The Plan may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate.

If You have any questions regarding the information contained in this section, You may call the Member Services telephone number on Your Identification Card or visit **www.anthem.com**

Coverage for or payment of the service or treatment reviewed is not guaranteed even if the Plan decides Your services are Medically Necessary. For benefits to be covered, on the date You get services:

1. You must be eligible for benefits.
2. You must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under Your Plan;
4. The service cannot be subject to an Exclusion under Your Plan; and
5. You must not have exceeded any applicable limits under Your Plan.

1. Types of Reviews:

   Pre-service Review – A review of a service, treatment or admission for a benefit coverage determination, which is done before the service or treatment begins or admission date.

   Precertification – A required Pre-Service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative.

   For admissions following Emergency Care, You, Your authorized representative or Doctor must notify the Claims Administrator within 2 business days after the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a problem and/or the mother and baby

are not discharged at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

Continued Stay/Concurrent Review – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge or Your medical condition, without such care or treatment. Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

Failure to Obtain Precertification Penalty:

IMPORTANT NOTE: IF YOU OR YOUR NON NETWORK PROVIDER DO NOT OBTAIN THE REQUIRED PRECERTIFICATION, YOUR CLAIM WILL BE DENIED. ONCE INFORMATION IS RECEIVED CLAIMS CAN BE RE-OPENED BASED ON MEDICAL INFORMATION PROVIDED. THIS DOES NOT APPLY TO MEDICALLY NECESSARY SERVICES FROM A NETWORK OR BLUECARD PROVIDER.

The following list is not all inclusive and is subject to change; please call the Member Services telephone number on Your Identification Card to confirm the most current list and requirements for Your Plan.

2024 Precertification List

Inpatient Admission:

Acute Inpatient
Acute Rehabilitation
LTACH (Long Term Acute Care Hospital)
Skilled Nursing Facility
OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay)

Diagnostic Testing:

BRCA Genetic Testing

Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability and Congenital Anomalies

Gene Expression Profiling for Managing Breast Cancer Treatment

Gene Mutation Testing for Cancer Susceptibility and Management

Genetic Testing for Inherited Diseases

Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP) Attenuated FAP and MYH-Associated Polyposis

Preimplantation Genetic Diagnosis Testing

Prostate Saturation Biopsy

Testing for Biochemical Markers for Alzheimer's Disease

Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling

Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders

Durable Medical Equipment (DME)/Prosthetics:

Augmentative and Alternative Communication (AAC) Devices with Digitized or Synthesized Speech Output

Compression Devices for Lymphedema

Electric Tumor Treatment Field (TTF)

Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)

High Frequency Chest Compression Devices for Airway Clearance

Implantable Infusion Pumps

Intrapulmonary Percussive Ventilation (IPV) Device

Microprocessor Controlled Knee-Ankle-Foot Orthosis

Microprocessor Controlled Lower Limb Prosthesis

Myoelectric Upper Extremity Prosthetic Devices

Noninvasive Electrical Bone Growth Stimulation of the Appendicular Skeleton

Standing Frames

Ultrasonic Diathermy Devices

Ultrasound Bone Growth Stimulation

Powered Wheeled Mobility Devices Gender-Affirming Surgery

- If the benefit is covered, Precertification is required.

Human Organ and Bone Marrow/Stem Cell Transplants

Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including kidney only transplants)

Outpatient: All procedures considered to be transplant or transplant related, including, but not limited to:

- Donor Leukocyte Infusion
- Intrathecal treatment of Spinal Muscular Atrophy (SMA) Spinraza (nusinersen)
- Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
- (CAR) T-cell immunotherapy treatment, including, but not limited to:
- Axicabtagene ciloleucel (Yescarta™)
- Tisagenlecleucel (Kymriah™)
- Brexucabtagene Autoleucel (Tecartus)
- lisocabtagene maraleucel (Breyanzi)

- idecabtagene vicleucel (Abecma)
- Carvykti (ciltacabtagene autoleucel) (CAR-T)

– Gene Replacement Therapy (If the benefit is covered, Precertification is required). Including, but not limited to:
  - Gene Therapy for Ocular Conditions/ Voretigene neparvovec-rzyl (Luxturna™)
  - Gene Therapy for Spinal Muscular Atrophy/ onasemnogene abeparvovec-xioi (Zolgensma®)
  - Gene Therapy for Hemophilia
  - Gene Therapy for Beta Thalassemia Betibeglogene autotemcel (ZYNTEGLO)
  - Gene Therapy for Cerebral Adrenoleukodystrophy (CALD)

Mental Health/Substance Use Disorder (MH/SUD):
Precertification Required

Acute Inpatient Admissions
Transcranial Magnetic Stimulation (TMS)
Residential Care
Behavioral Health in-home Programs
Applied Behavioral Analysis (ABA)*
Intensive Outpatient Therapy (IOP)**
Partial Hospitalization (PHP)**

*Precertification for ABA is recommended and applies unless the group specifically opts out of clinical review for this benefit. Retrospective review is allowed.

** Please check benefits for any exclusions, or specific Precertification requirements.

Other Outpatient and Surgical Services:
Aduhelm (aducanumab)
Air and Water Ambulance (excludes 911 initiated emergency transport)
Abdominoplasty and Panniculectomy
Ablative Techniques as a Treatment for Barrett's Esophagus
Allogeneic, Xenographic, Synthetic Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting
  - Insertion/injection of prosthetic material collagen implants

Axial Lumbar Interbody Fusion
Balloon Sinus Ostial Dilation
Bariatric Surgery and Other Treatments for Clinically Severe Obesity (If the benefit is covered, Precertification is required.)
Blepharoplasty, Blepharoptosis Repair, and Brow Lift
Bone-Anchored and Bone Conduction Hearing Aids
Breast Procedures; including Reconstructive Surgery, Implants, and other Breast Procedures
Bronchial Thermoplasty
Cardiac Contractility Modulation Therapy
Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
Cardioverter Defibrillator
Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty
Cervical and Thoracic Discography

Cochlear Implants and Auditory Brainstem Implants

Corneal Collagen Cross-Linking

Cosmetic and Reconstructive Services: Skin Related, including, but not limited to:

- Brachioplasty
- Chin Implant, Mentoplasty, Osteoplasty Mandible
- Procedures Performed on the Face, Jaw, or Neck (including facial dermabrasion, scar revision)

Cosmetic and Reconstructive Services of the Trunk and Groin, including, but not limited to:

- Brachioplasty
- Buttock/Thigh Lift
- Congenital Abnormalities
- Lipectomy/Liposuction
- Repair of Pectus Excavatum/Carinatum
- Procedures on the Genitalia

Cosmetic and Reconstructive Services of the Head and Neck, including, but not limited to:

- Facial Plastic Surgery Otoplasty - Rhinophyma
- Rhinoplasty or Rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty)
- Rhytidectomy (Face lift)
- Cranial Nerve Procedures
- Ear or Body Piercing
- Frown Lines
- Neck Tuck (Submental Lipectomy)

Cryosurgical Ablation of Solid Tumors Outside the Liver

Deep Brain, Cortical, and Cerebellar Stimulation

Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems

Doppler-Guided Transanal Hemorrhoidal Dearterialization (THD)

Electrophysiology-Guided Noninvasive Stereotactic Cardiac Radioablation

Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities)

Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis

Focal Laser Ablation for the Treatment of Prostate Cancer

Functional Endoscopic Sinus Surgery (FESS)

Home Parenteral Nutrition

Hyperbaric Oxygen Therapy (Systemic/Topical)

Immunoprophylaxis for respiratory syncytial virus (RSV)/ Synagis (palivizumab)

Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry

Implantable Infusion Pumps

Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)

Implanted Devices for Spinal Stenosis

Implanted Artificial Iris Devices

Implanted Port Delivery Systems to Treat Ocular Disease

Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain

Intracardiac Ischemia Monitoring

Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)

Keratoprosthesis
Leadless Pacemaker
Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies
Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
Lysis of Epidural Adhesions
Mandibular/Maxillary (Orthognathic) Surgery
Manipulation Under Anesthesia
Mastectomy for Gynecomastia
Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
Meniscal Allograft Transplantation of the Knee
Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis
Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring
Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
Partial Left Ventriculectomy
Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention
Penile Prosthesis Implantation
Percutaneous and Endoscopic Spinal Surgery
Percutaneous Neurolysis for Chronic Neck and Back Pain
Percutaneous Vertebral Disc and Vertebral Endplate Procedures
Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
Perirectal Spacers for Use During Prostate Radiotherapy
Photocoagulation of Macular Drusen
Presbyopia and Astigmatism-Correcting Intraocular Lenses
Private Duty Nursing in the Home Setting (If the benefit is covered, Precertification is required.)
Reduction Mammaplasty
Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention
Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
Sacroiliac Joint Fusion, Open
Self-Expanding Absorptive Sinus Ostial Dilation
Sipuleucel-T (Provenge®) Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
Surgical and Ablative Treatments for Chronic Headaches
Therapeutic Apheresis
Total Ankle Replacement
Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins
Transcatheter Heart Valve Procedures
Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia, and Gastroparesis
Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects
Treatment of Osteochondral Defects
Treatment of Temporomandibular Disorders
Treatment of Varicose Veins (Lower Extremities)
Treatments for Urinary Incontinence

Vagus Nerve Stimulation

Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome and Varicocele

Venous Angioplasty with or without Stent Placement/Venous Stenting

Viscocanalostomy and Canaloplasty

Wireless Cardiac Resynchronization Therapy for Left Ventricular Pacing

Wearable Cardioverter-Defibrillator

Out-of-Network Referrals:
Out-of-Network Services for consideration of payment at Network benefit level (may be authorized, based on Network availability and/or Medical Necessity.)

Radiation Therapy/ Radiology Services

Intensity Modulated Radiation Therapy (IMRT)

MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications

Proton Beam Therapy

Cryosurgical or Radiofrequency Ablation to Treat Solid Tumors Outside the Liver

Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)

Catheter-based Embolization Procedures for Malignant Lesions Outside the Liver

Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule

Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy (Azedra, Lutathera, Pluvicto, Zevalin)

Xofigo (Radium Ra 223 Dichloride)

Services not requiring Precertification for coverage, but recommended for pre-determination of Medical Necessity due to the existence of post service claim edits and/or the potential cost of services to the member if denied by Anthem for lack of Medical Necessity:

Procedures, equipment, and/or specialty infusion Drugs which have Medically Necessary criteria determined by Corporate Medical Policy or Adopted Clinical Guidelines.

Utilizing an Out-of-Network Provider may result in significant additional financial responsibility for You. Except for Surprise Billing Claims, if You use an Out-of-Network Provider, You may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount. Depending on the service, this difference can be substantial.

The ordering Provider, Facility or attending Physician should contact the Claims Administrator to request a Precertification or predetermination review ("requesting Provider"). The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, You may designate an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is Responsible for Precertification?

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with the Claims Administrator to ask for a Precertification. However, You may request a Precertification or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventive care clinical coverage guidelines, to assist in making Medical Necessity decisions. The Claims Administrator reserves the right to review and update these clinical coverage guidelines periodically. Your Employer's Group Health Plan Document takes precedence over these guidelines.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to Your request. To request this information, contact the Customer Service telephone number on Your Identification Card.

If You are not satisfied with the Plan's decision under this section of Your benefits, please refer to the Your Right To Appeal section to see what rights may be available to You.

Important Information

The Claims Administrator may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if at the Claims Administrator's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, the Claims Administrator may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. The Claims Administrator may also exempt Your claim from medical review if certain conditions apply.

Just because the Claims Administrator exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that the Claims

Administrator will do so in the future, or will do so in the future for any other Provider, claim or Member. The Claims Administrator may stop or modify any such exemption with or without advance notice. You may determine whether a Provider is participating in certain programs by contacting the customer service number on the back of your ID card.

The Claims Administrator also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then the Claims Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

2. Request Categories:

   - **Urgent –** A request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the Member to severe pain that cannot be adequately managed without such care or treatment.
   - **Pre-Service –** A request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.
   - **Concurrent/Continued Stay Review -** A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
   - **Post-Service -** A request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

3. Decision and Notification Requirements

   The Claims Administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on Federal laws. You may call the phone number on the back of Your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorizations	24 hours from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-Urgent Continued Stay/Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make a decision, the Claims Administrator will tell the requesting Provider of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed by the required timeframe, the Claims Administrator will make a decision based upon the information it has.

The Claims Administrator will notify You and Your Provider of its decision as required by Federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information
From time to time certain medical management processes (including utilization management, case management, and disease management) may be waived, enhanced, changed or ended. An alternate benefit may be offered if in the Plan's sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

Certain qualifying Providers may be selected to take part in a program or a provider arrangement that exempts them from certain procedural or medical management

processes that would otherwise apply. Your claim may also be exempted from medical review if certain conditions apply.

Just because a process, Provider or Claim is exempted from the standards which otherwise would apply, it does not mean that this will occur in the future, or will do so in the future for any other Provider, claim or Member. The Plan may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a provider arrangement by contacting the Member Services number on the back of Your Identification Card.

The Claims Administrator also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then the Claims Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

4. Health Plan Individual Case Management

   The Claims Administrator's health plan case management programs (Case Management) helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Claims Administrator's programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

   The Claims Administrator's Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving

   If You meet program criteria and agree to take part, the Claims Administrator will help You meet your identified health care needs. This is reached through contact and team work with You and/or your authorized representative, treating Doctor(s), and other Providers.

   In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving You information about external agencies and community-based programs and services.

   In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service through the Claims Administrator's Case Management program. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. The Claims Administrator's will

make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis, if in the Claims Administrator's discretion the alternate or extended benefit is in the best interest of the Member and the Plan. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to You or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify You or your representative in writing.

All admissions approved by the Health Care Management Pre-certification Program will be covered in accordance with Plan provisions. Admissions which are not approved by the pre-determination review process are subject to denial or reductions in payment for hospital and doctors charges. The member will not be responsible for hospital and doctor costs unless the member has been verifiably notified in writing that an admission request has been denied and the member enters the hospital against all medical advice, including the member's own doctors.

However if the member's Network doctor or hospital fails to request pre-determination approval for an inpatient hospital stay, the member will not be held responsible for any expenses resulting from denials or reductions in payments for covered services.

(h) Benefits

Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details. All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers**.**

1. Ambulance Service

   Medically Necessary ambulance services are a Covered Service when:

   a) You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

      And one or more of the following criteria are met:

   b) For ground ambulance, You are taken:

      - From your home, the scene of an accident or medical Emergency to a Hospital;
      - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital

- Between a Hospital and a Skilled Nursing Facility or other approved Facility.

c) For air or water ambulance, You are taken:

- From the scene of an accident or medical Emergency to a Hospital;
- Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
- Between a Hospital and an approved Facility.

Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-Emergency Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, for non-Emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if You are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering Your health. Ambulance services for your convenience or the convenience of Your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A Doctor's office or clinic;
- A morgue or funeral home

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if You are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if You are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation Facility), or if You are taken to a Physician's office or your home.

Hospital to Hospital Transport

If You are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give You the medical services You need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You**.** Coverage is not available for air ambulance transfers simply because You, Your family, or Your Provider prefers a specific Hospital or Physician.

2. Assistant Surgery

   Services rendered by an assistant surgeon are covered based on Medical Necessity.

3. Breast Cancer Care

   Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

4. Breast Reconstructive Surgery

   Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

5. Cardiac Rehabilitation

   Covered Services are provided as outlined in the **Schedule of Benefits.**

6. Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to You as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

a) Federally funded trials approved or funded by one of the following:

   i. The National Institutes of Health.

   ii. The Centers for Disease Control and Prevention.

   iii. The Agency for Health Care Research and Quality.

   iv. The Centers for Medicare & Medicaid Services.

   v. Cooperative group or center of any of the entities described in (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

   vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

   vii. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

      (i) The Department of Veterans Affairs.

      (ii) The Department of Defense.

      (iii) The Department of Energy.

b) Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

c) Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require You to use a Network Provider to maximize your benefits.

Routine patient care costs include items, services, and Drugs provided to You in connection with an approved clinical trial that would otherwise be covered by this Plan.

All other requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. The Plan reserves its right to exclude any of the following services:

- The Experimental/Investigative item, device, or service; or
- Items and services that are provided only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

7. Consultation Services

   Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.

   Staff consultations required by Hospital rules are excluded. Referrals, the transfer of a patient from one Physician to another for treatment, are not consultations under this Plan.

8. Dental Services – Related to Accidental Injury

   Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an Accidental Injury, except where the chewing or biting results from an act of domestic violence or directly from a medical condition.

   Treatment must be completed within the timeframe shown in the Schedule of Benefits.

Other Dental Services

Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:

- The Member is under the age of five (5);
- The Member has a severe disability that requires hospitalization or general anesthesia for dental care; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

9. Diabetes

Equipment and Outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for Outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

10. Dialysis Treatment

The Plan covers Covered Services for Dialysis treatment. After 30 months, the Plan will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare, per Medicare requirements.

11. Durable Medical Equipment

This Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or Injured;
- It is ordered by a Physician;

- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the Member's physical disorder

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation will not be covered. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

12. Emergency Services

*Life-threatening Medical Emergency or serious Accidental Injury***.**

Coverage is provided for Hospital emergency room care including a medical or behavioral health screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition; and within the capabilities of the staff and Facilities available at the Hospital, such further medical or behavioral health examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any Prior Authorization from the Plan.

Stabilize means, with respect to an Emergency Medical Condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

The Maximum Allowed Amount for emergency care from an Out-of-Network Provider will be the greatest of the following:

- The amount negotiated with Network Providers for the Emergency service furnished;
- The amount for the Emergency Service calculated using the same method the Claims Administrator generally uses to determine payments for Out-of-Network

services but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or

- The amount that would be paid under Medicare for the Emergency Service.

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network are shown in the Schedule of Benefits.

13. General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

14. Habilitative Services

Benefits also include habilitative health care services and devices that help You keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

15. Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the **Schedule of Benefits**. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network or Out-of-Network Providers.

Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.

- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce Outpatient benefits available under the Physical Therapy section shown in this Plan.

- A Member must be essentially confined at home.

Covered Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:

- Food, housing, homemaker services, sitters, home-delivered meals.
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
- Services and/or supplies which are not included in the Home Health Care plan as described.
- Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse.
- Any services for any period during which the Member is not under the continuing care of a Physician.
- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member.
- Any services or supplies not specifically listed as Covered Services.
- Routine care and/or examination of a newborn child.
- Dietician services.

- Maintenance therapy.
- Dialysis treatment.
- Purchase or rental of dialysis equipment.

16. Hospice Care Services

You are eligible for Hospice care if Your Doctor and the Hospice medical director certify that You are terminally ill and likely to have less than twelve (12) months to live. You may access Hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by Your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for Covered Services beyond those listed above that are given for disease modification or palliation, such as but not limited to, chemotherapy and radiation therapy, are available to a Member in Hospice. These Services are covered under other parts of this Benefit Booklet.

17. Hospital Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

a) Network

Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent Semiprivate rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Service and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.

- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

Determined by Medical Necessity.

b) Out-of-Network

Hospital Benefits

- If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **"Schedule of Benefits"** section.

18. Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

19. Human Organ and Tissue Transplant Services

Notification

To maximize your benefits, You need to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider to receive the maximum benefits.

Contact the customer service telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or benefit booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

At a Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Call the Claims Administrator for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

In order to maximize Your benefits, the Claims Administrator strongly encourages You to call its' transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. The Claims Administrator will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone

number on the back of Your Identification Card **and ask for the transplant coordinator.** Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call the Claims Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide *assistance with reasonable and necessary travel expenses as* determined by the Claims Administrator when You obtain prior approval and are required to travel more than 50 miles from Your residence to reach the facility where Your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the Facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

20. Licensed Speech Therapist Services

Services must be ordered and supervised by a Physician as outlined in the **Schedule of Benefits.** Speech Therapy is not covered when rendered for the treatment of Developmental Delay.

21. Maternity Care & Reproductive Health Services

Covered Services are provided for Network Maternity Care subject to the benefit stated in the **Schedule of Benefits**. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the **Schedule of Benefits**.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well-baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See "Changing Coverage (Adding a Dependent)" to add a newborn to Your coverage.)

Under federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the Member's attending Physician.

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Infertility Services

Your Plan also includes benefits for the diagnosis of Infertility. See the Schedule of Benefits for benefit limitations, Coinsurance and Copayment amounts Sterilization Services

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or Injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

22. Medical Care

General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

23. Nutritional Counseling

Nutritional counseling related to the medical management of a disease state as stated in the Schedule of Benefits.

24. Out-of-Network Freestanding Ambulatory Facility

Any services rendered or supplies provided while You are a patient or receiving services at or from a Out-of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

25. Out-of-Network Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **"Schedule of Benefits"** section.

26. Obesity

Prescription Drugs and any other services or supplies for the treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan

27. Oral Surgery

Covered Services include only the following:

- Fracture of facial bones;
- Removal of impacted teeth;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do not include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and

- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Member is covered by this Plan and performed within the timeframes shown in the Schedule of Benefits after the accident.

Although this Plan covers certain oral surgeries as listed above, many oral surgeries are not covered. Covered Services also include the following:

- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

28. Other Covered Services

Your Plan provides Covered Services when the following services are Medically Necessary:

- Chemotherapy and radioisotope, radiation and nuclear medicine therapy
- Diagnostic x-ray and laboratory procedures
- Dressings, splints, casts when provided by a Physician
- Oxygen, blood and components, and administration
- Pacemakers and electrodes
- Use of operating and treatment rooms and equipment
- HIV Testing will be provided on the same basis as other covered diagnostic tests. Such tests must be appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition.
- Treatments for Rabies-benefits are provided at 100% of the Allowable Charge.

29. Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

30. Outpatient Hospital Services

The Plan provides Covered Services when the following outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays and laboratory services. Certain procedures require Precertification.

31. Outpatient Surgery

Network Hospital Outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under “Hospital Services”.

32. Physical Therapy, Occupational Therapy, Chiropractic Care

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), or a licensed chiropractor (D.C.) as outlined in the **Schedule of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual provider. No coverage is available when such services are necessitated by Developmental Delay.

33. Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements.

34. Preventive Care

Preventive Care services include screenings and other services for adults and children. All preventive services will be covered as required by the Affordable Care Act (ACA). This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when You use a Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under diagnostic services instead of this benefit, if the coverage does not fall with ACA-recommended preventive services.

Covered Services fall under the following broad groups:

a) Services with an “A” or “B” rating from the United States Preventive Services Task Force.

Examples of these services are screenings for:

- Breast cancer (mammograms);
- Cervical cancer (Pap smears);
- Colorectal cancer (colonoscopies);
- High Blood Pressure;
- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child and Adult Obesity

b) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention,

c) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

d) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

i. Women's contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.

ii. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

iii. Gestational diabetes screening.

e) Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:

i. counseling;

ii. Prescription Drugs; and

iii. Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

f) Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

i. aspirin;

ii. folic acid supplement;

iii. vitamin D supplement; and

iv. bowel preparations.

Please note that certain age and gender and quantity limitations apply.

You may call Customer Service using the number on Your Identification Card for additional information about these services or view the Federal government's web sites,

http://www.healthcare.gov/center/regulations/prevention.html, or http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.)

35. Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic Injuries; electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

36. Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance . Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan

Note: Coverage for reconstructive services does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

37. Retail Health Clinic

Benefits are provided for Covered Services received at a Retail Health Clinic (e.g., CVS Minute Clinics).

38. Skilled Nursing Facility Care

Benefits are provided as outlined in the **Schedule of Benefits**. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- a favorable prognosis;
- a reasonably predictable recovery time; and
- services and/or Facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member's residence.

Covered Services include:

- semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- use of special care rooms;
- pathology and radiology;
- physical or speech therapy;
- oxygen and other gas therapy;
- drugs and solutions used while a patient; or
- gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- A Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for mental illness including drug addiction, chronic brain syndromes and alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- No specific medical conditions exist that require care in a Skilled Nursing Facility; or
- The care rendered is for other than Skilled Convalescent Care.

40. Surgical Care

Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

41. Treatment of Accidental Injury in a Physician's Office

All Outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Member's Physician's office benefit if services are rendered by a Network Provider; services rendered by Out-of-Network Providers are subject to Deductible and Coinsurance requirements.

42. Prescription Drugs Administered by a Medical Provider

This Plan covers Prescription Drugs when they are administered to You as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables and any drug that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to You. Benefits for Drugs that You inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under your Employer's Prescription Drug Plan. Also, if Prescription Drugs are covered under your Employer's Prescription Drug Plan they will not be covered under this benefit.

Covered Prescription Drugs
To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under Federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider, and Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Compound Drugs are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound Drug are FDA approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and are not essentially the same as an FDA approved product from a Drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

What's Not Covered
- Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, and require a Prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a Drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- Drugs not approved by the FDA.

Important Details About Prescription Drug Coverage
Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing Doctor may be asked to give more details before the Plan decides if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, the Claims Administrator has established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:
- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),

- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of an Anthem Prescription Drug List (a formulary developed by the Claims Administrator which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. The Claims Administrator will give the results of the Plan's decision to both You and Your Provider.

For a list of Prescription Drugs that need precertification, please call the phone number on the back of Your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with the Claims Administrator to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section **Health Care Management - Precertification** for more details.

If precertification is denied You have the right to file an appeal as outlined in the **Your Right To Appeal** section of this Benefit Booklet.

Designated Pharmacy Provider

The Plan in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. A Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider Agreement with the Claims Administrator. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to You or Your Provider and administered in Your Provider's office, You and Your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with You and Your Provider to obtain Precertification and to assist shipment to Your Provider's office.

You may also be required to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. The Plan reserves the right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to You. The Plan may from time to time, change with or without advance notice, the Designated Pharmacy

Provider for a Drug, if in the Plan's discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network level.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of Your Identification Card or check the Claims Administrator's website at www.anthem.com.

Therapeutic Substitution
Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed Drugs. The Claims Administrator may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of Your Identification Card.

Voluntary Site of Care Redirection
Our Voluntary Site of Care Redirection program identifies Members taking clinician-infused or injected specialty Prescription Drugs (non-oncology) in the Hospital outpatient setting. This program attempts to suggest to Members to lower-cost infusion suites or a home setting that can meet the same specialty Prescription Drug treatment needs. By performing a detailed claims and active precertification analysis, Anthem is able to identify Members and their prescribing physicians who may benefit from site of care redirection. These Members receive outreach from a team of registered nurses who help inform Members of the availability of alternative sites as well as the potential savings by using these alternative locations.
Currently, Members who are prescribed Specialty Prescription Drug treatment can receive their clinician-infused or injected Prescription Drugs across an array of alternative settings typically selected by the prescribing or treating Provider. The outpatient Hospital setting can result in a much higher cost for the same infusion service. Lowering overall claim cost can also result in savings based on the Member's plan design and other factors.

How the Program Works
Anthem collaborates with our preferred Medical Specialty Provider to deliver the Voluntary Site of Care Redirection program. Our Provider has a national presence but provides a local touch for Members.
Members who utilize Prescription Drugs on a defined list receive letters to notify them of clinically appropriate, lower-cost site of care options. Following the letters, skilled nurses will make a series of up to three phone calls to discuss the program with the Member. If the Member chooses to redirect care a use a lower cost setting, our Medical Specialty Provider coordinates the care either at home or an infusion suite, and continues to provide clinical care and ongoing monitoring.

c) LIMITATIONS AND EXCLUSIONS

These limitations and exclusions apply even if a qualified practitioner has performed or prescribed a Medically Necessary procedure, treatment or supply. This does not prevent your qualified practitioner from providing or performing the procedure, treatment or supply. Regardless, the procedure, treatment or supply will not be a covered expense.

1. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military Facilities except as required by law.
2. Services for Custodial Care.
3. Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.
4. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.
5. Charges for treatment received before coverage under this option began or after it is terminated.
6. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator’s judgment, Experimental or Investigational for the diagnosis for which the Member is being treated.
7. Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or Injury, as determined by the Claims Administrator.
8. Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.

9. Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed medically necessary).
10. Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
11. Services paid under Medicare. With respect to end-stage renal disease (ESRD), after 30 months, Medicare shall be treated as the primary payor whether or not the Participant has enrolled in Medicare Part B.
12. Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.
13. Court-ordered services, or those required by court order as a condition of parole or probation, unless Medically Necessary and approved by the Plan.
14. Outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this medical plan. Although coverage for Outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under your medical benefits when rendered in a Hospital, in a Physician's office, or as part of a Home Health Care benefit. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in your Physician's office.
15. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
16. Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet The Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
17. Vitamins, minerals and food supplements, as well as vitamin injections not determined to be medically necessary in the treatment of a specific illness. Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary.

18. Services for Hospital confinement primarily for diagnostic studies.
19. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when medically necessary to correct damage caused by an accident, an Injury or to correct a congenital defect.
20. Donor Search/Compatibility, except as otherwise indicated.
21. Contraceptive Drugs, except for any above stated covered contraceptive devices.(See prescription drug benefits)
22. Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
23. Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided in this Benefit Booklet.
24. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
25. Christian Science Practitioner Services.
26. Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products unless otherwise required by law. (See prescription drug benefits)
27. Services provided in a Residential Treatment Center (RTC).
28. Services provided in a Halfway House.
29. Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Member by a local, state or federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Member is not required to pay for them or they are provided to the Member for free.
30. Routine care is not covered. Except for above stated covered preventive care services.
31. Services or supplies provided by a member of your family or household.

32. Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator for out-of-network claims.
33. Fees or charges made by an individual, agency or Facility operating beyond the scope of its license.
34. Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
35. Services for any form of telecommunication, unless otherwise noted in the benefits.
36. Charges for any of the following:
    a) Failure to keep a scheduled visit;
    b) Completion of claim forms or medical records or reports unless otherwise required by law;
    c) For Physician or Hospital's stand-by services;
    d) For holiday or overtime rates.
    e) Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
    f) Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
37. Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered Facility, which makes their services available.
38. Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
39. Reversal of vasectomy or reversal of tubal ligation.
40. Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and actinic changes.
41. Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy,

purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy and boot camp therapy.

42. Vision care services and supplies, including but not limited to eyeglasses, contact lenses and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery or for soft contact lenses due to a medical condition, i.e. diabetes. (See Vision Plan for coverage.)
43. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
44. Services for weight loss programs, services and supplies. Weight loss programs included but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss).
45. Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

d) CLAIMS PAYMENT

Providers who participate in the BlueCard® PPO Network have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore, if the BlueCard® PPO Network Hospitals, Physicians and Ancillary Providers are used, claims for their services will generally not have to be filed by the Member. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the provider requests a claim form to file a claim, a claim form can be obtained by contacting the HR Service Center at 1-800-344-8339 or by email to hrsc@volvo.com or by visiting www.anthem.com.

Please note You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign providers from sending Your claims and other personal information to the Claims Administrator.

1. How to File Claims

Under normal conditions, the Claims Administrator should receive the proper claim form within 12 months after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for You.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan.

When You receive Covered Services from a Network Physician or other Network licensed health care provider, payment for Covered Services will be made directly to the provider.

For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from the HR Service Center or the Claims Administrator. Claims should include Your name, Plan and Group numbers exactly as they appear on Your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

Save all bills and statements related to Your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

2. Maximum Allowed Amount

a) General

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that You receive. Please see the Inter-Plan Programs section for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and

- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. In addition, when You receive Covered Services from an Out-of-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When You receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

b) Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or an Out-of-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered

Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services You receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by the Claims Administrator:

i. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

ii. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or

iii. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or

iii. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

iv. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

Unlike Network Providers, Out-of-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out of Pocket costs to You. Please call Customer Service for help in finding a Network Provider or visit the Claims Administrator's website at www.anthem.com.

Customer Service is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out of Pocket responsibility. Although Customer Service can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

c) Member Cost Share

i. For certain Covered Services and depending on Your plan design, You may be required to pay a part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

ii. Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Out-of-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Out-of-Network Providers. Please see the Schedule of Benefits in this Benefit Booklet for Your cost share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or cost share amounts may vary by the type of Provider You use.

iii. The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by

Your Provider for non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Benefit Booklet and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

iv. In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or Facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

d) Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

3. Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowed Amount. **If services are performed by Out-of-Network Providers,** then You are responsible for any amounts charged in excess of the Plan's Maximum Allowed Amount **with or without a referral or regardless if allowed as an Authorized Service**. Contact the Claims Administrator for more information.

4. Processing Your Claim

You are responsible for submitting Your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain You have Your Identification Card with You. Be sure Hospital or Physician's office personnel copy Your name, and identification numbers (including the 3-letter prefix) accurately when completing forms relating to Your coverage.

5. Timeliness of Filing for Member Submitted Claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

6. Necessary Information

In order to process Your claim, the Claims Administrator may need information from the provider of the service. As a Member, You agree to authorize the Physician, Hospital, or other provider to release necessary information.

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

7. Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

8. Member's Cooperation

You will be expected to complete and submit to Anthem all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If You fail to cooperate (including if You fail to enroll under Part B of the Medicare program where Medicare is the responsible payer), You will be responsible for any charge for services.

9. Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement sent by the Claims Administrator, to help You understand the coverage You are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by Your coverage;
- the amount for which You are responsible (if any); and
- general information about Your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

10. Inter-Plan Programs

a) Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain healthcare services outside of Anthem's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem's service area, You will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from nonparticipating healthcare Providers. Anthem's payment practices in both instances are described below.

b) BlueCard® Program

Under the BlueCard® Program, when You access covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling Anthem's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever You access covered healthcare services outside Anthem's service area and the claim is processed through the BlueCard Program, the amount You pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for Your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate your liability for any covered healthcare services according to applicable law.

You will be entitled to benefits for healthcare services that You accessed either inside or outside the geographic area Anthem serves, if this Booklet covers those healthcare services. Due to variations in Host Blue network protocols, You may also be entitled to benefits for some healthcare services obtained outside the geographic area Anthem serves, even though You might not otherwise have been entitled to benefits if You had received those healthcare services inside the geographic area Anthem serves. But in no event will You be entitled to benefits for healthcare services, wherever You

received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Plan.

c) Non-Participating Healthcare Providers Outside Anthem's Service Area

i. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem's Service Area by non-participating providers, the Plan may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or Federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the non-participating provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for Out-of-Network Emergency services.

ii. Exceptions

In certain situations, the Plan may use other pricing methods, such as billed charges or the pricing the Plan would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount the Plan will pay for services provided by nonparticipating providers. In these situations, You may be liable for the difference between the amount that the nonparticipating provider bills and the payment the Plan make for the Covered Services as set forth in this paragraph.

11. Unauthorized Use of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

12. Assignment

You authorize the Claims Administrator, on behalf of the Employer, to make payments directly to Providers for Covered Services. The Claims Administrator also reserves the right to make payments directly to You. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or

that person's custodial parent or designated representative. Any payments made by the Claims Administrator will discharge the Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

13. Questions About Coverage or Claims

If You have questions about Your coverage, contact Your Plan Administrator or the Claims Administrator's Customer Service Department. Be sure to always give Your Member Identification number.

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a Network Provider, call them directly or call the Claims Administrator.

The Plan does not supply You with a Hospital or Physician. In addition, neither the Plan nor the Claims Administrator is responsible for any Injuries or damages You may suffer due to actions of any Hospital, Physician or other person. In order to process Your claims, the Claims Administrator or the Plan Administrator may request additional information about the medical treatment You received and/or other group health insurance You may have. This information will be treated confidentially.

An oral explanation of Your benefits by an employee of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding.

Any correspondence mailed to You will be sent to Your most current address. You are responsible for notifying the Plan Administrator or the Claims Administrator of Your new address.

e) YOUR RIGHT TO APPEAL

The Plan wants Your experience to be as positive as possible. There may be times, however, when You have a complaint, problem, or question about Your Plan or a service You have received. In those cases, please contact Member Services by calling the number on the back of Your Identification Card. The Claims Administrator will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with the resolution of Your complaint, You have the right to file an appeal, which is defined as follows:

For purposes of these appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which You have not received the benefit or for which You may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which You have received the service.

If Your claim is denied or if Your coverage is rescinded:
- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable Federal regulations.

Notice of Adverse Benefit Determination
If Your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:
- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under ERISA, if this Plan is subject to ERISA, within one year of the grievance or appeal decision if You submit a grievance or appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about Your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on Medical Necessity or experimental treatment, or about Your right to request this explanation free of charge, along with a discussion of the claims denial decision; and,
- information regarding Your potential right to an External Appeal pursuant to Federal law.

For claims involving urgent/concurrent care:

- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify You or Your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or Your authorized representative must file Your appeal within 180 calendar days after You are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting Your claim. The Claims Administrator's review of Your claim will take into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination.

The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, You may obtain an expedited appeal. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, You or Your authorized representative must contact the Claims Administrator at the number shown on Your Identification Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g., Urgent Care). You or Your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

You must include Your Member Identification Number when submitting an appeal.

Upon request, the Claims Administrator will provide, without charge, reasonable access

to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

The Claims Administrator will also provide You, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with Your claim. In addition, before You receive an adverse benefit determination or review based on a new or additional rationale, the Claims Administrator will provide You, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided
When the Claims Administrator considers Your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal
If You appeal a claim involving urgent/concurrent care, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

If You appeal any other pre-service claim, the Claims Administrator will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

If You appeal a post-service claim, the Claims Administrator will notify You of the

outcome of the appeal within 60 days after receipt of Your request for appeal.

Appeal Denial
If Your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

If, after the Plan's denial, the Claims Administrator considers, relies on or generates any new or additional evidence in connection with Your claim, the Claims Administrator will provide You with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal decision on a new or additional rationale without first providing You (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond the Claims Administrator's control.

Voluntary Second Level Appeals
If You are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If You would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review
If the outcome of the mandatory first level appeal is adverse to You and it was based on medical judgment, or if it pertained to a rescission of coverage, You may be eligible for an independent External Review pursuant to Federal law.

You must submit Your request for External Review to the Claims Administrator within four (4) months of the notice of Your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal appeal. However, You are encouraged to submit any additional information that You think is important for review.

For pre-service claims involving urgent/concurrent care, You may proceed with an expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To proceed with an expedited External Review, You or Your authorized

representative must contact the Claims Administrator at the number shown on Your Identification Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by You or Your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

You must include Your Member identification number when submitting an appeal.

This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other benefits under this health care plan. There is no charge for You to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an Appeal before filing a lawsuit
No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If Your health benefit plan is sponsored by Your Employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and Your appeal as described above results in an adverse benefit determination, You have a right to bring a civil action under Section 502(a) of ERISA within one year of appeal decision.

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

f) COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's Maximum Allowed Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group **and non group** insurance **contracts** and subscriber contracts; Health Maintenance Organization (HMO) contracts; uninsured arrangements of group or group-type coverage; coverage under group or **non group closed panel** plans; group-type contracts; m**edical care components of long term care contracts, such as skilled nursing care;** medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); other governmental benefits, except for Medicare, Medicaid or **a government** plan **that,** by law, **provides** benefits **that are** in excess of those of any private insurance plan or other non-governmental plan.
2. Plan does not include: **Accident only coverage; specified disease** or **specified accident coverage; limited health benefit** coverage; benefits for non-medical components of long term care policies; Hospital indemnity **coverage** benefits or **other fixed indemnity coverage;** school accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and **Medicare supplement policies**.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has

two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the

Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.

5. The amount that is subject to the Primary high-Deductible health plan's Deductible, if the Claims Administrator has been advised by You that all Plans covering You are high-Deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When You are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an Employee, Member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of Federal law, Medicare is

secondary to the Plan covering You as a Dependent and primary to the Plan covering You as other than a Dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering You as an Employee, Member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering You as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
   - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
   - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
     - the Plan covering the custodial parent;
     - the Plan covering the Spouse of the custodial parent;
     - the Plan covering the non-custodial parent; and then
     - the Plan covering the Spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of items 1. or 2. above will determine the order of benefits as if those individuals were the parents of the child.
4. For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouses plan, Rule 5 applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule in item 1 above to the Dependent child's parent(s) and the Dependent's spouse.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active Employee, that is, an Employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off Employee is the Secondary Plan. The same would hold true if You are a Dependent of an active Employee and You are a Dependent of a retired or laid-off Employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA. If You are covered under COBRA or under a right of continuation provided by other Federal law and are covered under another Plan, the Plan covering You as an Employee, Member, subscriber or retiree or covering You as a Dependent of an Employee, Member, subscriber or retiree is the Primary Plan and the COBRA or other Federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- Dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an Employee or as a retired Employee and is covered under his or her own Plan as an Employee, Member, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a Dependent of an Employee, Member or subscriber or retired Employee and is covered under the other plan as a Dependent of an Employee, Member, subscriber or retiree).

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered You longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule 6 - If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When a Member is covered under two or more Plans which together pay more than the Allowable expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is primary. However, when this Plan is secondary under the Order of Benefit Determination Rules, it starts with this Plan's Allowable expense, deduct the Primary Plan's payment and then deduct any Deductibles, Coinsurance or Copayments.

If You are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts it needs from, or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts the Claims Administrator needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:
1. the Plan has paid or for whom the Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary
To the extent permitted by law, this Plan will pay Benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:
- Subscribers with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare
If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge You if they don't accept Medicare) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Allowable Expense.

If You are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if You had been enrolled in Medicare.

g) SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained and You have a right to a Recovery or have received a Recovery from any source.

1. Recovery

   A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

2. Subrogation

   The Plan has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

   - The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
   - You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
   - In the event that You or Your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.

- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

3. Reimbursement

   If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

   - You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

   - Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.

   - You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.

   - Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.

   - You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:

    1. the amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or

    2. You fail to cooperate**.**

- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

- The Plan shall also be entitled to recover any of the unsatisfied portions of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.

- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

4. Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal Injury or illness to You occurred and all information regarding the parties involved.

- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- You must not do anything to prejudice the Plan's rights.

- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or illness to You.

- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal Injury protection policy regardless of any election made by You to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

General Information

1. Workers' Compensation

   The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent employer liability or indemnification law.

2. Other Government Programs

   Except insofar as applicable law would require the Plan to be the primary payor, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

3. Medicare Program

   Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to Federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and Federal law.

   Except when Federal law required us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to You shall be reimbursed by or on Your behalf to us, to the extent we have made payment for such services. For the purposes of the calibration of benefits, if You have not enrolled in Medicare Part B, we will calculate benefits as if You had enrolled. You should enroll in Medicare Part B as soon as possible to avoid potential liability.

4. Right of Recovery and Adjustment

   Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered

   The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, The Claims Administrator has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. The Claims Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

5. Relationship of Parties (Employer-Member-Claims Administrator)
   Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

   The Employer is fiduciary agent of the Member. The Claims Administrator's notice to the Employer will constitute effective notice to the Member. It is the Employer's duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of

Members if the Employer fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.

6. Relationship of Parties (Claims Administrator - Network Providers)
   The relationship between the Claims Administrator and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Claims Administrator, nor is the Claims Administrator, or any employee of the Claims Administrator, an employee or agent of Network Providers.

   Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Out-of-Network Providers, and disease management programs. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or the Claims Administrator.

7. Anthem Health Plans of Virginia, Inc. Note
   The Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the Employer and Anthem Health Plans of Virginia, Inc. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the Commonwealth of Virginia. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, **an association of independently licensed Blue Cross and Blue Shield plans,** with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

8. Notice

   Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business; to You at the Subscriber's address as it appears on the records or in care of the Employer.

9. Fraud

   Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

10. Conformity with Law

Any provision of the Plan which is in conflict with the applicable federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

11. Clerical Error

Clerical error, whether of the Claims Administrator or the Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

12. Policies and Procedures

The Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

13. Value-Added Programs

The Claims Administrator may offer health or fitness related programs to Members, through which You may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under Your Employer's Group health Plan and could be discontinued at any time. The Claims Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

14. Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

15. Employer’s Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

16. Reservation of Discretionary Authority

The Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Benefit Booklet. The Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable appeals procedures.

17. Governmental Health Care Programs

Under Federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Employees can remain on the Group's Health Plan and receive group benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

18. Medical Policy and Technology Assessment

The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Physicians from various medical specialties including the Claims Administrator's medical directors, Physicians in academic medicine and Physicians in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

19. Payment Innovation Programs

The Claims Administrator pays Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by the Claims Administrator from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to the Claims Administrator under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect Your access to health care. The Program payments are not made as payment for specific Covered Services provided to You, but instead, are based on the Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by or to the Claims Administrator under the Program(s), and You do not share in any payments made by Network Providers to the Claims Administrator under the Program(s).

20. Care Coordination

The Plan pays Network Providers in various ways to provide Covered Services to You. For example, sometimes the Plan may pay Network Providers a separate amount for each Covered Service they provide. The Plan may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Plan may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Plan may pay Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate Network Providers for coordination of Member care. In some instances, Network Providers may be required to make payment to the Plan because they did not meet certain standards. You do not share in any payments made by Network Providers to the Plan under these programs.

21. Program Incentives

The Plan may offer incentives from time to time, at its discretion, in order to introduce You to covered programs and services available under this Plan. The purpose of these incentives include, but is not limited to, making You aware of cost effective benefit options or services, helping You achieve Your best health, and encouraging You to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and

discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as the Plan offers the incentives program. The Plan may discontinue an incentive for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, it is recommended that You consult Your tax advisor.

g) Definitions

1. Accidental Injury

   Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

2. Administrative Services Agreement

   The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

3. Ambulance Services

   A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

4. Authorized Service(s)

   A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Member **may** be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the "Claims Payment" section.

5. Behavioral Health Care

   Includes services for Mental Health and Substance Abuse. Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

6. Benefit Period

   One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

7. Centers of Excellence (COE) Network

   A network of health care Facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

   A network of health care professionals contracted with the Claims Administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

8. Claims Administrator

   The company the Plan Sponsor chose to administer its health benefits. Anthem Health Plans of Virginia was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

9. Coinsurance

   If a Member's coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

10. Combined Limit

    The maximum total of Network and Out-of-Network benefits available for designated health services in the **Schedule of Benefits**.

11. Complications of Pregnancy

Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

12. Congenital Anomaly

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

13. Coordination of Benefits

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

14. Copayment

A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the **Schedule of Benefits** for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the provider when services are rendered.

15. Cosmetic Surgery

Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not

restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

16. Covered Dependent

Any Dependent in a Subscriber's family who meets all the requirements of the Eligibility section of this Benefit Booklet, has enrolled in the Plan, and is subject to Administrative Service Fee requirements set forth by the Plan.

17. Covered Services

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

18. Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

19. Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person

without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

20. Deductible

The portion of the bill You must pay before Your medical expenses become Covered Services.

21. Dependent

The Spouse and all children until attaining age limit stated in the Eligibility section. Children include natural children, legally adopted children and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree. Mentally retarded or physically disabled children remain covered no matter what age. You must give the Claims Administrator evidence of Your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from the Claims Administrator or Your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective.

22. Designated Pharmacy Provider

A Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with the Claims Administrator or a Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

23. Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a Facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

24. Developmental Delay

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no

apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

25. Durable Medical Equipment

Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease of Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

26. Effective Date

The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves each future Member according to its normal procedures.

27. Elective Surgical Procedure

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

28. Emergency Medical Condition

("Emergency services," "emergency care," or "Medical Emergency") Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

29. Employee

A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

30. Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

31. Experimental/Investigative

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a Service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service on health outcomes;

- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and

- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- Documents of an IRB or other similar body performing substantially the same function; or

- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or Facilities or by other treating Physicians, other medical professionals or Facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- Medical records; or

- The opinions of consulting Providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device,

Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

32. Facility

A Facility, including but not limited to Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health Facility, as defined in this Benefit Booklet. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

33. Formulary

A document setting forth certain rules relating to the coverage of pharmaceuticals, that may include but not be limited to (1) a listing of preferred Prescription medications that are covered and/or prioritized in order of preference by the Claims Administrator, and are dispensed to Members through pharmacies that are Network Providers, and (2) Precertification rules. This list is subject to periodic review and modification. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not included in the Formulary.

34. Freestanding Ambulatory Facility

A facility, with a staff of Physicians, at which surgical procedures are performed on an Outpatient basis-no patients stay overnight. The facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed by the appropriate agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

35. Group Health Plan or Plan

An employee welfare benefit plan (as defined in Section 3(1) of ERISA), established by the Employer, in effect as of the Effective Date.

36. Home Health Care

Care, by a licensed program or provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

37. Home Health Care Agency

A provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include

observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed by the appropriate agency.

38. Hospice

A provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate agency.

39. Hospice Care Program

A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

40. Hospital

An institution licensed by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic Facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- an extended care Facility; nursing home; place for rest; facility for care of the aged;
- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

41. Identification Card

The latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

42. Ineligible Charges

Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

43. Ineligible Provider

A provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a provider are not eligible for payment.

44. Infertile or Infertility

The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

45. Initial Enrollee

A person actively employed by the Employer (or one of that person's Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

46. Injury

Bodily harm from a non-occupational accident.

47. Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

48. Intensive Care Unit

A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

49. Intensive Outpatient Programs

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per

day, 3 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licenses and accredited.

50. Late Enrollees

Late Enrollees mean Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan: (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Plan, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan that coverage was declined because other coverage existed.

51. Maternity Care

Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

52. Maximum Allowed Amount

The maximum amount that the Plan will allow for Covered Services You receive. For more information, see the "Claims Payment" section.

53. Medical Necessity (Medically Necessary)

Procedure, supplies, equipment, or services that we conclude are:

- Appropriate for the symptoms, diagnosis, or treatment of a medical condition; and
- Given for the diagnosis or direct care and treatment of the medical condition; and
- Within the standards of good medical practice within the organized medical community; and
- Not mainly for the convenience of the Doctor or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely given.

The most appropriate procedure, supply, equipment, or service must meet the following requirements:

- There must be valid scientific evidence to show that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and will have a

greater change of benefit, without a disproportionately greater risk of harm or complications, than other possible treatments; and

- Generally approved forms of treatment that are less invasive have been tried and did not work or are otherwise unsuitable; and
- For Hospital stays, acute care as an Inpatient is needed due to the kind of services the patient need or the severity of the medical condition, and that safe and adequate care cannot be given as an outpatient or in a less intensive medical setting.

The most appropriate procedure, supply, equipment, or service must also be cost-effective compared to other alternative interventions, including no intervention or the same intervention in an alternative setting.

Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of Your illness, Injury or disease, the service is (1) not more costly than another service or group of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example, we will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the Drug could be provided in a Physician's office or the home setting.

54. Member

Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.

55. Network Provider

A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or Facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements.

56. New Hire

A person who is not employed by the Employer on the original Effective Date of the Plan.

57. Non-Covered Services

Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

58. Out-of-Network Provider

A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers.

59. Out-of-Pocket Maximum

The maximum amount of a Member's Coinsurance payments during a given calendar Plan year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services.

60. Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

61. Pharmacy

An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or an Out-of-Network Provider.

62. Physical Therapy

The care of disease or injury by such methods as massage, hydrotherapy, heat, or similar care.

63. Physician

Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to

practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

64. Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

65. Plan Administrator

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. The Plan Administrator is not the Claims Administrator.

66. Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. The Plan Sponsor is not the Claims Administrator.

67. Prescription Drug (Drug) (Also referred to as Legend Drug)

A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or Injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved, as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin.

68. Primary Care Physician

A provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

69. Prior Authorization

The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

70. Provider

A duly licensed person or Facility that provides services within the scope of an applicable license and is a person or Facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. If you have a question if a Provider is covered, please call the number on the back of Your Identification Card.

71. QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order

A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the Plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each Plan to which the order applies.

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a Group Health Plan Member or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or

- enforces a state law relating to medical child support payment with respect to a Group Health Plan.

72. Residential Treatment Center/Facility

A Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more Doctors available at all times.
- Residential treatment takes place in a structured Facility-based setting.
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.

- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

73. Retail Health Clinic

A Facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

74. Semiprivate Room

A Hospital room which contains two or more beds.

75. Skilled Convalescent Care

Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

76. Skilled Nursing Facility

An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by the Claims Administrator to meet the reasonable standards applied by any of the aforesaid authorities.

77. Specialist (Specialty Care Physician/Provider or SCP)

A Specialist is a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

78. Specialty Drugs

Typically high cost drugs that are injected in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Drugs require preauthorization to be considered Medically Necessary.

79. Spouse

For the purpose of this Plan, a Spouse is defined as shown in the Eligibility section of this Benefit Booklet

80. Therapeutic Equivalent

Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

81. Transplant Providers

Network Transplant Provider - A Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by a designee of the Claims Administrator. Such Provider has entered into a transplant provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by a designee of the Claims Administrator.

82. Urgent Care

Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

83. Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section "Prescription Drugs Administered by a Medical Provider"), procedures, and/or Facilities.

84. You and Your

Refer to the Subscriber, Member and each Covered Dependent.

e) Health Benefits Under Federal Law

1. Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Claims Administrator's Network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of Your Identification card or refer to the Claims Administrator's website, www.anthem.com. For children, You may designate a pediatrician as the PCP.

2. Access to Obstetrical and Gynecological (ObGyn) Care

You do not need Prior Authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or refer to the Claims Administrator's website, www.anthem.com.

3. Statement of Rights Under the Newborns' and Mother's 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 (e.g., Your Physician, nurse midwife, or Physician assistant), 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). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your Plan Administrator.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

4. Statement of Rights Under the Women's Cancer Rights Act of 1998

   If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

   - 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.

   These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. **See the Schedule of Benefits.**

   If You would like more information on WHCRA benefits, call Your Plan Administrator.

5. Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If You or Your Spouse are required, due to a QMCSO, to provide coverage for Your child(ren), You many ask Your Employer of Plan Administrator to provide You, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

6. Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day/visit limits on medical/surgical benefits. In general, group health plans

offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment/Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

85. GET HELP IN YOUR LANGUAGE

You have the right to get this information and help in Your language for free. Call the Member Services number on Your Identification Card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for Members with visual impairments. If You need a copy of this document in an alternate format, please call the Member Services telephone number on the back of Your Identification Card.

SECTION 2 Employee Contributions for Health Care (Anthem PPO and Keystone HMO)

	Weekly Contributions
Employee Only	$16
Employee Plus One	$24
Family	$36

Contributions will be taken on a pre-tax basis. This requires employees to follow the IRS Section 125 rules which include enrolling for coverage for themselves and their dependents within 31 days of their eligibility date. If you do not enroll timely you must wait until the next Annual Enrollment Period.

(a) Wellness Incentives

The Health for Life Wellness program is the cornerstone for promoting and achieving a culture of health among the Mack organization and incorporates the following features.

(a) A contribution credit of $8 per week will reduce the members required health care contribution upon the attainment of all of the following:

1. Completion of annual Health Assessment (HA)
2. Completion of an annual biometric screening that measures blood pressure, cholesterol, glucose, and Body Mass Index (BMI), and
3. Annual written attestation that you do not use tobacco or the timely completion of a tobacco cessation program.

(b) HA and biometric screenings will be performed on-site **on an annual basis**.

(c) Annual cash incentives of up to $150 can be earned by meeting the following screen criteria:

1. Blood pressure in accordance with guidelines developed by the American College of Cardiology and the American Heart Association Task Force,
2. Total cholesterol less than or equal to 200 or total cholesterol/HDL ratio less than or equal to 5.0, and
3. BMI less than or equal to **25** or have improved BMI at least one (1) point from the prior year biometric screening, or waist measurement of less than or equal to 35 for women and less than or equal to 40 for men.

For each criterion that is achieved, the employee will receive a $50 cash payment in their paycheck **no later than December 31st**.

The Company will update the target criteria when there is a nationally recognized change to the guidelines or enhancements that align with best practice recommendations. The Company will consult with the provider of its wellness program to ensure any changes are appropriate. The program criteria will be communicated annually.

SECTION 3 PPO Prescription Drug Coverage

You and your eligible dependents can receive benefits through the Prescription Drug Card Program administered by Express Scripts. If you have questions you may call Express Scripts (ESI) Member Services 24 hours a day, seven day a week at **1-866-467-1239** or you may visit the Express Scripts website at https://www.express-scripts.com.

(a) How the Program Works – Retail Pharmacies

After you enroll for health coverage, you'll receive an ESI identification card. When you present the card at a participating pharmacy, you can receive up to a 34-day supply of medication. To find the closest participating pharmacies near you, call the toll free number or visit the ESI website. Your participating pharmacist will give you generic drugs

when they are available – unless your doctor indicates that the prescription must be filled with brand name drugs.

Effective **January 1, 2024**, you pay the following prescription drug copay for each retail prescriptions:

$10 for each generic drug prescription,

$30 for each **preferred** brand name drug prescription, and

$50 for each non-preferred brand name drug prescription

If you have your prescription filled at a non-participating pharmacy, you can still receive plan benefits. However, you'll have to pay for the prescription at the time it's filled and then file a claim with Express Scripts. Claim forms are available from the HR Service Center or online at https://www.express-scripts.com.

(b) Mail Order Drug Program

In addition to the Prescription Drug Card Program, you also can receive prescription drug benefits through the Mail Order Drug Program. Administered by Express Scripts, this program is designed to save you money by helping you pay for drugs used to treat chronic conditions such as hypertension or diabetes.

Under the program, you can order up to a 90-day supply of prescription drugs. And, medications are delivered right to your home, postage-paid. Like the Prescription Drug Card Program, the pharmacist will give you generic drugs when they are available – unless your doctor indicates that the prescription must be filled with brand name drugs.

Effective **January 1, 2024**, a co-payment equal to 2 times the amount described for a one month supply paid by the member is applicable for each separate prescription order and refill. This equals $20 for generic drugs and $60 for **preferred** brand drugs **and $100 for non-preferred brand drugs**.

Here is all you have to do when ordering maintenance drugs through the Mail Order Drug Program:

- When you need maintenance drugs, have your doctor give you a prescription for up to a 90-day supply plus refills up to one year (as appropriate). (If you must start taking the drug right away, also get a separate prescription for a 14-day supply, which you can fill at a participating pharmacy).
- Mail in your prescription. When you send your prescription, be sure to include the order form and payment in the provided envelope. You may

also ask your doctor to fax your prescription by calling 1-888-327-9791 for further instruction.

Your order will be filled and delivered through the mail within eight days of receipt, along with re-order instructions and pre-addressed envelope for future prescriptions and refills.

When you need refills, simply complete and mail your refill notice to the Mail Order Drug Program in the pre-addressed envelope, or call 1-866-467-1239 or go online to https://www.express-scripts.com, and follow the instructions for refilling your prescription.

(c) Specialty Medications

Specialty medications are drugs that are used to treat complex conditions, such as cancer, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Whether they're administered by a health care professional, self-injected or taken by mouth, specialty medications require an enhanced level of service.

Mack recommends that specialty pharmacy medications be accessed through Accredo Health Group, ESI's specialty mail order pharmacy, and not be purchases through retail pharmacies. Accredo's specialty mail pharmacy has enhanced services to monitor your care for these complex conditions. If you are not sure whether you are taking a specialty medication you can contact Express Scripts Customer Service at 1-866-467-1239 or go to https://www.express-scripts.com for more information regarding your prescriptions. You may also go online to www.accredo.com to receive more information about Accredo.

(d) Compound Drugs

For compound drugs to be covered under the Plan, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. Furthermore, the cost of the compound must be determined by Express Scripts to be reasonable (e.g. if the cost of any ingredient has increased more than 5% every other week or more than 10% annually, the cost will not be considered reasonable). Any denial of coverage for a compound drug may be appealed in the same manner as any other drug claim denial under the Plan.

(e) Cholesterol Care Value Program

Express-Scripts' Cholesterol Care Value Program (CCV) will help ensure members have appropriate access to a new and extremely costly class of anticholesterol medications, called PCSK9 inhibitors. These new self-injectable medications are priced significantly higher than the more cost-effective traditional cholesterol-lowering statins (Crestor and Lipitor). With the CCV program, the new PCSK9

inhibitors will require Prior Authorization to ensure appropriate use. To ensure members understand the potential side-effects and how to inject these medications, the PCSK9s can only be obtained from Express Scripts' Specialty Pharmacy, Accredo, where nurses and specialist pharmacists will be available to provide individualized care and coaching.

(f) **Advanced Utilization Management (Effective July 1, 2024)**

- **a. Program combines prior authorization, step therapy and drug quantity management for certain drugs.**
- **b. Members with a current prescription (as of October 1, 2023) for a medication identified for step therapy will be "grandfathered" and allowed to continue refilling that medication as long as they continue therapy. There are some drugs where grandfathering is not allowed due to certain specifications from the manufacturer that were agreed to.**

(g) **National Preferred Formulary (Effective March 1, 2024)**

A preferred list of drug products that typically limits the number of drugs available within a therapeutic class for the purposes of drug purchasing, dispensing and /or reimbursement. Products are selected on the basis of safety, efficacy and cost.

(h) **SaveOn SP (Effective May 1, 2024)**

A program that lowers the cost of a number of specialty drugs for both the members and the plan by taking advantage of manufacturer assistance programs. If participants participate in this program, they will have a zero cost for certain specialty medications. The prescriptions will still be filled through Accredo, your existing specialty mail pharmacy. Eligible participants will be contacted by the vendor.

(i) **Generic Drug Rules (Effective 1/1/2024)**

If a participant requests a brand name drug when a generic drug is available, the plan will only cover the cost of the generic drug. Participants will need to pay the difference in cost between the brand and the generic drug plus the generic copay. If there is a clinical reason for a participant to receive a brand drug, they will need to contact Member Services to discuss if a clinical exception can be made.

(j) Definitions

1. *Brand name drug* means the trade name under which a drug is advertised and sold.

2. *Compound drug* as defined by the U.S. Food and Drug Administration (FDA) is a medication that requires a licensed pharmacist to combine, mix or alter the ingredients of a medication when filling a prescription. The FDA does not verify the quality, safety and/or effectiveness of compound medications.
3. *Copayment* means the amount to be paid by the member for each separate prescription order or refill of a covered drug.
4. *Covered drug* means injectable insulin or any prescription legend drug that is dispensed according to a prescription order provided that:
    - The drug is medically necessary,
    - The amount of the prescription charge exceeds the copayment,
    - The drug is not included or includible in the cost of other services or supplies provided to the member, and
    - The drug is not entirely consumed at the time and place of the prescription order.
5. *Generic name drug* means the chemical name of the a drug that the FDA approved as therapeutically equivalent to a brand name drug.
6. *Member* means either the covered employee under this program or any of the employee's eligible dependents.
7. *Non-Participating Provider* means any provider of pharmaceutical services that has not entered into a participating contract with Express Scripts.
8. *Participating Provider* means any pharmacy or organization legally licensed to dispense drugs which has entered into an agreement with Express Scripts. The participating provider will charge the member the co-payment amount.
9. *Pharmacy* means a licensed establishment where prescription drugs are dispensed by a licensed pharmacist.
10. *Prescription Legend Drug* means any medicinal substance – the label of which under the FDA, is required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription" and includes compounded medication containing at least one prescription legend drug.
11. *Prescription Order* means the request for medication by a physician or dentist.

(k) Prior Authorization

The following drug categories require your physician to obtain prior authorization through Express Scripts.

1. Androgens and anabolic steroids
2. Anorexiants
3. Anti-narcoleptice agents (Nuvigil, Provigil)
4. Cosmetic drugs (Botulinum)
5. Dermatologicals for age 36 and older (Retin A)
6. Dermatologicals /Misc (Penlac Solution)

7. Erectile Dysfunction agents

(l) Quantity/Dose Duration

4. Anti-Emetics
5. Anti-Fungal Agents
6. Erectile Dysfunction Agents
7. Hypnotic Agents
8. Migraine Therapy (Milligram based)

(m) Exclusions

Your Prescription Card and Mail Order Drug programs do not cover the following:

1. Drugs determined to be investigational or experimental by the FDA (Federal Drug Administration),
2. Non-Federal Legend Drugs (not approved by FDA), Federal Legend Non-Drugs (Over the counter medications (OTC) that don't require a prescription), and Non-Federal Legend Non-Drugs (vitamins, supplements and topical agents that do not require a prescription).
3. Glucowatch Products (diabetic wrist watch),
4. Insulin pump supplies,
5. Emergency contraceptive products through mail order,
6. Implant products obtained by mail order,
7. Nutritional supplements and combo nutritional products,
8. Relenza/Tamiflu products obtained through mail order
9. Drugs to treat impotency for males under age 18
10. Ostomy supplies
11. Dental fluoride products
12. Certain injectable medications that are not covered through Specialty Pharmacy and are usually not self-injectable (injectable provided in an outpatient or physician setting)
13. Cosmetic medications like Renova,
14. Biologicals, immunizations, vaccines, allergy serum, blood parts (except specialty products),
15. Charges for therapeutic devices or appliances, support garments, or other non-medical substances.
16. Prescriptions that you're entitled to receive without charge from any local, state or federal programs, including Worker's Compensation, and
17. Prescriptions refilled in excess of the number specified by the physician, or for any refill dispensed after one year from the initial prescription.
18. The charge for more than a 34-day supply of medication, except those covered up to 90 day through Mail Order.

SECTION 4 Managed Behavioral Health

Behavioral Health plans are incorporated into the current health plans and no longer have separate administration. See Appendix B, Article 4, Section 1 and Section 7 of the Benefit Agreement for relevant benefit information.

SECTION 5 Dental Benefits Program

The Mack UAW Dental Expense Benefit Program will be administered by Delta Dental for all UAW members who are employed by the Company and their covered dependents effective January 1, 2018.

The Dental Expense Benefits Program, as in effect June 1, 2009, as amended below will continue to be provided at Company expense with the following specifications:

(a) Payment of Benefits

Benefits will be provided for eligible, necessary dental services when billed by the licensed dentist in charge of the case.

Pre-authorization is routinely required for cases requiring $125 or more in benefits, including Space maintainers, Inlays, Crowns, Prosthetics, Periodontics and Orthodontics.

For services covered under the Preventive Program, the Restorative Program, and the Prosthetic Rider, the maximum amount payable by the Plan in any one calendar year shall be $1,850 per member for services rendered on or after January 1, 2011; and $1,950 per member for services rendered on or after January 1, 2020. The maximum payable under the Orthodontic Rider is outlined in Section 5(e).

(b) Preventive Services - 100%

1. Oral examinations
2. X-rays of the teeth
3. Topical fluoride application for member under age 19
4. Cleaning, scaling and polishing of teeth
5. One lifetime application of tooth sealant on permanent posterior molars for dependent child age 14 or younger.
6. Brush Biopsy – Effective January 1, 2017

(c)Restorative Program – 90%

1. Repair of broken dentures
2. Palliative emergency treatment of conditions causing dental pain
3. Fillings consisting of silver amalgam and synthetic tooth color restorations
4. Simple extractions
5. Endodontic (treatment of the tooth's nerve)
6. Consultation
7. Space maintainers (not made of precious metals)
8. General Anesthesia administered in a Dentist's office
9. Oral Examinations performed to determine the need for and, if required, to plan a course of orthodontic treatment (includes study models and diagnostic x-rays)
10. Inlays and Crowns (Not part of a bridge. No payment will be made for precious metal restorations unless the tooth cannot be restored with another material)
11. Oral Surgery – including fracture treatment, cyst removal and surgical extractions. (Out-of-hospital only)
12. Apicoectomy – dental root resection
13. Periodontics:
14. Examination of gums and underlying bone
15. Treatment of gums
16. Gum surgery to remove infection and reshaping of the gums to prevent future problems
17. Bone surgery

(d) Prosthetic Rider - 50%

1. Full or Partial dentures
2. Removable bridges (fixed bridges only when the replacement cannot be made by other methods)
3. All necessary abutment work
4. Relining of dentures as necessary

(e) Orthodontic Rider - 50%

Active treatment, including initial installation of necessary appliances.

Maximum: $2,000 effective January 1, 2020

Orthodontic benefits will be available for members under age 19, and for handicapping malocclusion only. Orthodontic Benefits will be continued beyond age 19 for a patient who is receiving orthodontic services upon the attainment of age 19 until the earlier of (1)

completion of the current treatment plan or, (2) exhaustion of the maximum life-time orthodontic benefit**.**

(f) Accidental Injury to Sound Teeth

Accident related procedures are not subject to the annual program dollar maximum. A separate per calendar year benefit of $1,950 effective January 1, 2020, will apply subject to subrogation provisions. Benefits will not be tied to the accident date but to the eligibility for the type of service reported when provided. The dental office is responsible for reporting when accident related.

(g) Exclusions

1. Services received from a dental or medical department maintained by or on behalf of any employer, a mutual benefit association, labor union, trustee or similar person or group.
2. Services for which the member incurs no charge.
3. Services for any occupational condition, ailment or injury arising out of and in the course of covered employment under Worker's Compensation or Occupational Disease Laws, Federal Employers' Liability Acts, or other similar State or Federal Employers' Liability Acts, or other similar State or Federal legislation; or provided by the United States Veterans Administration; or provided without cost to the member by any federal, state, county, or municipal hospital, agency or instrumentality.
4. Services with respect to congenital malformations or primarily for cosmetic or esthetic purposes.
5. Services, the cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim.
6. Services or supplies provided by any governmental body or instrumentality, whether federal, state or local, pursuant to any program under which any periodic payment of premiums, rate, enrollment fee or other similar charge is made by or for the member.
7. Appliances or restorations used solely to increase vertical dimensions.
8. Charges for services to the extent that such charges exceed the charge that would have been made and actually collected if no coverage existed hereunder.
9. Services in a hospital performed by a dentist who in any case is compensated by the hospital for similar services when performed for patients.
10. Local anesthesia when billed for separately by the dentist.
11. Gold foil restorations.
12. Complete mouth X-rays are limited to not more than once in any five year period, unless special need is shown.

13. Oral examinations, periapical and bitewing X-rays, fluoride applications, and prophylaxis services are limited to not more than twice each calendar year.
14. In all cases involving covered services in which the dentist and patient select a more expensive course of treatment than is customarily provided by the Dental Profession, consistent with sound professional standards of dental practice for the dental condition concerned, the Plan will pay the fee allowed for the lesser procedure. The dentist may charge the patient the difference for any amount over that for which the Plan is liable.
15. In the event a member transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist performs services for one dental procedure, the Plan shall be liable for not more than the amount it would have been liable for had but one dentist performed the service.
16. Services other than those specifically covered herein.
17. Unusual procedures and techniques.
18. In the event any services to which a member is entitled under this program are also covered under any other health benefit plan, the Plan reserves the right to take into account the services provided or paid for under such plan in its determination of amounts payable for services under this program.
19. Any denture or bridge replacement made less than 5 years after a denture or bridge placement or replacement which was covered under this Agreement.
20. Authorized benefits for a bridge or denture completed within 60 days after termination under this Agreement are the only benefits available after such termination.
21. Charges for an appliance, or modification of one, for which an impression was made before the member became covered under the Plan.
22. Charges for a crown, bridge, or gold restoration for which the tooth was prepared before the member became covered under the Plan.
23. Charges for root canal therapy if the pulp chamber was opened before the member became covered under the Plan.
24. Charges for orthodontic procedures for which appliances were installed before the patient was covered by the Mack Dental Plan.

(h) Definitions

1. *"Dentist"* means a doctor of dental surgery (D.D.S.) or medical dentistry (D.M.D.) whose scope of practice is the diagnosis, prevention and treatment of diseases of the teeth and related structures.
2. *"Member"* means either the covered person under this Program or any of the covered person's eligible dependents.
3. *"Plan"* means the Company or a third party which enters into an agreement to provide the benefits stipulated under this Program.

(i) How to File a Claim

Most dental providers will file your dental claim for you and your dependents. You need to provide your Delta Dental Identification Card (ID) to your provider. If your provider will not file your claim, you will need to obtain a claim form from the Delta Dental website, www.consumertoolkit.com.

When you complete your claim form, please return to the Claims Administrator address on your ID Card. If your provider does not fill out the appropriate section on the form, please submit an itemize bill which contains the following:

- Patient's name
- Employee name
- Date of service
- Type of service performed
- Amount of charge
- Name, address, phone number and tax identification number of provider.

Using a network provider (Delta Dental) will ensure you the most comprehensive reimbursement for your claim.

(j) Recovery of Overpayments

The Claims Administrator has the right to recover overpayments and payments made for benefits that were covered by another group health plan, governmental program or a statutory plan such as Workers' Compensation or automobile no-fault. If payment has been made, but is determined to have been paid erroneously, the Claims Administrator may recover these payments from the party who received the erroneous payment.

(k) Subrogation

If you have expenses for dental services that resulted from the negligence or wrong doing of a third party, and you reach a settlement or a judgment, the Claims Administrator may recover any benefits paid by this Plan.

(l) When coverage ends

- Dental coverage will end on the earliest of the following dates:
- The date the Dental Plan is terminated,
- The last day of the month that your employment terminates,
- The date you no longer belong to a class of employees eligible for the coverage,

- The date you or your enrolled dependents are no longer eligible for coverage, and
- When your COBRA coverage continuation ends.

SECTION 6 Vision Benefits Program

The Vision Expense Benefits Program as in effect January 1, 2017, as amended below, will continue to be provided at Company expense with the following specifications:

Coverage for vision care benefits will apply to all eligible employees and their eligible dependents. Coordination of benefits will apply.

(a) Covered Expenses

Your Blue View Vision Network

Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters, Sears Optical, Target Optical, JCPenney Optical and most Pearle Vision locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts.

Out-of-network: If you choose to, you may receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement of your out-of-network allowance. In-network benefits and discounts will not apply.

	IN-NETWORK	OUT-OF-NETWORK
Routine eye exam Once per calendar year	$0 copay	$75 Allowance
Eyeglass frames One pair every calendar year	$110 allowance, 20% off any remaining balance	$60 Allowance
Eyeglass lenses One pair every calendar year in standard plastic with choice of the following options:		
Single vision lenses	$0 copay	$40 Allowance
Bifocal lenses	$0 copay	$50 Allowance
Trifocal lenses	$0 copay	$60 Allowance

Lenticular lenses	$0 copay	$75 Allowance
Eyeglass lens enhancements		
When obtaining covered eyewear from a Blue View Vision provider, members may choose to add any of the following lens enhancements at no extra cost.		
Transitions Lenses (for a child under age 19)	$0 copay	No allowance on lens
Standard Polycarbonate (for a child under age 19)	$0 copay	enhancements when
Factory scratch coating	$0 copay	obtained out-of-network
Contact lenses		
Once every calendar year instead of eyeglass lenses		
Elective Conventional lenses; or	$130 allowance; 15% of any remaining balance	$130 Allowance
Elective Disposable Lenses; or	$130 allowance; (no additional discount)	$130 Allowance
Non-Elective Contact Lenses	Covered in full	$130 Allowance
Contact lenses fit and follow-up		
Available once a comprehensive eye exam has been completed		
Standard contact lens fitting	$0	$35 Allowance
Premium contact lens fitting	10% off retail price then apply $55 allowance	$35 Allowance

ADDITIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS		**In-network Member Cost (after any applicable copay)**
Retinal Imaging		Not more than $39
Eyeglass lens upgrades		
When obtaining eyewear from a Blue View Vision provider, members may choose to upgrade their new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies	Transition lenses (Adults)	$75
	Standard Polycarbonate (Adults)	$40
	Tint (Solid and Gradient)	$15
	UV Coating	$15
	Progressive Lenses	
	Standard	$65
	Premium Tier 1	$85

	Premium Tier 2	$95
	Premium Tier 3	$110
	Anti-Reflective Coating	
	Standard	$45
	Premium Tier 1	$57
	Premium Tier 2	$68
	Other Add-ons and Services	20% off retail price

Additional Pairs of Eyeglasses	Complete Pairs	40% off retail price
Anytime from any Blue View Vision network provider	Eyeglass materials purchased separately	20% off retail price
Eyewear Accessories	Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc	20% off retail price
Conventional Contact Lenses After covered benefits have been used	Discount applies to materials only	15% off retail price

b) Exceptions and Limitations

- Benefits are not available for any lenses not requiring a prescription, including sunglasses
- Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design
- Medical or surgical treatment of the eye or any medication resulting from this treatment is not payable under the Vision Plan
- Benefits are not available for Orthoptics, vision training or subnormal vision aids
- Benefits are not available for services or materials provided as a result of Workers' Compensation or for examination required as a condition of employment

(c) How to File a Claim

Blue View Vision in network providers will file your claim for you and your dependents. You need to provide your Vision Identification Card to your provider. If your provider will not file your claim, you will need to obtain a claim form from your local Human Resources office or the HR Service Center. If you utilize an out of network provider, they will not file your claim for you.

When you complete your claim form, please return to the Claims Administrator address on your ID Card. If your provider does not fill out the appropriate section on the form, please submit an itemize bill which contains the following:

- Patient's name
- Employee name
- Date of service
- Type of service performed
- Amount of charge
- Name, address, phone number and tax identification number of provider.

Out-of-Network Claims

Fax: 866-293-7373

Email: conclaims@eyewearspecialoffers.com

Mail: Blue View Vision
Attn: OON Claims
PO Box 8504
Mason, OH 45040-7111

Using a Blue View Vision provider (Anthem) will ensure you the most comprehensive reimbursement for your claim.

(d) Recovery of Overpayment

The Claims Administrator has the right to recover overpayments and payments made for benefits that were covered by another group health plan, governmental program or a statutory plan such as Workers' Compensation or automobile no-fault. If payment has been made, but is determined to have been paid erroneously, the Claims Administrator may recover these payments from the party who received the erroneous payment.

(d) Subrogation

If you have expenses for vision services that resulted from the negligence or wrong doing of a third party, and you reach a settlement or a judgment, the Claims Administrator may recover any benefits paid by this Plan.

(e) When coverage ends

- Vision coverage will end on the earliest of the following dates:
- The date the Vision Plan is terminated,
- The last day of the month that your employment terminates.,
- The date you no longer belong to a class of employees eligible for the coverage,
- The date you or your enrolled dependents are no longer eligible for coverage, and,
- The date your continuation coverage ceases as described in the COBRA Continuation Section.

SECTION 7 Keystone HMO

Keystone Health Plan Central, a Capital BlueCross Company, provides an HMO plan of benefits as an alternative to Mack employees residing in the 21 counties of Pennsylvania serviced by Keystone. HMOs, unlike PPOs, only provide benefit coverage if you are using participating network providers and hospitals. There are no out-of-network benefit payments.

This plan is not an insured benefit plan. The benefits provided are funded by Mack who is responsible for their payment. Keystone provides network providers and claims payment services but assumes no financial risk or obligation with respect to claims.

Verification of Benefits
You or your provider may call Customer Service with any benefit inquiry or verification of your benefits during normal business hours (8:00 am to 8:00 pm eastern time). Please remember a benefit inquiry/verification is not a verification of coverage or guarantee of payment. Call the Customer Service Number on your Identification Card.

(a) Schedule of Benefits

SUMMARY OF COST-SHARING	**Amounts *Members* Are Responsible For:**
Deductible (per calendar year)	$**350** per member $**700** per family
Copayments	
• **Office Visits - PCP** *(performed by a Family Practitioner, General Practitioner, Internist,*	$15 copayment per visit

Pediatrician, Preventative Medicine specialist, or participating Retail Clinic)	
• Specialist Office Visit	$30 copayment per visit
• **After Hours Office Visit** (in addition to the PCP office visit copayment)	$0 copayment per visit
• Emergency Room	$**150** copayment per visit, waived if admitted
• Urgent Care	$**40** copayment per visit
• **Inpatient** (Per Admission)	$0
• **Outpatient Surgery Copayment** (facility)	$0
Behavioral Health/Substance Abuse Care **Hospital Inpatient Services** **Outpatient Services** **• Copayment applies to visits/consults only. Other services (including IOP and PHP) are subject to deductible and coinsurance** **Physician Services (In person and/or virtual)** **• Online visits are covered and mirror the professional office Behavioral Health visit benefit** **Applied Behavioral Analysis** **Note: Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with federal law.**	0% per visit $10 $10 0%
Coinsurance	No member coinsurance
Out-of-Pocket Maximum	$6,350 per member; $12,700 per family
Coverage Lifetime Maximum	None

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:
PREVENTIVE CARE: Administered in accordance with Preventive Health Guidelines and PA state mandates		
Preventive Care Services		
• Pediatric Preventive Care		Covered in full, waive deductible
• Adult Preventive Care		Covered in full, waive deductible
Immunizations		Covered in full, waive deductible
Mammograms		
• Screening Mammogram	One per benefit period	Covered in full (no referral necessary), waive deductible
• Diagnostic Mammogram		Covered in full after deductible
Gynecological Services		
• Screening Gynecological Exam	One per benefit period	Covered in full (no referral necessary), waive deductible
• Screening Pap Smear	One per benefit period	Covered in full (no referral necessary), waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET		
Acute Care Hospital Room & Board		Covered in full after deductible
Acute Inpatient Rehabilitation	60 days/benefit period	Covered in full after deductible
Skilled Nursing Facility	Unlimited days/benefit period	Covered in full after deductible
Surgery		
• Surgical Procedure		Covered in full after deductible
• Anesthesia		Covered in full after deductible
Maternity Services and Newborn Care		Covered in full after deductible
Diagnostic Services		

• Radiology		Covered in full after deductible
• Laboratory		Covered in full, waive deductible
• Medical tests		Covered in full after deductible
Outpatient Therapy Services		
• Physical Medicine	90 (visits each type/benefit period)	Copayment applies
• Occupational, Respiratory & Speech Therapy	60 (visits/benefit period)	Copayment applies
• Manipulation Therapy	2 weeks (14 consecutive days) of acute care service per accident or injury	Copayment applies
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH & SUD detoxification inpatient services		Covered in full, waive deductible
MH & SUD detoxification outpatient services		Covered in full, waive deductible
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient
Urgent Medical Care		
• In Service Area		Covered in full after copayment (additional copayment for AH visit)
• Outside Service Area		Covered in full after Emergency Room copayment
Medical Transport		
• Emergency Ambulance		Covered in full, waive deductible
• Non-Emergency Ambulance		Covered in full (between facility providers)

Summary of Benefits (CONTINUED)	**Limits and Maximums**	**Amounts Members Are Responsible For:**
Home Health Care Services	Unlimited visits/benefit period	Covered in full after deductible
Hospice Care	$7,500 lifetime max	Covered in full after deductible

Durable Medical Equipment (DME)		50% coinsurance
Prosthetic Appliances and Orthotic Devices		Covered in full after deductible
Diabetic Supplies and Education		Covered in full when obtained at Participating (DME) Provider
		50% coinsurance when obtained at a Participating Pharmacy
Infertility Services	Unlimited benefit lifetime max/subscriber & spouse each	Covered in full after deductible
Assisted Fertilization		Not Covered
OTHER STANDARD PLAN FEATURES		
Preauthorization	Preauthorization is a clinical program in which our nurses work with physicians to approve and monitor certain health care services prior to the delivery of services. The purpose of Preauthorization is to ensure all members receive medically appropriate treatment to meet their individual needs.	
Disease Management	Disease Management Programs are a collaborative process that assess the health needs of a member with a chronic condition and provides education, counseling and on-demand information designed to increase a member's self-management of his/her diabetes, asthma, heart disease, and/or depression.	
Nurse Line	Nurse Line is staffed 24 hours a day, 7 days a week by experienced Registered Nurses to provide information and support for any health-related concern. Call 800-452-BLUE.	
Better Health WorksSM Personal Profile	Answer questions about yourself and the way you live and, based on the answers you provide, you will receive customized recommendations for your health situation. Support is available to follow through on these recommendations and to make positive health changes.	
mycapbluecross.com	Members register for on-line access to their personal account to check claim status, compare hospital quality and treatment costs, print temporary proof of coverage, read the SimplyWellsm member newsletter, view explanation of benefits, and much more.	

(b) STANDARD BENEFIT EXCLUSIONS.

The following list highlights ***some*** standard benefit exclusions. It is ***NOT*** intended to be a complete list or a complete description of all categories of benefit exclusions:

Cosmetic procedures – Acupuncture – Routine foot care; or support devices of the feet – Eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses – Corneal surgery and other procedures to correct refractive errors – Prescription and over-the-counter drugs dispensed by a pharmacy or home health care agency provider – All dental services rendered after stabilization of a member in an emergency following an accidental injury – Treatment of obesity and/or morbid obesity - Any treatment leading or relating to or in connection with assisted fertilization, including donor services – Certain non-neonatal circumcision - Infertility services - Private duty nursing services - Procedures to reverse sterilization.

(c) Additional Plan Information

1. Inpatient admissions as well as certain other services and equipment may require preauthorization.
2. Participating providers agree to accept our allowance as payment in full—often less than their normal charge.
3. For more information or to locate a participating provider, visit **www.capbluecross.com**.

(d) HMO Drug Benefits Provided Through Express Scripts

HIGHLIGHTS	**AMOUNTS YOU ARE RESPONSIBLE FOR:**		
	Retail Pharmacy (up to a 30-day supply)	**Mail Service Pharmacy (up to a 90-day supply)**	**Specialty Pharmacy (up to a 30-day supply)**
DEDUCTIBLE			
Per benefit period*	None		
PRESCRIPTION DRUG TIER		**BENEFIT**	
Generic Prescription Drugs	$**10** copayment	$**20** copayment	$**10** copayment
Preferred Brand Prescription Drugs	$**30** copayment	$**60** copayment	$**30** copayment
PRESCRIPTION DRUG TIER (Contraceptives)		**BENEFIT**	
Generic Prescription Drugs	$0 copayment	$0 copayment	Not covered
Select Brand Prescription Drugs**	$0 copayment	$0 copayment	Not covered
Preferred Brand Prescription Drugs	$**30** copayment	$**60** copayment	Not covered
PRESCRIPTION CATEGORY		**BENEFIT**	
Contraceptives	Covered	Covered	Not covered

Fertility Drugs ($1,000 benefit lifetime maximum)	Covered (50% coinsurance)	Covered (50% coinsurance)	Not covered
Sexual Dysfunction Drugs	Covered	Covered	Not covered
Weight Loss Drugs	Not covered	Not covered	Not covered
Non-Specialty Drugs (self-administered)	Covered	Covered	Not covered
Specialty Drugs (self-administered)	Not covered	Not covered	Covered
Nicotine Cessation Products (prescription)	Not covered	Not covered	Not covered
Vitamins (prescription, non-prenatal)	Covered	Covered	Not covered
Prenatal Vitamins (prescription)	Covered	Covered	Not covered
Anti-Flu Therapies	Covered	Not covered	Not covered
Diabetic Supplies	Covered	Covered	Not covered
Topical Retinoid (Acne) Products	Covered with age limit	Covered with age limit	Not covered
Over-the-Counter Equivalents	Not covered	Not covered	Not covered
UTILIZATION PROGRAM		**BENEFIT**	
Generic Substitution Program		**Voluntary Generic Substitution** – In addition to the coinsurance/ copayment, the member pays the difference between the brand and generic drug price (when there is a generic alternative) regardless of whether the physician or member requests the brand be dispensed.	
Quantity Level Limits (per prescription, per day supply or per copayment)		**Applicable to selected drugs. Please refer to the National Preferred formulary or go to** www.expressscripts.com.	
SaveOn (Effective 5/1/2024)		**A program that lowers the cost of a number of specialty drugs for both the members and the plan by taking advantage of manufacturer assistance programs. If participants participate in this program, they will have a zero cost for certain specialty medications. The prescriptions will still be filled through Accredo, your existing specialty mail pharmacy. Eligible participants will be contacted by the vendor.**	
Advanced Utilization Management (Effective 7/1/2024)		**Advanced Utilization Management** **a. Program combines prior authorization, step therapy and drug quantity management for certain drugs.** **b. Members with a current prescription (as of October 1, 2023) for a medication identified for step therapy will be "grandfathered" and allowed to**	

	continue refilling that medication as long as they continue therapy. There are some drugs where grandfathering is not allowed due to certain specifications from the manufacturer that were agreed to.

(e) HMO Drug Exclusions

1. Which are not medically necessary as determined by Express Scripts or its designee;
2. Unless otherwise set forth in the group contract, drugs that do not legally require a prescription as determined by Express Scripts;
3. For prescription drugs that have an over-the-counter equivalent;
4. For devices or appliances, including but not limited to, therapeutic devices, artificial appliances, or similar devices or appliances, except for diabetic supplies;
5. For the administration or injection of prescription drugs;
6. For prescription drugs received in and billed by a hospital, nursing home, home for the aged, convalescent home, home health care agency, or similar institution;
7. For allergy serums, desensitization serums, venom;
8. Which are considered by Express Scripts or its designee to be experimental or investigational;
9. For any illness or injury which occurs in the course of employment if benefits or compensation are available or required, in whole or in part, under a workers' compensation policy and/or any federal, state or local government's workers' compensation law or occupational disease law, including but not limited to, the United States Longshoreman's and Harbor Workers' Compensation Act as amended from time to time. This exclusion applies whether or not the member makes a claim for the benefits or compensation under the applicable workers' compensation policy/coverage and/or the applicable law;
10. For any illness or injury suffered after the member's effective date of coverage which resulted from an act of war, whether declared or undeclared;
11. Which are received by veterans and active military personnel at facilities operated by the Veteran's Administration or by the Department of Defense, unless payment is required by law;
12. Which are received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;
13. For the cost of benefits resulting from accidental bodily injury arising out of a motor vehicle accident, to the extent such benefits are payable under any medical expense

payment provision (by whatever terminology used, including such benefits mandated by law) of any motor vehicle insurance policy;

14. For items or services paid for by Medicare when Medicare is primary consistent with the Medicare Secondary Payer Laws. This exclusion shall not apply when the contract holder is obligated by law to offer the member the benefits of this coverage as primary and the member so elects this coverage as primary;
15. For care of conditions that federal, state or local law requires to be treated in a public facility;
16. Which are court ordered services when not medically necessary and/or not a covered benefit;
17. Which are rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law;
18. Which exceed the allowable amount;
19. Which are cost-sharing amounts, differences between brand drug and generic drug prices (i.e. ancillary charges), and balances paid to non-participating pharmacies required of the member under this coverage;
20. For prescription drugs that require prior authorization if prior authorization is not obtained before dispensing the prescription drugs;
21. For quantities that exceed the limits/levels established by Express Scripts;
22. For which a member would have no legal obligation to pay;
23. Which are incurred prior to the member's effective date of coverage;
24. Which are incurred after the date of termination of the member's coverage except as provided for in the Certificate of Coverage;
25. Which are received by a member in a country with which United States law prohibits transactions;
26. For prescription drugs utilized primarily to enhance physical or athletic performance or appearance;
27. For clinical cancer trial costs (e.g., drugs under investigation; patient travel expenses; data collection and analysis services), except for costs directly associated with medical care and complications, related to a Capital approved trial, which would normally be covered under standard patient therapy benefits;
28. For travel expenses incurred in conjunction with benefits unless specifically identified as a covered benefit elsewhere in the Certificate of Coverage;
29. For all prescription drugs and over-the-counter drugs dispensed during travel by a physician employed by a hotel, cruise line, spa, or similar facility;
30. For durable medical equipment;
31. For blenderized baby food, regular shelf food, or special infant formula;
32. For immunization agents, biological sera, blood, blood products;
33. For prescription drugs utilized to treat infertility;

34. For requests for reimbursement of covered drugs submitted after the allowed timeframe for reimbursement;
35. For all prescription drugs and over-the-counter drugs dispensed in a physician's office or by a facility provider;
36. For anti-flu therapies;
37. For prescription drugs in connection with sexual dysfunction. This exclusion applies even if such drugs are medically necessary to treat an illness or medical condition unrelated to sexual dysfunction so long as there are other drugs which can be used to treat the non-sexual dysfunction condition besides the sexual dysfunction drug;
38. For prescription drugs utilized for weight loss purposes;
39. For prescription drugs utilized to promote hair growth;
40. For prescription drugs utilized for cosmetic purposes;
41. For smoking cessation products;
42. For prescription vitamins (other than prenatal);
43. For topical retinoid products;
44. For injectable medications that cannot be self-administered;
45. For coverage through coordination of benefits;
46. Which are received through the designated and/or non-participating mail service pharmacy for mail service dispensing and submitted for reimbursement under retail dispensing benefits;
47. Which are received through a retail pharmacy for retail dispensing and submitted for reimbursement under mail service dispensing benefits;
48. For prescription drugs utilized in connection with non-covered medical services; and
49. For any other prescription drugs, service or treatment, except as provided in the Certificate of Coverage

SECTION 8 Company and Employee Contributions

(a) While Employed

The Company will make the required contributions on behalf of each employee while the employee is at work (as defined below) for medical, prescription drug, dental, and vision coverage described in this Article IV equal to cost of coverage less the required Employee Contributions for health care as defined in Article IV, Section 2. Coverage is based on the employee's marital status and number of the employee's dependents, provided that such coverage is not in excess of the coverage described in the next paragraph.

The coverage for which the Company will contribute under the foregoing will be based on the employee's timely election for:

(i) Employee only,

(ii) Employee and spouse, or

(iii) Employee and family (including spouse and eligible children).

For purposes of this Section, an employee shall be considered "at work" in any month if the employee receives pay from the Company for any time during such month.

Employee Contributions will be taken on a pre-tax basis. When you enroll in health care benefits you must do so for you and your eligible dependents within 31 days of your eligibility effective date. Your benefit election (including waiver of coverage) for you and your eligible dependents will remain in effect throughout the calendar year. You may not make changes to your health care coverage elections until the next annual enrollment period unless you have a life event change (see examples below) and you make that change within 31 days of the life event. This is because you are making your required health care contributions on a pre-tax basis (before taxes) and therefore, the IRS requires Mack to follow certain tax rules (IRS Code Section 125).

Pre-tax contributions are taken from your pay before Federal, Social Security and (in some locations) State taxes are taken. Because your taxable income is reduced, you pay fewer taxes and you never will pay tax on that income. This reduction in pay has no effect on the value of your other benefits for which you are entitled.

Eligible dependents may be added (or dropped) during your annual enrollment period or within 31 days of the life event change. Examples of life event changes include the following:

- Marriage, divorce, legal separation,
- Birth of child, adoption or placement for adoption,
- Death of a spouse or child,
- When your child is no longer an eligible dependent,
- You, your spouse or your child lose coverage under another benefit plan or that coverage is significantly changed (your spouse loses his/her job or is reduced to part-time status), or
- Your COBRA coverage continuation period ends from another employer.

If you do not enroll your new dependents within the 31 days requirement, you must wait until the next annual enrollment period to do so. You must also drop your ineligible dependents within 31 days to reduce your medical contributions.

(b) During Sick Leave

During the period you are on an approved sick leave or receiving **Accident and Sickness (A&S) Benefits** and unable to work your customary job or other available work or if you are receiving Long-Term Disability benefits after exhaustion of Accident and Sickness Benefits (Article III, Section 3 of Appendix B), the Company will **continue** medical, prescription drug, dental, and vision coverage, for you and your eligible dependents for the duration of such absence **as long as employee contributions continue to be deducted**; but not in excess of the period equal to your seniority when the absence commenced. You must have been enrolled in health care coverage at the commencement of your approved sick leave for such coverage to be extended.

(c) During Layoff

If you are laid off, coverage under Article IV will be provided to you and your eligible dependents, without cost, through the month following the month, in which the layoff occurs. This includes employees laid off under any predetermined bumping system which limits job selection for bumping purposes and those employees taking a voluntary layoff under any collective bargaining agreement permitting the same. Any returning veteran, who would be entitled to reinstatement under the Master Bargaining Agreement because of sufficient seniority, who is not reinstated and is placed on layoff, will have his/her coverage reinstated at no cost for the balance of the month in which he/she is placed on layoff.

Medical, prescription drug, dental, and vision coverages will continue to be provided for you and your eligible dependents, without cost, during any layoff meeting the conditions of Section 2 of Article III of the SUB Plan. Continuation of health coverage is also extended if you are laid off under any predetermined bumping system which limits job selections for bumping purposes and during any voluntary layoff under any collective bargaining agreement permitting the same. Coverage is extended for each full calendar month of layoff (for which you receive no pay from the Company) for a maximum period determined in accordance with the applicable table in Article III, Section 6 (c). The day the employee reports for work shall be deemed to be the employee's last day worked prior to layoff, but only for purposes of determining the period of continuation and eligibility for Company-paid coverage.

If there is no break in seniority, you may also continue medical, prescription drug, dental, and vision coverage during your layoff for an additional twelve consecutive months following the last month your coverage was continued at no cost by the Company under this Section 8 (c), by paying in advance the full monthly premium for such coverage.

The Company will furnish employees with the same information in writing as contained in Article III, Section 6 (c) as to their individual status under this Section 8 (c) at the time of layoff.

(d) Surviving Spouses

(i) If you are killed as the result of an on-the-job accident with the Company, the coverage outlined in Article IV for which you were eligible for and enrolled in at the time of your death will continue at no cost until your spouse remarries, and

(ii) If you die and your surviving spouse qualifies for Bridge Survivor Income Benefits (or who would have otherwise qualified for Bridge Survivor Income Benefits except they attained age 62 during the period of Transition Benefits) under the provisions of the Pension Plan, coverage outlined in Article IV for which you were eligible and enrolled will continue at no cost for the six months immediately following the date coverage would have ended.

(e) Sponsored Dependents

The Company will make available group medical and prescription drug coverage (but not, dental and vision expense coverage) provided for in this Article IV to sponsored dependents at the group rate cost. The employee shall furnish proof satisfactory to the Company that such sponsored dependent meets the eligibility requirements outlined in Article II, Section 2 (b).

SECTION 9 Continuation of Coverage

(a) Sick Leave

During the period you are on approved sick leave and unable to work at your customary job or other available work, the Company will continue your medical, prescription drug, dental and vision coverage **as long as your employee premiums are paid** if you are eligible and enrolled in coverage.

(b) Leave of Absence (Other Than Sick Leave)

During any period you are on an approved leave of absence pursuant to the applicable collective bargaining agreement, [other than leave with the International Union, leave because of election to federal, state, county or municipal office, or military leave (subject to the employee's rights under the Uniformed Services Employment and Reemployment Rights Act)], the Company will continue your medical, prescription drug, dental, and vision coverage, if you are enrolled **as long as your employee premiums are paid,** through the end of the month following the month in which the leave begins. Thereafter, employees have the right to initiate their Federal COBRA rights.

If you are on an approved local union leave you may continue your dental and vision coverage for the duration of such leave starting with the month following the last month for which coverage was provided by Company, by paying in advance the required full monthly premium.

During the period you are on vacation the Company will continue your medical, prescription drug, dental and vision coverage in force subject to the required Employee Contributions for health care as defined in Section 2.

(c) Layoff

Subject to any applicable federal or state law, you may continue your medical, prescription drug, dental and vision coverage by paying the full group rate cost, while on layoff if you have not incurred a break in seniority. Coverage can continue through the twelfth consecutive month following the last month the Company paid for this coverage as defined in Section 8 of this Article IV.

(d) Recall While Disabled

If you are recalled from layoff and are not physically able to return to work because of a disabling illness or injury incurred during your layoff, you will be eligible for benefits under the Insurance Program, provided you furnish the Company with proof satisfactory to the Company physician of your bona fide illness or injury. In addition, you cannot be entitled to such benefits if you are eligible to receive comparable benefits under any insurance program provided by another employer.

(e) While a Grievance is Pending

If you are terminated, discharged or suspended for disciplinary reasons, your medical and prescription drug coverage, dental and vision coverage will be continued at Company expense through the month following the month in which the termination, discharge or suspension occurred. If you are terminated and have a grievance pending for the reasons set forth in Section 6 (e) of Article III of the Program, medical

and prescription drug coverage, dental and vision coverage may be continued by you paying the full group rate **through COBRA** until the grievance is resolved. If you are reinstated, or the disciplinary layoff is reduced, the Company will reimburse you for the insurance contributions which the Company otherwise would have paid.

(f) Return to Active Employment

In the event your active employment ceases for any reason, and there was no break in your seniority, then upon your return to active employment your insurance coverage will commence immediately if you were enrolled in coverage when your active employment ceased.

(g) Termination of Employment

Accident & Sickness benefits, Long Term Disability benefits, life, and accident death and dismemberment benefits will cease as of the last day worked. Medical, prescription drug, dental, and vision, will cease on the last day of the month in which you last work.

You have 31 days following the termination of your life insurance coverage to convert to a non-group, individual life insurance policy. The HR Service Center will supply you with the necessary information and forms to exercise this privilege.

You have the right to exercise your Federal COBRA rights, which allow you to continue medical, prescription drug, dental, and vision coverage. See Section 12 for additional information on COBRA.

There are no conversion privileges for AD&D insurance, Accident and Sickness benefits or Long Term Disability.

SECTION 10 Federal Medical Benefits Provided By Law

(a) As stated in Article IV, section 1(c), the Program will supplement benefits provided by the government, such as the Medicare benefits available under the Social Security Act to the extent allowed by the Medicare Secondary Payer Act and other applicable federal and state laws. Compliance by the Company with such laws shall be deemed full compliance with the provisions of this Program with respect to such employees eligible for benefits under such laws. If, as a result of such laws, the level of benefits provided for any group of employees or their dependents is generally lower than the corresponding level of benefits under the Program, the Company shall upon mutual agreement with the Union provide a plan of benefits supplementary to the federal benefits to the extent necessary to make total benefits as nearly comparable as

practicable to the benefits provided under the Program, with such contributions by employees as are mutually determined to be consistent with the contributions established in this Program.

(b) The provisions of Subsection (a) above to the contrary notwithstanding and upon mutual agreement between the Company and the Union, the Company, may, if federal laws permit, substitute a plan of benefits for the benefits provided by the federal laws referred to in Subsection (a) above and modify the applicable provisions of this Program to the extent and in the respects necessary to secure the approval of such substitution from the appropriate governmental authority. The Company may make such plan available to employees and require from them such contributions as are mutually determined to be consistent with the contributions established in this Section.

(c) Medical, prescription drug, dental and vision coverage provided to you under Article IV may be reduced by the amount of such benefits provided under any Federal or State law. In cases where you exercise an option under any Federal or State law to take cash payments in lieu of medical, prescription drug, dental or vision benefits, the equivalent of such payments will be required as a contribution toward the benefits provided in Article IV, but not to exceed Company cost for the Program.

SECTION 11 Coordination of Benefits

Coordination of benefits is required under the Medical, Prescription Drug, Dental and Vision Programs when you incur eligible expenses and are covered by another group health plan, a governmental program, or a statutory plan such as automobile No-Fault.

The Plan uses guidelines established by the National Association of Insurance Commissioners (NAIC) to determine the order in which coordinating plans will pay benefits. Under these guidelines, a plan without a coordination provision is always the primary plan. If all plans have coordinating provisions, the plan covering the patient directly as an employee, rather than as a dependent, will be primary, and the others will be secondary. If a child is covered under both parents' plans, the plan of the parent whose birthday falls earlier in the calendar year will be primary. If both parents have the same birthday, the plan that has covered a parent longer will be primary.

When parents are separated or divorced, their plans pay in this order:

1. The plan of the parent with financial responsibility for medical expenses of the child, when established under a court decree.

2. The plan of the parent with custody of the child.

3. The plan of the spouse of the parent with custody of the child.

4. The plan of the parent not having custody of the child.

5. In cases where dependent children of separated/divorced parents are subject to joint custody (and neither parent is designated as specifically responsible for health care expenses), the birthday rule is applied.

If benefits have been provided before the Claims Administrator knows of a court decree establishing financial responsibility for the medical expenses of the child, the first point listed above does not apply.

The Plan will not coordinate with an individual insurance policy purchased by you.

In addition to the voluntary incentive set forth in this Article IV, Section 11(d) above, the Company and Union will jointly study and, if feasible, implement a new Coordination of Benefits provision to require a working spouse to enroll in his/her employer's medical plan, if there is no monthly premium contribution nor out of network penalties.

COMPUTATION OF BENEFITS

When the Mack Program is the primary plan, benefits will be paid without regard to any other plan. The secondary plans may then coordinate benefits so that total benefits paid by all of the plans will not exceed total expenses incurred by the member.

If the Mack Program is not the primary plan, the primary plan will pay benefits without regard to the Mack Program. The Mack Plan will subtract the benefits paid by the primary plan from the eligible expenses incurred. The Mack Plan will pay the lesser of the remaining eligible expenses or the maximum amount that would have been payable if the Mack Plan was primary. In no event, however, will the combined benefit payments from both plans exceed the eligible expenses incurred.

The Plan will have the right to give or receive any information, without prior consent, that may be necessary to administer the Coordination provisions.

The Plan has the right to recover overpayments and payments made for benefits that were covered by another group health plan, a governmental program, or a statutory plan such as Workers' Compensation or automobile No-Fault. If a payment has been made, but is determined to have been paid erroneously, the Plan may recover these payments.

If you have expenses that resulted from the negligence or wrongdoing of a third party and you reach a settlement or receive a judgment, the Plan may recover any benefits paid by the Plan. The Plan may also attempt to recover benefits by filing a lawsuit.

SECTION 12 **Continuation of Coverage Under COBRA** (Consolidated Omnibus Budget Reconciliation Act of 1985, as Amended)

This section only applies to individuals who were considered active employees on or after January 1, 1988, and their dependents.

Under federal law, the Plan offers you, your spouse, and your dependent children the opportunity to elect to purchase a temporary extension of your health care coverage (called "COBRA continuation coverage") at group rates in certain instances ("qualifying events") where coverage under the Plan would otherwise end.

COBRA continuation coverage under this Plan is administered by Businessolver COBRA Services. Businessolver can be reached at 1-833-929-1113.

(a) Eligibility for COBRA Continuation Coverage

"Qualified beneficiaries" are eligible for COBRA continuation coverage if their coverage under the plan would otherwise end due to a qualifying event and if they were covered by the Plan on the day before such qualifying event occurs. Qualified beneficiaries include you, your spouse, and your dependent children. Moreover, any child who is born to or placed for adoption with you during a period when you are receiving COBRA continuation coverage will also be a qualified beneficiary. However, if you are married during a period when you are receiving COBRA continuation coverage, your new spouse will not be a qualified beneficiary.

You have the right to elect to purchase COBRA continuation coverage if you lose coverage under the Plan due to either of the following qualifying events: (1) a reduction of your hours of employment so that you no longer meet the eligibility requirements or (2) because of the voluntary or involuntary termination of your employment (for reasons other than your gross misconduct).

Your spouse and your dependent children have the right to purchase COBRA continuation coverage if they lose coverage under the Plan due to any of the following four qualifying events:

1) Your death;
2) The voluntary or involuntary termination of your employment (for reasons other than your gross misconduct) or the reduction of your hours of employment;
3) Your divorce or legal separation from your spouse; or
4) You become entitled to Medicare.

In addition, any child of yours has the right to purchase COBRA continuation coverage if coverage under the Plan is lost because such child ceases to be a "Dependent" under the Plan.

All notices of qualifying events must be provided to our benefits administrator, Businessolver, via their website volvobenefits.com. You will be required to provide proof of your qualifying event when you provide notice of that event. Businessolver can be reached at 1-833-929-1113.

Moreover, the filing of a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event for retirees. If a proceeding in bankruptcy is filed with respect to the Company and that bankruptcy results in the loss of coverage of any retiree covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

(b) Duration of COBRA Continuation Coverage

The duration of COBRA continuation cove*r*age depends upon the nature of the qualifying event causing the loss of coverage. Where coverage under the Plan is lost because of your termination of employment or reduction in hours, you, your spouse, and/or your dependent children will be afforded the opportunity to purchase COBRA continuation coverage for 18 months from the date of the qualifying event.

If your spouse and/or dependent children lose coverage under the Plan due to any qualifying event other than your termination of employment or reduction in hours, they will be afforded the opportunity to purchase COBRA continuation coverage for 36 months from the date of the qualifying event.

Where your spouse and/or dependent children lose coverage under the Plan because of your termination of employment or reduction in hours, the 18-month period of COBRA continuation coverage may be extended to 36 months if they experience a second qualifying event during the initial 18-month period. Secondary qualifying events include your death, divorce, or the cessation of your child's status as a dependent child under the Plan. If your spouse and/or dependent children experience a secondary qualifying event, they should notify Businessolver of the occurrence of such event within 60 days of the event and advise the Plan if they wish to extend coverage.

Moreover, in the event of your termination of employment or a reduction in your hours, coverage for you, your spouse, and/or your dependent children may be extended from 18 months to 29 months if one of you is determined by the Social Security Administration to be disabled, either at the time of the initial qualifying event

or at any time during the first 60 days of COBRA continuation coverage. Notice of such disability determination must be provided to the Plan on a date that is both within 60 days after the date of the determination and before the end of the 18-month period applicable to the initial qualifying event.

If the disability extension applies with respect to a qualifying event, it applies with respect to each qualified beneficiary entitled to COBRA continuation coverage because of that qualifying event. Thus, the 29-month maximum coverage period applies to each qualified beneficiary who is not disabled as well as to the qualified beneficiary who is disabled and it applies independently with respect to each of the qualified beneficiaries.

The qualified beneficiary must notify the Plan within 60 days if he or she is no longer disabled. The disability extension of COBRA continuation coverage will terminate upon recovery from disability if 18 months of continuation coverage have already been received.

If more than one qualifying event occurs, no more than 36 months of COBRA continuation coverage will be available. Coverage will end sooner if Volvo ceases to provide any group health coverage, or if you or the individual covered under COBRA, after electing COBRA continuation coverage:

- initially becomes covered under another group health plan that does not have a pre-existing condition limitation, or
- fails to make required contributions when due, or
- initially becomes eligible for Medicare benefits. For purposes of termination of COBRA continuation coverage, an individual becomes eligible for Medicare benefits upon the effective date of enrollment in Part A or Part B, whichever occurs earlier.

(c) Scope of Continuation Coverage

If a qualified beneficiary elects continuation coverage, the Plan will permit him or her to continue the Medical, Prescription Drug, Vision, and Dental Coverage that he or she was receiving immediately before the qualifying event. Such coverage will be identical to those coverages provided under the Plan to similarly situated employees, spouses and/or dependent children. COBRA continuation coverage does not include the continuation of Life Insurance, AD&D Insurance, A&S or LTD Coverages.

(d) Cost of COBRA Continuation Coverage

You must pay the entire cost for COBRA continuation coverage. In the event you become eligible to elect COBRA continuation coverage, your Human Resources Department will advise you of your cost for coverage. In the case of disabled

participants who continue coverage after 18 months (up to 29 months) the maximum cost for COBRA coverage will be 150% of the cost for the extra coverage period.

Your first payment, covering the entire period since the date of the qualifying event, is due within 45 days after the date on which COBRA continuation coverage is elected. Thereafter, you must pay for COBRA continuation coverage on a monthly basis, and payment is due at the Plan by the first of every month. You will receive a 30-day grace period each month. As such, payment must be received by the end of the grace period on last day of the current month of eligibility. Failure to pay any premium in a timely manner (either by the end of the 45-day initial premium payment period or by the end of the monthly grace period) could cause your COBRA continuation coverage to be retroactively terminated. The Plan is not required under COBRA to send premium billing statements.

Payment of benefits for any period may be delayed until your payment is received for that period. If you use the Plan during any period, you will be responsible for the premiums for that period.

To the extent alternative continuation privileges are available under the Program that satisfy all the requirements for COBRA continuation coverage, such alternative continuation privileges will be integrated with the COBRA continuation coverage.

(e) COBRA Continuation Coverage Notification

In the event of a divorce or legal separation, enrollment in Medicare, or a child no longer qualifying as a dependent, you must notify your Human Resources Department as soon as possible, but no later than 60 days after the event. Within 14 days, your dependents will be advised of their rights to continue coverage under the Plan.

In the event of a termination of employment, reduction of hours, or your death, you, your spouse, and/or your dependent children will automatically be notified of this opportunity to continue coverage. If you do not receive such notice within 14 days, please contact the Human Resources Service Center.

If your family experiences another qualifying event while receiving COBRA continuation coverage, and if your spouse and dependent children wish to extend the duration of their continuation coverage as described above, you must make sure that the Human Resources Service Center is notified of the second qualifying event within 60 days after the occurrence of such second qualifying event.

In order to protect your family's rights, you should keep the Human Resources Service Center informed of any changes in the addresses of you or your family members. You should also keep a copy, for your records, of any notices you send to the Human Resources Service Center.

(f) Election of COBRA Continuation Coverage

You, your spouse, and/or your dependent children will have at least 60 days in which to elect continuation coverage. This election period will end the later of 60 days from the date you are notified of your continuation coverage rights or 60 days from the date of your loss of coverage. The Plan is not required to pay benefits until you have elected continuation coverage and paid the applicable premium. If, however, you, your spouse, and/or your dependent children apply for benefits under the Plan during the election period and benefits are paid from the plan, you will be considered to have elected continuation coverage, and you will be legally responsible for the premiums for that coverage.

In accordance with the Trade Act of 2002, you will be afforded a second 60-day COBRA election period if you become eligible for trade adjustment assistance (TAA) under the Trade Act of 1974. You may be eligible to receive TAA if your employment is adversely affected by international trade (increased imports or a shift of production to another country). If you are a TAA-eligible individual and you did not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of a TAA-related loss of coverage, you may elect continuation coverage during a 60-day period that begins on the first day of the month in which you are determined to be TAA-eligible, provided such election is made not later than 6 months after the date of the TAA-related loss of coverage. You may elect coverage for yourself and your eligible dependents who are also qualified beneficiaries. Any continuation coverage elected during the second election period will begin with the first day of the second election period, and not on the date on which coverage originally lapsed.

Any coverage which has been extended will end for you or your covered dependents on the first date on which any of the following occurs:

- the maximum coverage period for your qualifying event ends;
- you fail to pay the cost of COBRA continuation coverage on a timely basis;
- the date after electing COBRA continuation coverage, that the qualified beneficiary initially becomes covered for benefits under another group plan, unless the new plan contains a pre-existing condition exclusion or limitation which applies to any pre-existing condition of you and/or your dependent;
- the date that group health plan coverage ends for all employees of the Company;
- the date, after electing COBRA coverage, that the qualified beneficiary initially becomes entitled to Medicare benefits (except in certain cases).

- the date on which the Social Security Administration determines that a covered person receiving 11 additional months of COBRA continuation coverage under a disability extension (beyond the initial 18-month period) is no longer disabled.

(g) Effect of Failure to Elect Continuation Coverage

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage to the maximum time available to you.

(h) If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact your HR Service Center at 800-344-8339, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA website at www.dol.gov/ebsa.

SECTION 13 Adoption Assistance

Mack UAW Bargaining employees are eligible for the Volvo Group Corporate Adoption Assistance Policy. This policy may change in the future, so please contact People Services for the most current information.

a) Eligibility:

Children under the age of 19 (including stepchildren) whose adoptions are finalized on or after 11/15/2023 are eligible. An adoption will be

considered final only when an adoption decree is entered by a court of competent jurisdiction.

Only one adoption per employee (or couple if both parents work for the Company or an affiliated company) per calendar year is eligible for reimbursement. Adoption of multiple children (e.g., twins, siblings) at one time is considered one adoption.

b) Qualified Expenses:

The Adoption Assistance program reimburses up to $3,000 of eligible expenses for each adoption (including the adoption of multiple children at one time). Eligible expenses are only those expenses that are directly related to and for the principal purpose of the legal adoption of an eligible child.

Examples of covered expenses include:

- **Legal fees/court costs**
- **Adoption agency fees**
- **Placement fees**
- **Medical expenses for the child prior to the time of adoption of the child**
- **Immigration fees for the child**
- **Temporary foster care charges which are paid to the foster care provider immediately preceding the placement of the child in the home of the adopting family**
- **Travel expenses required to pick up a child from another location**
- **Other expenses directly related to the legal adoption of a child which are not in violation of state or federal laws**

c) Non-Qualified Expenses:

Expenses that do not qualify include, but are not limited to:

- **Donations**
- **Costs associated with legal guardianship**

d) Applying for Reimbursement:

Once the child's adoption is final, complete the Adoption Assistance Program Reimbursement Request Form available from the HRSC or the Intranet violin website. Send this completed claim form, along with receipts for eligible expenses, and a copy of the adoption decree to the Human Resources Service Center. The claim will be reviewed and a

payroll check will be issued upon approval. Reimbursement checks will not be issued to any third party, such as adoption agencies, attorneys or medical providers.

Adoption assistance claims will be paid only if they are received in the HRSC within 180 days of the finalized adoption of the child. If the adoption decree is not available within the 180 days, the deadline will be extended to within seven days of the receipt of decree.

e) Withholding Taxes:

Some or all of the qualified expenses reimbursed to employees may not be subject to federal income taxation. A tax advisor should be consulted for guidance on the taxation of these reimbursed amounts. The employee is responsible for the determination and payment of any tax liability that may result from the receipt of reimbursed adoption expenses. No federal withholding will be taken from the reimbursement.

f) Social Security Taxes:

As of the date of issuance of this policy, adoption assistance benefits are not exempt from Social Security and Medicare taxes. Therefore, these taxes and any other legally mandated taxes will be withheld from adoption reimbursements to the employee. For more information about the tax treatment of adoption assistance benefits, the employee may refer to IRS Publication #968 (Tax Benefits for Adoption).

ARTICLE V

General

SECTION 1 Group Practice

In the event that a group practice direct service medical or dental care plan is established or is available in any location where a facility of the Company is located, the parties agree that, subject to the group practice plan satisfying both parties as to the comprehensiveness and quality of services provided, each employee in such location will annually be offered the opportunity to choose between the group practice plan and the medical or dental care coverage as outlined herein. The Company will pay to the group practice plan, on behalf of those employees selecting such coverage an amount equal to what it would have paid for the coverage outlined herein.

SECTION 2 Issue Resolution

(a) The question of whether or not an employee is eligible for participation in the Program within the meaning of this Agreement may be determined through the grievance procedure at the plant where the employee works or worked.

(b) In the event of any conflict between the provisions of the Insurance Program, (i.e., Appendix "B") and the provisions of any Insurance Policy or Rider, the provisions of the Insurance Program will supersede the provisions of such Policies or Riders to the extent necessary to eliminate such conflict.

(c) It is understood that no grievance procedure of any collective bargaining agreement between the parties hereto shall apply to the Insurance Program or any insurance contract in connection therewith and that any claim for an insured benefit will be presented for settlement only to the insurer. Claims that are not settled in accordance with the terms of the Insurance Program shall be resolved in accordance with the Claims Review and Appeals Procedure in Article V, Sections 3 and 4.

SECTION 3 Claims Review and Appeals Procedures (except Express Scripts)

The law provides that the Plan must set up reasonable rules for filing a claim for benefits. In general, you (or your designated beneficiary) must file a written claim on the appropriate form. Claims are normally filed by your provider.

Your claim and appeal rights as described herein may be asserted on your behalf by your authorized representative (including a UAW Representative).

The law allows a reasonable amount of time for the Claims Administrator to evaluate a claim and to decide whether to pay benefits based on the information contained in the written claim.

You are entitled to receive written notice as to the status of your claim – whether it is allowed, in full or in part, or denied. The timing of such notice depends upon the type of claim that has been filed. The specific time periods are described below. If your claim is denied in whole or in part, you may appeal the denial by following the specified appeal procedures for each plan. Some plans have multiple levels of appeal, except life insurance and long term disability, which are determined by the carrier. The group health plan for example, has multiple levels of appeal, including the right for an external review of the denial in certain situations. The first level of appeal for health plans is a mandatory

appeal with the Claims Administrator. If you are not satisfied with that determination, you may wish to initiate a second, voluntary appeal for your claim. For your voluntary appeal, you must choose to use either the external review for the group health plan or the UAW appeal process described later in this Section.

(a) Timing of Notice of Initial Determination

You are entitled to receive written notice as to the status of your claim – whether it is allowed, in full or in part, or denied. The timing of such notice depends upon the type of claim that has been filed.

In the case of a health claim involving urgent care, you will receive notice of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account all medical emergencies and circumstances, but not later than 72 hours after the Plan receives your claim, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You shall then be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall then notify you of its benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information or the end of the period afforded to you to provide the additional specified information.

If the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, the Plan shall notify you of any reduction or termination by the Plan of such course of treatment before the end of such period of time or number of treatments. Such notice shall be provided at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

If you have a claim for urgent care and you wish to extend a course of treatment beyond the period of time or number of treatments that constitutes such urgent care, the Plan shall decide your request as soon as possible, taking into account all medical emergencies and circumstances, and the Plan shall notify you of its benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the period of time or number of treatments.

In the case of any other pre-service health claim, the Plan shall notify you of the Plan's benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the

Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the Plan's control and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which a determination will be made. If such an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension shall specifically describe the information required and you shall be afforded at least 45 days from receipt of such notice within which to provide the specified information.

In the case of any other post-service health claim, the Plan shall notify you of the Plan's benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the Plan's control and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a determination will be made. If such an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension shall specifically describe the information required and you shall be afforded at least 45 days from receipt of such notice within which to provide the specified information.

In the case of a claim for disability benefits, the Plan shall notify you of the Plan's benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim. This period may be extended by the plan for up to 30 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the Plan's control and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension and the date by which a determination will be made. If prior to the end of the first 30-day extension period, the Plan determines that, due to circumstances beyond the control of the Plan, a decision cannot be rendered within the extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Plan notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the determination will be made. In the case of any extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The claimant shall be afforded at least 45 days to provide the specified information.

In the case of a claim for life insurance benefits, the Plan shall notify you of the Plan's benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended by the Plan for up to 90 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the Plan's control and notifies you, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension and the date by which a determination will be made. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(b) If Claim is Denied

If your claim under the Plan is denied, either in full or in part, you will receive a written notice that explains the reasons for the denial and references to the specific Plan provisions on which the denial was based. If your claim was denied because you did not furnish complete information or documentation, the notice will state the additional materials needed to support your claim and why such information is necessary. The notice will also tell you how to request a review of the denied claim and will also include a statement of your right to bring a lawsuit under section 502 of the Act following a denial on review.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the benefit determination, the notice of denial will set forth either the specific rule, guideline, protocol or other similar criterion, or a statement that such was relied upon and will be provided to you free of charge upon request.

If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice shall set forth 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 such an explanation will be provided free of charge upon request.

In the case of a denial of a claim involving urgent care, the notice will describe the expedited review process applicable to such claims.

(c) Appeal of Claim Denial

You shall have a reasonable opportunity to appeal any denial of your claim, and such appeal shall involve a full and fair review of your claim.

Your appeal shall be submitted within 180 days of your receipt of the notice that your claim has been denied. As part of your appeal you may submit written comments, documents, records and other information relating to your claim. You may also be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim. The

review of your claim shall take into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review on appeal shall not afford any deference to the initial denial. If the denial of your claim is based in whole or in part on a medical judgment, the review shall involve consultation with a health care professional who has appropriate training and experience in the field involved in the medical judgment and who was not an individual consulted in connection with the initial benefit determination. Additionally, you will be notified of the identity of medical or vocational experts whose advice was obtained by the Plan in connection with your claim, without regard to whether the advice was relied upon in the denial of the claim.

In the case of a claim involving urgent care, the review process may be expedited in that you may request an expedited appeal either orally or in writing and all necessary information, including the plan's determination on review, may be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

(d) Timing of Notification on Appeals

In the case of a claim involving urgent care, the Plan shall notify you of the Plan's determination on appeal as soon as possible, taking into account all medical emergencies and circumstances, but not later than 72 hours after receipt of the request for review.

For a pre-service health claim, the Plan shall notify you of the Plan's determination on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the request for review.

For a post-service health claim, the Plan shall notify you of the Plan's determination on appeal within a reasonable period of time, but not later than 60 days after receipt of the request for review.

For a claim involving disability benefits, the Plan shall notify you of the Plan's determination on appeal within a reasonable period of time, but not later than 45 days after receipt of the request for review. This period may be extended by the Plan for up to 45 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the Plan's control and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension and the date by which a determination will be made. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

For a claim involving life insurance benefits, the Plan shall notify you of the Plan's determination on appeal within a reasonable period of time, but not later than 60 days after receipt of the request for review. This period may be extended by the Plan for up to 60 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the Plan's control and notifies you, prior to the expiration of the initial 60-day period, of the circumstances requiring the extension and the date by which a determination will be made. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(e) Denial of Appeals

If your appeal is denied, either in full or in part, you will receive a written notice that explains the reasons for the denial and references to the specific Plan provisions on which the denial was based. The notice will tell you 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. The notice will describe the voluntary appeal procedures described below and will include a statement of your right to bring a lawsuit under section 502 of the Act.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, the notice of denial will set forth either the specific rule, guideline, protocol or other similar criterion, or a statement that such was relied upon and will be provided to you free of charge upon request.

If the denial on appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice shall set forth either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to our medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

(f) Additional Voluntary Appeals For Medical Claims – Member may choose between an External or UAW Review

1. External Review

If the outcome of the mandatory first level appeal is adverse to You and it was based on medical judgment, You may be eligible for an independent External Review pursuant to federal law.

You must submit Your request for External Review to the Claims Administrator within four (4) months of the notice of Your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal

appeal. However, You are encouraged to submit any additional information that You think is important for review.

- For pre-service claims involving urgent/concurrent care, You may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To proceed with an Expedited External Review, You or Your authorized representative must contact the Claims Administrator at the number shown on Your identification card and provide at least the following information:
- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by You or Your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

You must include Your Member Identification Number when submitting an appeal.

This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other benefits under this health care plan. There is no charge for You to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

2. UAW Appeal Process
   Procedures will be developed at the local operations with respect to discussions between Company and Local Union representatives in regard to the status of benefit claims presented under the Insurance Program.

In the event that local procedures do not result in disposition of the claim, the Corporate Human Resources Department will furnish upon request of the Director of the UAW Heavy Truck Department any necessary information concerning the status of a claim upon which the question has arisen.

After the Corporate Human Resources Department has furnished information concerning the status of a claim, the Director of the UAW-Heavy Truck Department may request a meeting with representatives of the Company for the purpose of discussing any specified claims upon which questions remain. The date upon which such meetings are to be held will be determined by mutual agreement. All questions raised with respect to such claims will be based on the provisions of the Insurance Program, and the responses to such questions will be in accordance with such Program.

In the event the response of the Corporate Human Resources Department does not resolve the claim, and, in the opinion of the Union, the response violates any provision of the Insurance Program, the Union may request the appointment of an Impartial Arbitrator to hear and determine such dispute. Such Arbitrator will be the Permanent Arbitrator under the Master Agreements unless within thirty days after such request another person is selected by mutual agreement.

The Arbitrator shall make his decision in accordance with the applicable provisions of the Insurance Program and he shall have no authority to add to or subtract from or modify any of the terms of the Insurance Program, nor to change or add to any benefit provided by the Insurance Program, nor to waive or fail to apply any requirement of eligibility for a benefit under the Insurance Program.

No decision of an Arbitrator in one case shall create a basis for a retroactive adjustment in any other case prior to the date of written filing of such other claim.

There shall be no appeal from any ruling by the Arbitrator which is within his authority. Each such ruling shall be final and binding on the Union and its members, the employee or employees involved, and on the Company. Any case referred to the Arbitrator on which he has no authority to rule shall be referred back to the parties.

The Company and the Union shall bear equally the fees and expenses of the Arbitrator.

(g) Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If Your health benefit plan is sponsored by Your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and Your appeal as described above results in an adverse benefit determination, You have a right to bring a civil action under Section 502(a) of ERISA.

SECTION 4 Claims Review Procedures and Appeals for Prescription Drugs (Express Scripts)

A pre-service claim is a request for coverage of a medication when your plan requires you to obtain approval before a benefit will be payable. For example, a request for prior authorization is considered a pre-service claim. For these types of claims (unless urgent as described below) you will be notified of the decision not later than 15 days after receipt of a pre-service claim that is not an urgent care claim, provided you have submitted sufficient information to decide your claim. A Post-Service claim is a request for coverage or reimbursement when you have already received the medication. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim.

If sufficient information to complete the review has not been provided, you will be notified that the claim is missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information. If all of the needed information is received within the 45-day time frame, you will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45-day period, your claim is considered "deemed" denied and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you

are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

(a) Urgent Claims (Expedited Reviews)

An urgent care claim is defined as a request for treatment when, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim provided there is sufficient information to decide the claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim that information is necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim is considered "deemed" denied and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

(b) Non-Urgent Appeal

If you are not satisfied with the decision regarding your benefit coverage or you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered "deemed" denied because missing information was not timely submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician).

To initiate an appeal for coverage, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied and
- any additional information that may be relevant to your appeal

This information should be mailed to:
Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. If your appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim).

If you are not satisfied with the coverage decision made on your appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

This information should be mailed to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you have the right to bring a civil action under ERISA section 502(a).

In addition, for cases involving medical judgment or rescission, if your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you have the right to an independent review by an external review organization. Details

about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

(c) Urgent Appeal (Expedited Review)

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not timely submitted) if your situation is urgent. An urgent situation is one where in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. To initiate an urgent claim or appeal request, you or your physician (or other authorized representative) must call 1-800-753-2851 or fax the request to 1-888 235-8551. Claims and appeals submitted by mail will not be considered for urgent processing unless and until you call or fax and request that your claim or appeal be considered for urgent processing. In the case of an urgent appeal (for coverage involving urgent care), you will be notified of the benefit determination within 72 hours of receipt of the claim. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance of any final adverse determination. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of Appeal prior to an external review.

If your appeal is denied and you are not satisfied with the decision of the appeal (i.e., your “final adverse benefit determination”) or any appeal denial notice (i.e., “adverse

benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you have the right to bring a civil action under ERISA section 502(a).

In addition, for cases involving medical judgment or rescission, if your appeal is denied and you are not satisfied with the decision (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., your "adverse benefit determination" or "final adverse benefit determination") does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you have the right to an independent review by an external review organization.

In addition, in urgent situations where the appropriate timeframe for making a non-urgent care determination would seriously jeopardize your life or health or your ability to regain maximum function, you also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time you request the independent external review. If you are not satisfied or you do not agree with the determination of the external review organization, you have the right to bring a civil action under ERISA section 502(a).

Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

(d) External Review Procedures

The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal in accordance with the above process and

also request an external independent review at the same time, alternatively, you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day).

Your request should be mailed or faxed to:

Express Scripts
Attn: External Review Requests
P.O. Box 631850
Irving TX 75063-0030
Phone: 1 800 753 2851
Fax: 1 888 235 8551

(e) Non-Urgent External Review

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and you will be notified within 1 business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review and if the IRO has determined that your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a). If the IRO has determined that your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review and you have the right to bring civil action under ERISA section 502(a).

(f) Urgent External Review

Once you have submitted your urgent external review request, your claim will immediately be reviewed to determine if you are eligible for an urgent external review.

An urgent situation is one where in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

If you are eligible for urgent processing, your claim will immediately be reviewed to determine if your request is eligible to be forwarded to an IRO, and you will be notified of the decision. If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your appeal information will be compiled and sent to the IRO. The IRO will review your claim within 72 hours and send you, the plan and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

SECTION 5 Health Care Coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994

As provided by the Uniformed Services Employment and Reemployment Act of 1994, you and your dependents have the right to continue your group health benefits – including medical, prescription drug, dental and vision coverage – if you are on military leave of absence.

For the first 31 days of your military leave, your cost for coverage will be equal to the rate paid by active employees. If your military service lasts longer than 31 day the Company will subsidize the cost of COBRA benefits for two months, reducing the cost to the same level active employees pay. After two months, your cost will be 102% of the Company's cost. This period of coverage will count towards your COBRA allotment of 24 months if you do not return to work.

Please contact the HR Services Center for information about the coverage available under the Uniformed Services Employment and Reemployment Rights Act of 1994.

SECTION 6 About your Privacy

HIPAA imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, or PHI, includes virtually all identifiable health information held by any health plan including the medical, prescription drug, dental and vision plans and the EAP – whether received in writing, in electronic medium, or as on oral communication.

Mack has implemented policies and practices to appropriately protect the privacy of your protected health information. PHI that you provide will be handled in accordance with the Mack/Volvo HIPAA Privacy Policy.

SECTION 7 Plan Administrative Information

The Company is the Plan Administrator and is responsible for the general administration of the Plans and for carrying out the provisions thereof. The Plan delegates discretionary authority to the Plan Administrator to interpret the Plan on all issues of coverage and operation.

The Company is the named fiduciary with respect to the Plans and may delegate to various officers, employees and committees of the Company authority, as well as the right of delegation, to carry out such of its responsibilities as it deems proper to the extent permitted by the Employee Retirement Income Security Act of 1974 as now in effect or as hereafter amended.

Plan Name
The official plan document covering the plans in Appendix B is the Volvo Welfare Benefits Plan. Appendix B of the UAW Benefits Agreement highlights the welfare benefits for the active employees of Mack Trucks, Inc. or other UAW facilities covered under the Mack Master Agreement.

Plan Type
This plan is a welfare benefits plan.

Plan Sponsor and Plan Administrator
Mack Trucks, Inc.
8003 Piedmont Triad Parkway
Greensboro, NC 27409

Employer Identification Number
22-1582040

Plan Number
506

Plan Year
January 1 through December 31

Claims Administrators
Multiple claim administrators provide services to benefits covered under Appendix B.

Anthem Blue Cross Blue Shield (PPO and Vision Plans)
P.O. Box 105187
Atlanta, GA 303348-5187
Phone: 1-844-855-1942

Express Scripts (Prescription Drug Plan)
One Express Way
St. Louis, MO 63121
Phone: 1-866-467-1239

Keystone Health Plan Central (HMO Plan)
A Subsidiary of Capital BlueCross
2500 Elmerton Avenue
Harrisburg, PA 17110
Phone: 1-866-683-2242

Delta Dental (Dental Plan)
P.O. Box 9089
Farmington Hills, MI, 48333-9089
Phone: 1-800-662-8856

The Prudential Insurance Company of America (Life Insurance and AD&D Plan)
751 Broad Street
Newark, New Jersey, 07102
Phone: 1-800-524-0542

The Hartford Life and Accident Company (LTD Plan)
200 Hopmeadow Street
Simsbury, CT 06089
Phone: 1-800-915-1153

Businessolver (COBRA Administration)
1025 Ashworth Rd
West Des Moines, IA 50265
1-833-929-1113

Agent for Legal Process
Mack Trucks, Inc.
8003 Piedmont Triad Parkway
Greensboro, NC 27409

SECTION 8 Your Rights Under ERISA

As a participant in the Mack Welfare Benefits Plan for the UAW Employees covered under the Mack Master Agreement, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and all documents filed by the Plan with the U.S. Department of Labor, such copies of the latest annual report (Form 5500 Series) and plan descriptions.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. Volvo is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, your spouse or your 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 preexisting conditions under the Plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the 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.

In addition to creating rights for plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the employee benefit plan. The individuals 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 Mack, the union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare 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 within certain time schedules.

Under ERISA, there are steps you can 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 Volvo 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 Volvo. 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 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 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.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement of 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, 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.

SECTION 9 Letters of Understanding

LETTER # 1

Reissued: **November 15, 2023**

Mr. **John Eblin**
Assistant Director
UAW Heavy Truck Department, Solidarity House
8000 East Jefferson Avenue
Detroit, Michigan 48214

Dear Mr. **Eblin**:

The Company and the Union agree to revise the psychiatric and substance abuse benefits to comply with the federal Mental Health Parity Act when the law mandates these changes and to implement a managed psychiatric substance abuse program which provides quality psychiatric, substance abuse services at reasonable rates through direct contracting with a limited network of quality providers. Components of the program will include the following:

Inpatient (includes hospital, day/night programs, halfway houses, detox facilities, etc.) and outpatient closed panel of psychiatric and substance abuse professionals including psychiatrists, Ph.D. psychologists, masters degrees and licensed psychiatric social workers.

Enhanced outpatient benefits when network providers are used and care is coordinated by the Claims Administrator.

Patients will not have to complete any claim forms when network providers are used and care is coordinated by the Claims Administrator.

Network providers accept Plan payment as payment in full for covered services, except for any required employee copays when care is coordinated by the Claims Administrator.

EAP integrated with network providers and administrator.

Employees have choice of using network or non-network providers at any time.

When care is coordinated by the Claims Administrator, the employee receives the highest level of benefits described below. When care is not coordinated by the Claims Administrator, a lower level of benefits is provided as described below.

An experienced psychiatric and substance abuse management organization will be selected by the Company and the Union to perform provider recruitment, contracting and claims payment.

The Company and Union will review the Claims Administrator's systems/processes for quality assurance, credentialing, grievance and complaint procedures, utilization review and those other systems/processes deemed appropriate.

Benefits to be provided will be as follows:

	Coordinated	Not Coordinated
Inpatient:		
Plan Payment	100%	50% of allowable (network) rate, up to 30 days per calendar year.
Outpatient:		
Plan Payment	100%	50% of allowable rate
Copayment	$10 per visit	None
Number of Visits	60 visits per calendar year	30 visits per calendar year

Any referrals by a network provider to a non-network provider will be covered at 100% (less any applicable co-payments).

Emergency services will be covered at the "Coordinated" care level provided the Claims Administrator is notified within 48 hours or the first business day if the treatment occurs on a weekend.

Very truly yours,

Holly Georgell
Director, Employee & Labor Relations

LETTER #2

Reissued: **November 15, 2023**

Mr. **John Eblin**
Assistant Director
UAW Heavy Truck Department, Solidarity House
8000 East Jefferson Avenue
Detroit, Michigan 48214

Dear Mr. **Eblin**:

Mack and the UAW have long recognized the major problems we jointly confront with the U.S. health care system. The Company and the UAW share a serious concern about the high cost of the health care system and the large number of uninsured. The high cost of health expenditures diverts corporate funds from other business priorities that will enable Mack to compete more effectively in the market place. Despite the Company's and UAW's efforts to manage our health care programs offered to members of our Mack family, Company health care costs have continued to increase at unacceptable rates. Indeed, the increasing amount of national resources allocated to health care, at the expense of other national priorities, adversely impacts the nation's ability to compete with other industrialized countries. Both Mack and the UAW share the common objective for a high quality health care delivery system within our nation that is accessible to all and which functions in a cost effective manner. In this regard, Mack and the UAW jointly agree to support approaches directed towards achieving prompt and lasting private sector and national policy solutions which will assure high quality care to all individuals. Such approaches should include strong cost containment, equitable financing, and appropriate quality assurance mechanisms.

Very truly yours,

Holly Georgell
Director, Employee & Labor Relations

APPENDIX C

SUPPLEMENTAL UNEMPLOYMENT BENEFIT PLAN

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APPENDIX C

SUPPLEMENTAL UNEMPLOYMENT BENEFIT PLAN AGREEMENT

This Agreement shall become effective on **November 15, 2023**.

ARTICLE I

Regular Weekly Benefits

SECTION 1 Eligibility for a Regular Weekly Benefit

An employee **who has completed their probationary period** at time of layoff shall be entitled to a Regular Weekly Benefit if he:

(a) Was on a qualifying layoff, as described in Article III, Section 2, for all or part of a week; or
(b) Was eligible for a Reinstated Accident and Sickness benefit under Appendix B.
(c) Was not eligible for a Short Work Week Benefit.

SECTION 2 Amount of Regular Weekly Benefits

(a) An eligible employee shall receive $**345.00** for any qualifying week beginning on or after November 15, 2023.

(b) An eligible employee entitled to a reduced Regular Weekly Benefit because of ineligibility as provided in Article III, Section 2(b) with respect to part of the week, shall receive 1/5 of a Regular Weekly Benefit for each eligible workday.

SECTION 3 Duration of Regular Weekly Benefits

(a) Employees hired prior to March 25, 2013 will receive Regular Weekly Benefits in the amount set forth in Article I, Section 2 (a) based on the following table:

Seniority at Layoff	Maximum Number of Regular Weekly Benefits
3 to 10 years	26
10 or more years	52

(b) Employees hired prior to March 25, 2013 who are subsequently laid off will upon recall to work begin to regenerate their Regular Weekly Benefits (26 or 52 weeks as the case may be) on the basis of one (1) week of Regular Weekly Benefit for every one (1) full week of work up to their maximum number of eligible weeks as provided in section (a) above. A full week of work shall be defined as having worked or been paid forty (40) hours during a work week to include daily and weekend overtime hours worked and credit for hours paid under the Agreement for Jury Duty, Bereavement, Vacation, Holidays, or Military Leave training.

(c) Employees who have completed their probationary period and who were hired on or after March 25, 2013 who are subsequently laid off will receive Regular Weekly Benefits in the amount set forth in Article I, Section 2 (a) of up to a total maximum number of thirteen (13) weeks over the duration of the Agreement. Such employees will upon recall to work begin to regenerate Regular Weekly Benefits on the basis of one (1) week of Regular Weekly Benefit for every one (1) full week of work up to thirteen (13) weeks. A full week of work shall be defined as having worked or been paid forty (40) hours during a work week to include daily and weekend overtime hours worked and credit for hours paid under the Agreement for Jury Duty, Bereavement, Vacation, Holidays, or Military Leave training.

SECTION 4 Transitioning to a Regular Weekly Benefit Duration Level

An eligible employee who, by virtue of his length of seniority, transitions to the 26 weeks or 52 weeks Regular Weekly Benefits duration levels while on layoff, shall only become eligible for such newly acquired benefits duration level upon recall to active work.

ARTICLE II

Short Work Week Benefits

SECTION 1 Eligibility for a Short Work Week Benefit

An employee **who has completed the probationary period, including transitional workers who have converted to full time permanent status,** shall be entitled to a Short Work Week Benefit if:

(a) during such week he had less than 40 Compensated or Available Hours as defined in Article III, Section 1 of this Agreement, and

1) he performed some work for the Company, or

2) for such week he received some jury duty pay, bereavement pay, military pay, or vacation pay (excluding pay in lieu of vacation) from the Company, or

3) for such week, he received only holiday pay from the Company and, for the immediately preceding week, he either received a Short Work Week Benefit or had 40 or more Compensated or Available Hours.

(b) he was on a qualifying layoff, as described in Article III Section 2 for some part of the week.

SECTION 2 Amount of Short Work Week Benefit

(a) The Short Work Week Benefit shall be an amount equal to the product of the number by which 40 exceeds his Compensated or Available Hours (as defined in Article III, Section 1 of this Agreement) computed to the nearest tenth per hour, multiplied by his base hourly rate (excludes all premiums) at time of layoff, with the result multiplied by eighty percent (80%).

ARTICLE III

Benefit Determinations

SECTION 1 Compensated and Available Hours

For purposes of determining a benefit, an employee's Compensated or Available Hours during a week shall be calculated to include:

(a) All hours for which an employee receives pay from the Company during the week, including Holiday Pay, Bereavement Pay, Jury Duty/Witness Pay, Incidental Sick Pay, Military Leave Pay or Vacation Pay (excluding pay in lieu of vacation), with each hour paid at a premium rate to be counted as 1 hour, and

(b) All hours scheduled or made available to the employee by the Company but not worked by him (after having been given reasonable notice).

SECTION 2 Qualified Conditions of Layoff

(a) A layoff for the purposes of this Agreement includes any layoff resulting from a reduction in force or temporary layoff, or from the discontinuance of a plant or operation, and any layoff occurring or continuing because the employee was unable to do the work offered by the Company although able to perform other work in the plant to which he would have been entitled if he had had sufficient seniority.

(b) An employee's layoff for all or part of any week will be deemed qualifying for a Regular Weekly Benefit or a Short Work Week Benefit only if:

(1) such layoff or absence from work was not the consequence or result of:

(i) disciplinary suspensions or discharge, or

(ii) any strike, slowdown, work stoppage, picketing (whether or not by employees), or concerted action, at a Company facility or plants, or any dispute of any kind involving employees or other persons employed by the Company and represented by the Union whether at a Company facility, or elsewhere, or

(iii) any fault attributable to the employee, or

(iv) any war or hostile act of a foreign power (but not government regulation or controls connected therewith), or

(v) sabotage or insurrection, or

(vi) any act of God, or,

(vii) any refusal by the employee to accept available work when recalled pursuant to the Agreement.

(2) with respect to such week the employee was not eligible for and was not claiming:

(i) Company provided accident or sickness or Workers Compensation Benefits, or

(ii) any Company pension or retirement benefit;

(3) with respect to such Week the employee was not in military service (other than short-term active duty or training of 30 days or less) or on a military leave greater than 30 days.

(c) An eligible employee who is on a qualifying layoff and who is ordered for short-term active duty of 30 days or less in a National Guard, Reserve, or similar unit due to:

(1) training: will be deemed to be on a qualifying layoff for not more than two (2) weeks of Regular Weekly Benefits in a calendar year, or

(2) State or National emergency: will be deemed to be on a qualifying layoff for not more than four (4) weeks of Regular Weekly Benefits in a calendar year.

(d) (d) An eligible employee who is determined to be ineligible for a benefit for some part of a week due to the reasons listed in Section (b) above but who is otherwise eligible for some benefit for a part of the same week, shall be entitled to a reduced Benefit of 1/5 of a Regular Weekly Benefit for each regular workday (M – F) of eligibility during such week as provided in Article I, Section 2 (b).

SECTION 3 Acts of God

With respect to any layoff that results from an act of God, and the denial or reduction of either Regular Weekly Benefits or Short Work Week Benefits, the Company will give written notice to the Local Union Chairman. The written notice will be provided no later than the end of the week following the layoff and will show the reason or reasons for such denial or reduction of Regular Weekly Benefits or Short Work Week Benefits, and an explanation of the incident which caused the Company to determine that the layoff was the result of an act of God. For purposes of this Section, an act of God means an occurrence or circumstance directly affecting a Company facility or facilities which results from natural causes exclusively and is in no sense attributable to human negligence, influence, intervention, or control.

SECTION 4 Benefit Overpayments

If the Company determines that any benefit(s) paid under this Agreement should not have been paid or should have been paid in a lesser amount, he shall return the amount of overpayment to the Company. However, no repayment shall be required if the cumulative overpayment is $10 or less or if notice has not been given within 120 days from the date the overpayment was established or created; If the employee shall fail to return such amount promptly, the Company shall make a deduction from any future benefits (not to exceed $20 from any one benefit payment except in cases of fraud or willful misrepresentation) otherwise payable to such employee, or make a deduction from compensation payable by the Company to such employee (not to exceed $50 from any one paycheck except in cases of fraud or willful misrepresentation), or both. The Company is authorized to make such deduction from the employee's compensation.

SECTION 5 Deduction of Union Dues

The Company, upon authorization from an employee, shall deduct monthly Union dues from Regular Weekly Benefits paid under this Agreement and pay such sums directly to the Union in his behalf.

ARTICLE IV

Administration

SECTION 1 Authority of the Company

The Company shall have authority as is necessary and appropriate in order to carry out its duties under this Agreement, including, without limitation, the following:

(1) to investigate the correctness and validity of information furnished with respect to the eligibility and amount of a benefit;

(2) to make initial determinations with respect to benefits;

(3) to establish reasonable rules, regulations and procedures;

(4) to establish and maintain necessary records; and

(5) to prepare and distribute information explaining this Agreement

Any dispute as to the application of the provisions of this Appendix are subject to the grievance procedure contained in Article 5 of the Master Agreement.

APPENDIX D

TRANSFER TO OTHER LOCATIONS

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APPENDIX D

TRANSFER TO OTHER LOCATIONS

SECTION 1 Restatement of the Plan

Set forth in this Appendix D are the terms and conditions governing the transfer of employees to other plant, office, engineering, or parts distribution center locations. It is specifically understood that transfer under these provisions refers to transfer of work on or after the effective date of this Agreement from a plant, office, engineering or parts distribution center location covered by the Agreement.

SECTION 2 Transfers to New or Existing Locations

The terms of this Section 2 shall govern inter-location transfers (i.e., transfers between plants, offices, engineering, or parts distribution center locations operated by the Company and covered by the Agreement). The plant, office, engineering, or parts distribution center location operated by the Company and covered by the Agreement, from which work is transferred, shall hereinafter be referred to as the "old location". The plant, office, engineering, or parts distribution center location to which work is to be transferred shall hereinafter be referred to as the "new location ".

In the event of a transfer of one or more operations from an old location to a new location, the employees affected by such transfer shall have the right to transfer to the new location with the transferred work. However, the number of employees transferring shall not exceed the number of employees required to perform the work of the transferred operations at the new location. The classifications and the rates for such classifications in effect at the new location shall be applicable to the transferred work. In the event there are no classifications at the new location applicable to the transferred work, appropriate classifications and rates of pay shall be agreed upon between the Local Union and the Company at the new location. The parties shall use the framework of the classification and rate system of the new location, pursuant to Article 16, Section 55 of the Agreement. Upon transfer, the employee accepting such transfer waives all recall rights to the old location and shall carry to the new location full old location seniority. The employee's old location seniority shall be used for all affected contractual benefits.

Since each transfer of operations between Company locations is likely to be unique, the Company and the International Union and the affected Local Unions will meet promptly, pending transfer of work between such locations, to determine among other things:

1. The number of employees to be transferred

2. The method of canvassing and the employees to be canvassed in the old location

   (a) who are working on the jobs to be transferred and

(b) who possess the necessary qualifications (as defined in the applicable Local Supplemental Agreement) in seniority order in the jobs affected by the transfer, including such employees on layoff.

3. The number of employees, if any, in the new location who are on layoff but:

   (a) have seniority in the classifications affected by the transfer of work and

   (b) have recall rights to such classifications and

   (c) have more seniority than the canvassed employees at the old location who have indicated a desire to transfer.

4. The mechanics of the actual transfer of work from the old location to the new location, taking into consideration the following:

   (a) any problems of phasing out the work in the old location,

   (b) deviations from seniority in conjunction with the transfer required by the Company,

   (c) the desires of the employees by seniority preference on the timing of their individual transfer to the new location.

   Details as to the application of the principles set forth above as related to any particular transfer shall be the subject of discussion between the Company and the International Union and the Local Unions directly affected.

   While it is the desire of the parties to reach mutual agreement on the application of the terms of Appendix D to the particular transfer involved, failure to reach agreement on such application or delay in reaching such agreement shall not serve to delay the transfer of such work and the Company shall not be subject to any back pay or retroactive monetary liability under the grievance procedure or otherwise as the result of going forward with such transfer. This provision shall not operate, however, to prevent corrections from being made through the grievance procedure of the application of the principles agreed upon herein or agreements reached hereunder.

   Nothing in the preceding language shall negate the application of the Master Recall List provisions of Article 6.

SECTION 3 Relocation Allowance

An employee who is transferred from one Company location to another, pursuant to Section 2 of this Appendix D, will promptly be paid a relocation allowance, provided:

(a) The location to which the employee is to be relocated is at least fifty (50) miles from the location from which the employee was transferred, and

(b) As a result of such relocation, the employee changes permanent residence, and

(c) The employee makes application within six (6) months after commencement of employment at the new location.

SECTION 4 Relocation Allowance Amount

The amount of relocation allowance for employees transferred on or after the effective date of this Agreement will be determined as follows:

Miles Between Plants	Single Employees	Married Employees
50 - 99	$ 1,600	$3,200
100 - 299	$1,800	$3,600
300 - 499	$1,900	$3,800
500 & over	$3,000	$6,000

SECTION 5 Conditions Affecting Allowance Amount

(a) An employee's relocation allowance, when combined with any present or future federal or state relocation allowance or its equivalent, shall not exceed the maximum amount of the relocation allowance provided for under Section 4 above.

(b) Only one relocation allowance will be paid where two or more members of a family living in the same residence are relocated pursuant to this Appendix D.

(c) Employees who are single parents with dependents (as defined by IRS regulations) will be eligible to receive the married relocation amount provided the dependents are residing with the single parent at the time of the relocation.

APPENDIX E

MACK-UAW PROFIT SHARING PLAN

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MACK - UAW Profit Sharing Plan

A. Duration and Eligibility

1. The Plan is effective January 1, 2012.

2. The Plan shall remain in effect through the duration of the **November 15, 2023** Master Agreement, including any extensions of the contract.

3. Seniority employee members of UAW local unions hired prior to the effective date of this Agreement and covered by the Agreement are participants in the Profit Sharing Plan provided:

   (a) such employee worked during a Plan year, and

   (b) prior to the end of the applicable Plan year such employee is neither discharged nor voluntarily quits.

4. Employees hired or rehired on or after January 1, 2018 will become participants in the Profit Sharing Plan on January 1st following date of hire and will be subject to the eligibility provisions of A. 3. a) and b) above. For example, an employee hired on July 1, 2018 will become eligible to participate in the Profit Sharing Plan on January 1, 2019 with any earned payout payable on April 30, 2020.

5. Employees who quit and are subsequently rehired in the same plan year will be credited for all hours worked in the Plan year.

6. Discharged employees, if reinstated, will receive credit for all awarded back pay hours in addition to all hours worked during the Plan year.

7. In the event an otherwise eligible employee dies during a Plan year, his profit sharing benefit shall be paid to the person designated as his beneficiary under the Company's Group Life Insurance Plan.

8. Employees who retire during the Plan year receive credit for all hours worked in that Plan year.

9. Employees who voluntarily quit active employment on or after January 1 following the end of the applicable Plan year are eligible for the profit sharing payout.

10. Employees involuntarily separated from active employment on or after January 1 following the end of the applicable Plan year are not eligible for the profit sharing payout.

B. Formula for Fund Development.

1. The basis for which this Plan is funded is the return of shareholders' equity (ROE) percentage of the AB Volvo Group as published in its annual report. (For example, the 2010 ROE was 16%). The AB Volvo Group's ROE percentage calculation is

defined as Income for the period divided by average shareholders' equity. If the AB Volvo Group does not publish a ROE percentage in its annual report, the Company will calculate the ROE percentage using the definition above and forward the details of the calculation to the UAW.

2. Size of the profit sharing fund will be determined as follows:

   a. Based on the ROE percentage calculated in item B 1. aAbove, a profit sharing funding per bargaining unit employee will be determined based on the table below.

   b. The total profit sharing fund will then be calculated by multiplying the profit sharing funding per bargaining unit employee from the table below by the total annual average number of bargaining unit employees. Such average shall be the total of all bargaining unit employees on the last day of each month in the year divided by twelve (12).

   c. In determining the total of bargaining unit employees, the following guidelines shall apply:

      i) All bargaining unit employees actively at work or on vacation, but excluding employees on leaves of absence, are included.

      ii) Employees who are on sick leave or personal business and do not have hours worked during the pay period will not be counted in the headcount for that pay period.

      iii) Employees who retire will be eligible for the payout but will not be included in the headcount after retirement.

      iv) Employees who are on indefinite or temporary layoff and do not have hours worked during a pay period will not be counted.

ROE %	Payout Funding Per Bargaining Unit Employee
Less than 11.99%	$0
12% to 12.99	$400
13% to 13.99	$550
14% to 14.99	$700
15% to 15.99	$850
16% to 16.99	$1,000
17% to 17.99	$1,200
18% to 18.99	$1,400
19% to 19.99	$1,700
20% to 20.99	$2,000

21% to 21.99	$2,300
22% to 22.99	$2,600
23% to 23.99	$2,900
24% to 24.99	$3,200
25% and >	$3,580

3. Payout Calculation & Notification

   a. An average payout per hour worked will be computed by dividing the calculated fund (determined in item 2.b above) by the total number of straight time hours worked (during regularly scheduled eight (8) hour shift, five (5) day week) by all eligible bargaining unit employees. The payout per participant will be calculated by multiplying the average payout per hour by the number of straight time hours worked by the participant.

   b. The Company will provide three (3) copies of the final audited Profit Sharing report to the International Union by March 31st of the year following the end of the Plan year.

   c. All payouts, if any, will be made by April 30 of the year following the end of the Plan year, or by the last business day before April 30th.

   d. Bargaining unit employees will have the option to receive the payout as wages or to be deposited directly into their 401k account in lieu of being treated as wages. Such election may be made annually by April 15 following the end of the Plan year. The Company will supply duplicate forms to all bargaining unit employees to make this election. When payouts are received as wages all required deductions will be taken with FIT calculated at the rate dictated by federal regulations.

   e. The Company and the International Union will issue a joint written notice of the Plan's payout status prior to the direct deposit or distribution of the checks.

C. Other Understandings.

1. Time spent on Union duties by bargaining unit employees who are on the active payroll will be counted as hours worked.

2. Hours worked by employees on weekly payroll shall be the total straight time hours worked during the regularly scheduled eight (8) hour shift, five (5) day week, excluding all overtime hours but including holiday pay and observed vacation entitlement, as of the last pay period ending in each of the Plan years.

3. Detailed worksheets showing the calculations of the Profit Sharing Fund and payout amounts will be provided to the parties to this agreement, with the appropriate review and execution of the letter report by a public accounting firm selected by the Company.

4. The parties agree to refer any disagreements over the interpretation of the terms of this agreement to a mutually acceptable impartial person for resolution.

5. The Company will respond as soon as practicable to reasonable requests from the Union for information supporting the computations made by the Company in determining the profit sharing fund, straight time hours worked, and employment status.

6. The Company will, as soon as practicable, inform the union of any change to the AB Volvo Group's definition and calculation of return to shareholders' equity percentage, and the resulting impact upon the Profit Sharing Plan, provide necessary supporting information and discuss any appropriate modifications to the Plan.

Appendix F

Mack Trucks, Inc.

Legal Services Plan

Summary Plan Description

This Summary Plan Description (SPD) format replaced the prior contract language effective October 2, 2016. Although “new”, this SPD is not bolded or underlined for ease of reading.

This plan will be eliminated effective 12/31/2024

INTRODUCTION

The UAW-Mack Legal Services Plan was established by the Company, Mack Trucks, Inc. as a result of negotiations with the UAW. The Plan is intended to provide personal legal services for eligible active and certain laid-off employees and retired employees, their spouses and dependent children. The Plan became effective December 16, 1991.

This summary provides general information about the Plan, who is eligible to receive benefits under the Plan, what those benefits are, how to obtain benefits and what your rights under ERISA are.

MetLife Legal Plans has been selected to provide for legal plan benefits. The services will be provided through a panel of carefully selected Participating Law Firms. Lawyers in this network are called Plan Attorneys. These arrangements are described in detail in this summary. The actual provisions of the Plan are set out in a written document maintained by your employer. All statements made in this booklet are subject to the provisions and terms of that document, which controls in the event of conflict with this summary.

HOW TO GET LEGAL SERVICES

Web Site
To use the Legal Plan, visit the **MetLife** Legal Plans' web site at members.legalplans.com. Once there, click on the "Members Log in" icon at the top of the page. You will be taken to a secure page that will require you to enter your Social Security Number. After you enter your Social Security Number you will jump to a page that is specific for member services. On this page you can choose the following options:

- How Do I Use the Plan?
- Covered Services
- Attorney Locator
- Obtain Case Number
- Life Guide
- Self-Help Documents/Forms

Client Service Center
You may also use the Legal Services Plan by calling **MetLife** Legal Plans' Client Service Center at **1-800-821-6400** Monday – Thursday 8 a.m. to 7 p.m. and Friday 8 a.m. to 6 p.m., Eastern Time. Be prepared to give your Social Security Number. If you are a spouse or an eligible dependent child of an eligible person, you will need the Social Security Number of the employee through whom you are eligible. The Client Service Representative who answers your call will:

- Verify your eligibility for services;
- Make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage);
- Give you a Case Number which is similar to a claim number (you will need a new Case Number for each new case you have);
- Give you the telephone number of the Plan Attorney most convenient to you; and
- Answer any questions you have about the Legal Plan.

You then call the Plan Attorney to schedule an appointment at a time convenient to you. Evening and Saturday appointments are available. If you choose, you may select your own attorney. Also, where there are no Participating Law Firms, you will be asked to select your own attorney. In both of these circumstances, **MetLife** Legal Plans will reimburse you for these non-Plan attorneys' fees in accordance with a set fee schedule.

For services to be covered, you or your eligible dependents must have obtained a Case Number, retained an attorney and the attorney must begin work on the covered legal matter while you are an eligible member of the legal plan.

WHAT SERVICES ARE COVERED

The Legal Plan entitles you and your eligible dependents to receive certain personal legal services. The available benefits are very comprehensive, but there are limitations and other conditions which must be met. Please take time for yourself and your family to read the description of benefits carefully.

All benefits are available to you and your spouse and dependents, unless otherwise noted.

ADVICE AND CONSULTATION

Office Consultation and Telephone Advice
This benefit provides the opportunity to discuss with an attorney any personal legal problems which are not specifically excluded or prohibited matters. During the consultation, the attorney will explain the Participant's rights, point out his or her options and, if needed, recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the Plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense; seek outside counsel; or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to undertake his or her own representation.

CONSUMER PROTECTION

Consumer Protection Matters
This service covers the Participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds $300 and the controversy is evidenced by a written document such as a sales slip, contract, note or warranty. This service does not include disputes over insurance, land, construction, home improvements or matters involving real property.

Small Claims Assistance
This benefit includes counseling the Participant on prosecuting a small claims action; helping the Participant prepare documents; advising the Participant on evidence, documentation and witnesses; and preparing the Participant for trial. The service does not include the Plan Attorney's attendance or representation at the small claims trial.

DEBT MATTERS

Debt Collection Defense
This benefit provides Participants with negotiation with creditors for a repayment schedule, limiting creditor harassment, and representation in defense of any action for personal debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It does not include defense against a judgment, vacating a judgment, counter claims, cross claims, bankruptcy, any action arising out of divorce or post-decree matters, or any matter where the creditor is affiliated with the UAW or Mack Trucks.

Personal Bankruptcy
This benefit covers the Employee and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition and representation at all court hearings and trials. This benefit does not include bankruptcy or Wage Earner petitions for any business in which the Employee or spouse may have an interest, and is not available if the UAW or Mack Trucks is a creditor, even if the Employee or spouse chooses to reaffirm that specific debt.

DEFENSE OF CIVIL LAWSUITS

Civil Litigation Defense
This benefit covers the Participant for defense of civil proceedings in a trial court of general jurisdiction or before an administrative agency or a local, state, or federal agency. It does not apply where services are available or are being provided by virtue of a homeowner or vehicle insurance policy. It does not include divorce or post-decree defense, paternity, support or custody matters or litigation of a job-related incident.

DOCUMENT PREPARATION

Deeds
This benefit includes the preparation of any deed for which the Participant is either the grantor or grantee.

Demand Letters
This benefit covers the preparation of letters which demand money, property or some other property interest of the Participant, except an interest which is an excluded service, mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

Mortgages
This benefit includes the preparation of any mortgage for which the Participant is the mortgagor.

Notes
This benefit includes the preparation of any promissory note for which the Participant is the payor or payee.

FAMILY LAW

Adoption and Legitimization
All governmental agency and stepparent adoptions are fully covered for the Employee and spouse. Legitimization of a child for the Employee and spouse, including reformation of a birth certificate, is also a fully covered service.

Guardianship or Conservatorship
This service covers establishing a guardianship or conservatorship over a person and his or her estate by the Employee or spouse. It includes obtaining a temporary guardianship or conservatorship if necessary, gathering any necessary medical evidence, preparing the paperwork and attending the hearing. This benefit does not include representation of the person over whom guardianship or conservatorship is sought, or any proceedings involving annual accountings once guardianship or conservatorship has been established.

Name Change
This benefit covers the Participant for all necessary pleadings and court hearings for a legal name change.

Separation or Divorce
This benefit is available to the Employee only, not to a spouse or dependents. This service includes preparing and filing all necessary pleadings, motions and affidavits, and drafting settlement agreements as well as representation at the hearing or trial, regardless whether the Employee is a plaintiff or a defendant. This benefit does not include disputes which arise after the issuance of a divorce decree.

INSURANCE MATTERS

Insurance Claims
This benefit provides the Participant with assistance in making insurance claims with the Participant's own carrier, provided that carrier is not affiliated with the Employer. Litigation is not included.

PERSONAL INJURY

Personal Injury
Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs.

Property Damage
Subject to applicable law and court rules, Plan Attorneys will handle property damage matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs.

Social Security Disability
Subject to applicable law and court rules, Plan Attorneys will handle Social Security Disability matters at a fee 10% less than the prevailing fee. It is the Participant's responsibility to pay this reduced fee and all costs.

REAL ESTATE MATTERS

Boundary or Title Disputes
This service includes negotiations and litigation arising in connection with boundary or title disputes involving a Participant's primary residence, where coverage is not available under the Participant's homeowner or title insurance policies.

Eviction and Tenant Problems (Tenant Only)
This service assists the Participant as a tenant with matters involving leases, security deposits or other disputes with a residential landlord. The benefit also covers eviction defense, up to and including trial, if necessary. It does not include representation as a plaintiff in a lawsuit against the landlord.

Refinancing of Home
This benefit includes the review or preparation, by an attorney representing the Participant, of all relevant documents (including the mortgage, deed and documents pertaining to title, insurance, recordation

and taxation), which are involved in the refinancing of a Participant's primary residence. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property, unimproved land, rental property or property held for business or investment. Home equity loans are not included under this benefit.

Sale or Purchase of Home
This benefit includes the review or preparation, by an attorney representing the Participant, of all relevant documents (including the purchase agreement, mortgage, deed and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's primary residence. The benefit also includes attendance of an attorney at closing, in cities where it is the custom to do so. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, unimproved land, rental property or property held for business or investment. Home equity loans are not included under this benefit.

TRAFFIC MATTERS

Traffic Defense
This benefit covers representation of the Participant in defense of any traffic ticket or driving under influence charge, including court hearings, negotiation with the prosecutor and trial. It also covers representation in proceedings to restore a driving license.

WILLS AND ESTATE PLANNING

Living Trusts
This benefit includes the preparation of a living trust for the Participant. It does not include tax planning.

Living Wills
This benefit covers the preparation of a living will for the Participant.

Powers of Attorney
This benefit includes the preparation of any power of attorney when the Participant is granting the power.

Probate
Subject to applicable law and court rules, Plan Attorneys will handle probate matters at a fee 10% less than the prevailing fee. It is the Participant's responsibility to pay this reduced fee and all costs.

Wills and Codicils
This benefit covers the preparation of a will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

EXCLUSIONS
Certain matters are excluded from coverage under the Legal Plan. No services, not even a consultation, can be provided for the following matters:

Payment made to a third party such as costs, witness fees, filing fees or fines;
Appeals or class actions;
Business, farm, patent or copyright matters;
Matters for which you are or have been receiving legal services before you received an Authorization Number;
Matters or disputes involving the UAW, Mack Trucks, **MetLife** Legal Plans, MetLife or a Plan Attorney;
Matters concerning employment including Company and statutory benefits.

ELIGIBILITY

Please see ARTICLE II, Section 2 (b) for detailed information regarding Eligibility for your dependents.

WHEN COVERAGE ENDS

- Coverage will end on the earliest of the following dates:
- The date the Plan is terminated,
- The last day of the month that your employment terminates,
- The date you no longer belong to a class of employees eligible for the coverage,
- The date you or your enrolled dependents are no longer eligible for coverage

AMENDMENT OR TERMINATION

While your employer expects to continue to offer participation in the Legal Service Plan, it reserves the right to amend, or terminate the Plan at any time. If the Plan is terminated, all covered services then in process will be handled to their conclusion under the Plan.

ADMINISTRATION AND FUNDING

The Legal Service Plan is provided for and administered through a contract with **MetLife** Legal Plans, Inc. **MetLife** Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services.

PLAN CONFIDENTIALITY, ETHICS AND INDEPENDENT JUDGMENT

Your use of the Plan and the legal services is confidential. The Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Your employer will know nothing about your legal problems or the services you use under the Plan. Plan administrators will have access only to limited statistical information needed for orderly administration of the Plan.

No one will interfere with your Plan Attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the Plan are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the Plan and he or she will not receive any further instructions, direction or interference from anyone else connected with the Plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. **MetLife** Legal Plans, Inc., or the law firm providing services under the Plan is responsible for all services provided by their attorneys.

You should understand that the Plan has no liability for the conduct of any Plan Attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Plan.

Plan attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call **MetLife** Legal Plans at **1-800-821-6400**. Your complaint will be reviewed and you will receive a response within two business days of your call.

OTHER SPECIAL RULES

In addition to the coverages and exclusions listed, there are certain rules for special situations. Please read this section carefully.

What if other coverage is available to you? If you are entitled to receive legal representation provided by any other organization such as a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this Plan. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this Plan, so long as you meet the eligibility requirements.

What if you are involved in a legal dispute with your dependents? You may need legal help with a problem involving your spouse or your children. In some cases, both you and your child may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation by the plan attorney. Your dependent will not be covered under the Plan.

What if you are involved in a legal dispute with another employee? If you or your dependents are involved in a dispute with another eligible employee or that employee's dependents, **MetLife** Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

What if the court awards attorneys' fees as part of a settlement? If you are awarded attorneys' fees as a part of a court settlement, the Plan must be repaid from this award to the extent that it paid the fee for your attorney.

DENIAL OF BENEFITS AND APPEAL PROCEDURES

Denials of Eligibility

MetLife verifies eligibility using information provided by Mack Trucks. When you call for services, you will be advised if you are ineligible and **MetLife** Legal Plans will contact Mack for assistance. If you are not satisfied with the final determination of eligibility, you have the right to a formal review and appeal. Send a letter within 60 days explaining why you believe you are eligible to:

UAW- Mack Trucks Legal Services Plan
7900 National Service Rd
Greensboro, NC 27409

Within 30 days, you will be provided with a written explanation.

Denials of Coverage

If you are denied coverage by **MetLife** Legal Plans or by any Plan Attorney, you may appeal by sending a letter to:

MetLife Legal Plans
Director of Administration
1111 Superior Ave, Suite 800
Cleveland, Ohio 44114-2507

The Director will issue **MetLife** Legal Plans' final determination within 30 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific Plan provisions on which the denial is based and a description of any additional information that might cause **MetLife** Legal Plans to reconsider the decision, and an explanation of the review procedure.

YOUR ERISA RIGHTS

Congress enacted the Employee Retirement Income Security Act (ERISA) to safeguard your interests and those of your beneficiaries under your employee benefit plans. As a participant in The Legal Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including collective bargaining agreements and copies of all documents filed by the Plan with U.S. Department of Labor; such as detailed annual reports and Plan descriptions;
Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies;

Receive a summary of the Plan's annual financial report from the Plan Administrator who is required by law to furnish this to you.

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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and consider your claim. Under ERISA, there are steps you can take to enforce the above rights. If you request materials 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 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 lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous. 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, you should contact the nearest Area Office of the U.S. Labor Management Services Administration, U.S. Department of Labor.

FOR YOUR INFORMATION:

Name of Plan: The UAW-Mack Trucks Legal Services Plan

Plan Sponsor: Mack Trucks, Inc.

Type of Plan: Welfare Benefit Plan for pre-paid legal services

Plan Administrator:
UAW- Mack Trucks Legal Services Plan
7900 National Service Rd
Greensboro, NC 27409

Agent for Service of Legal Process: Plan Administrator

Provider of Benefits:
MetLife Legal Plans
1111 Superior Ave, Suite 800
Cleveland, Ohio 44114-2507
1-800-821-6400

Plan Identification Number: 506-B
Sponsor's Employer Identification Number: 22-1582040

Effective Date: 12/16/91

Plan Year: January 1 - December 31

If you are having any kind of problem, please call MetLife Legal Plans at 1-800-821-6400. A MetLife Legal Plans representative will help you solve the problem to your satisfaction.

APPENDIX G
MACK-UAW 401(k) PLAN

SUMMARY PLAN DESCRIPTION
TABLE OF CONTENTS

ARTICLE I – Introducing Your 401(k) Plan Benefits

Mack Trucks, Inc. maintains the Mack-UAW 401(k) Plan (the "Plan" or the "401(k) Plan") for the benefit of eligible employees and their beneficiaries. Your benefit under the Plan helps to make your retirement years more financially secure.

The 401(k) Plan makes saving for retirement easy. It is designed to help supplement your income from other sources, such as the Pension Plan and Social Security.

Each year, Mack Trucks, Inc. (referred to in this SPD as the "Company" unless otherwise specified) allows you to contribute part of your annual pay into a personal account. All money in your account is invested as you choose in a wide array of individual and pre-mixed investment funds. You can receive your savings when you leave the Company and all affiliates for any reason.

This booklet is the summary plan description ("SPD") for the Plan. It summarizes the provisions of the Plan, restated effective January 1, 2014 (as amended through **February 1, 2024**). You may be subject to different rules if you terminated your employment before this most recent amendment date. Every effort has been made to ensure that the SPD accurately describes the Plan terms. In the case of any conflict between this SPD and the terms of the Plan, the terms of the Plan will control. If you have any questions, you may contact a Plan representative at 1-800-356-9240 between 8:30 am and 6:30 pm Eastern Time, on any business day. You may obtain a copy of the Plan document by writing to Plan Administrator. This SPD describes your 401(k) Plan benefits as negotiated under the collective bargaining agreement between the Union and the Company.

SECTION 1 Your Plan Benefits at a Glance

The Plan has many flexible features that help you plan for your future. Here are some highlights of the Plan.

Plan Feature	How It Works
Eligibility and Enrollment	If you meet the eligibility criteria for the Plan, you are entitled to enroll and commence making contributions to the Plan beginning on the first of the month following the date you attain seniority. If you were hired or rehired on or after June 1, 2009 and if you do not take action to enroll or decline enrollment by the 30th day following the date you can start making contributions, you will be automatically enrolled in the Plan and you will be deemed to have elected to contribute 3% of your Pay to the Plan as pre-tax elective contributions for your first year, and your contributions will automatically increase by 1% each year thereafter until you are contributing 6% of your Pay.
Your Elective Contributions, including Catch-up Contributions	You can save from 1% to 75% of your Pay in the Plan. You may also make separate elections each Plan Year to save from 10% to 75% of a cash payment (if you receive one) from the Mack-UAW Profit Sharing Plan; from 10% to 75% of a ratification bonus; and from 10% to 75% of a lump sum bonus. Separate elections are required for each such election. All elective contributions can be made on a pre-tax or **Roth after-tax basis or as a combination, as you elect. Generally, the 2024 limit on your elective contributions is $23,000. However, if you are age 50 or older by the end of the year,** you can contribute additional elective contributions, up to $**7,500** in **2024** (subject to the 75% maximum contribution percentage). These additional elective contributions are called “catch-up contributions.” These limits are adjusted each year by the IRS for cost-of-living increases. Elective contributions are amounts you elect to contribute on a pre-tax or Roth basis, including catch-up contributions.
Rollover Contributions	You can also transfer rollover contributions to the Plan from other qualifying retirement funds.

Plan Feature	How It Works
Company Contributions	If you were hired or rehired on or after June 1, 2009, the Company will contribute: (1) as matching contributions, 60% of the first 6% of Pay you contribute as elective contributions (other than those described below), such that you will receive the maximum match of 3.6% of your Pay if you elect to contribute 6% or more, plus (2) as fixed contributions, 4% of your Pay, plus (3) **as lump sum contributions, $1,000 each plan year from 2024 – 2028, provided you have earned one year of eligibility service as of the first day of such year.** The contributions described in (2) and (3) will be made even if you do not make elective contributions to the Plan. Catch-up contributions, contributions in accordance with the separate election to save from 10% to 75% of a cash payment from the Mack-UAW Profit Sharing Plan, or contributions of 10% to 75% of a ratification bonus or lump sums bonus, are not matched.
Choice of Investment Funds	You determine how your Plan account is invested. You may change your investments by calling Transamerica's toll-free number or by accessing their Internet site.
Automatic Payroll Deductions	It's easy to make elective contributions to your Plan account because they're taken out automatically each pay period. You may start, stop, or change your contributions at any time.
Loans and Withdrawals	Under certain circumstances, you may have access to your savings while you're still working for the Company.
Quarterly Statements	Each quarter, a statement will be available that shows all the activity in your plan account.
Access to Account Information and Plan questions	You may obtain your current account balance, execute transactions (for example, investment changes and withdrawals), and ask questions regarding the Plan, as described in Article VII.

The following pages explain how the 401(k) Plan works and include important rules and limitations. Please read this summary carefully.

ARTICLE II – Plan Membership

SECTION 1 Who Is Eligible

You are eligible to participate in the Plan if you:

- are employed by the Company and you are covered by a collective bargaining agreement between the Company and the International Union, UAW, Locals 171, 677, 1247, 2301, 2420, and effective on and **after February 1, 2024, Labor Codes, 299, 300T, 360T, 362T, 364T, 498T, and 864T**, and
- you have attained seniority under the collective bargaining agreement.

SECTION 2 When Participation Begins

You may begin participating in the Plan **as of the first payroll period following your date of hire or the date you become an eligible employee, if later, or as soon as administratively possible after that.** If you leave the Company and later return to work for the Company in the eligible class described above, you will be able to join the Plan again during any payroll period which begins after your return to work.

SECTION 3 Enrolling in the Plan

You are eligible to join the 401(k) Plan beginning with the first payroll period after meeting the eligibility and participation requirements.

When you become eligible to enroll, you will receive an enrollment kit that contains instructions regarding the enrollment process. You may also request a kit from Transamerica. To enroll, you may call the Plan's toll free number at 1-800-356-9240 or go to the Plan's website at https://www.transamerica.com/portal/volvo These Plan access features are available 24 hours a day, seven days a week. You may also enroll or ask a question by speaking with a Plan representative at that number between 8:30 am and 6:30 pm Eastern time, on any business day. If you are unable to enroll by either of these methods, please contact your local Human Resources Department. If you choose to participate, you'll need to:

- *Select the percentage of Pay you would like to save in pre-tax **or Roth** dollars or in a combination*
- *Authorize* the Company to make regular payroll deductions for your 401(k) Plan contributions
- *Indicate* which funds you want to invest in, and
- *Name* a beneficiary (or beneficiaries) to receive the value of your Plan account if you die. *Please note:* If you are married, your spouse is automatically your beneficiary. If you wish to name someone other than your spouse as your beneficiary, you'll need to complete a Beneficiary Designation Form, on which you must obtain your spouse's *written* consent, witnessed by a notary public or Plan representative. If you're single, you may name any person as your

beneficiary. If you die and are not survived by a designated primary or contingent beneficiary, your Plan beneficiary will be your spouse or if you do not have a spouse, your estate.

Contributing to the 401(k) Plan is *completely voluntary*. If you do not want to contribute when you first become eligible, you may begin contributing at a later date. Keep in mind, however, that you can save as little as 1% of your Pay in the Plan.

If you were hired on or after June 1, 2009 and if you do not take action to enroll or decline to enroll within 30 days after the date you become eligible to contribute, you will be automatically enrolled in the Plan as if you made an election to contribute 3% of pay to the Plan.

Your initial automatic enrollment percentage will be increased by 1% each year up to a maximum of 6%, unless you make a different choice. You may also elect to make changes via the web at https://www.transamerica.com/portal/volvo or by phone by calling 1-800-356-9240.

SECTION 4 Election Discrepancies

You must notify the Plan Administrator in writing of any discrepancies in your payroll deduction or investment election within 30 days of receipt of the first pay statement or investment confirmation statement reflecting the discrepancy. If you do not timely notify the Plan Administrator in writing, you will be deemed to have elected the payroll deduction or investment election reflected on your statement. To facilitate a prompt correction, you may also contact a Plan representative at 1-800-356-9240 between 8:30 am and 6:30 pm (in addition to providing written notice to the Plan Administrator).

ARTICLE III – Building Your Plan Account

Under the Plan, your account can grow in several ways:

- Your elective contributions
- Company contributions (if eligible)
- Your rollover contributions (if any), and
- Investment growth.

You may save from 1% to 75% of your annual pay in whole percentages on a pre-tax or Roth basis or combination.

The following pages explain how each works.

The Plan offers a number of interactive resources to help you plan for your retirement. You can log on to https://www.transamerica.com/portal/volvo to use a retirement goal calculator to estimate how much money you may need for retirement and what your current contribution percentage may need to be to pursue your goal. You can also use the paycheck calculator to see how your Plan contributions would impact your take-home pay. In addition, the Plan enables you to systematically increase the amount you save over time. These resources, as well as some of the pre-mixed investment funds described, enable you to pursue a disciplined approach to retirement savings.

SECTION 1 Your Pay

For purposes of determining contribution amounts under the Plan, the term "Pay" means your base hourly rate of pay, including cost-of-living allowances but excluding premiums or bonuses. Pay also includes amounts paid after your termination of employment if such amounts are paid before the later of 2½ months or the end of the year after you terminate employment and would have been paid to you if you had continued employment.

The amount of your Pay that can be taken into account each year is subject to a limit imposed by the IRS **($345,000 in 2024**).

SECTION 2 Your Elective Contributions

You may save from 1% to 75% – in whole percentages – of your Pay in the form of elective contributions. You may also make separate elections each Plan Year to save from 10% to 75% of a cash payment (if you receive one) from the Mack-UAW Profit Sharing Plan; from 10% to 75% of a ratification bonus; and from 10% to 75% of a lump sum bonus (see Section 5 of this article). Separate elections are required for each such election. If you are age 50, or will reach age 50 by the end of the year, you can contribute an additional amount, up to **$7,500 in 2024**. These additional contributions are called "catch-up" contributions. You can only make catch-up contributions if you reach, or you expect to reach, one of the legal limits on contributions for the year. Your catch-up contributions plus your other

elective contributions can't exceed 75% of your Pay. All elective contributions can be made on a pre-tax or Roth basis or a combination.

Legal Contribution Limitations. The Internal Revenue Service (IRS) imposes the following limits on how much money can be contributed on your behalf each year:

- Regular elective contributions (including amounts attributable to separate elections based on a profit sharing plan payment or a bonus, as described in Section 5 of this Article) cannot exceed an annual dollar limit **($23,000 in 2024**).
- The maximum amount that can be contributed to your account each year – in the form of your elective contributions (excluding catch-up contributions) and company contributions – cannot exceed a dollar amount (**$69,000 in 2024**) or 100% of your compensation, whichever is less.
- Your Pay that can be taken into account each year is subject to a limit ($**345,000 in 2024**).
- In some cases, highly-compensated employees may be restricted from making certain contributions to the Plan so that the Plan can comply with these and other IRS guidelines. You will be notified if you are affected by these restrictions.
- If you are age 50, or will reach age 50 by the end of the year, you can contribute an additional amount each year in excess of the foregoing limits ($**7,500 in 2024**) by making a separate election. These additional contributions are called "catch-up" contributions. You can make catch-up contributions only if you reach, or you expect to reach, one of the legal limits on contributions for the year. Your catch-up contributions plus your other elective contributions based on your Pay can't exceed 75% of your Pay each pay period. Your total elective contributions (including catch-up contributions) can't exceed **$30,500 in 2024**.

These limits are adjusted from time to time by the government for changes in the cost of living. Note that the limits on your elective contributions apply each year with respect to the aggregate amount of such contributions that you make into any tax-qualified retirement plan (including contributions to a plan maintained by another unrelated employer). To request a corrective distribution from the Plan if you exceed the limits in any year, you must contact the Plan Administrator by March 15th of the following year.

How Pre-tax Elective Contributions Work. Pre-tax elective contributions are deducted from your paycheck *before* federal – and, in most locations, state and local – income taxes are withheld. As a result, your taxable income is reduced, so you pay less in taxes. You *will* pay taxes on this money, including any investment earnings, when you receive your account balance at retirement (or earlier, if you withdraw the money).

Even though your taxable income is reduced when you make pre-tax elective contributions to the Plan, the level of your other pay-related benefits will *not* be affected. The value of these benefits continues to be based on your full pay (as defined under those plans) *before* you contribute to the 401(k) Plan.

Please note that pre-tax elective contributions do *not* reduce Social Security taxes or Social Security benefits.

How Roth Elective Contributions Work. **Roth elective contributions are contributions made with after-tax dollars. If you have Roth elective contributions in the Plan for at least five taxable years, and you are at least age 59½ at the time you receive a distribution (or if the distribution is due to death or total disability), you can withdraw the money, including investment income, without owing taxes (referred to as a "qualified Roth distribution"). While pre-tax elective contributions are tax-free when contributed but taxable when withdrawn, Roth elective contributions are taxable when contributed and tax-free when withdrawn in a qualifying distribution.**

The five-year period required to get the tax advantages of Roth elective contributions begins on January 1 of the year in which you make your first Roth elective contribution. For example, suppose that you make your first Roth elective contribution in December 2024. The five-year period begins on January 1, 2024 and ends on December 31, 2028. If you withdraw your Roth elective contributions after 2028, and after attaining age 59½, withdrawals including investment gains should be tax-free. You do not have to make Roth elective contributions continuously during the five-year period to get the tax advantages of Roth elective contributions. In addition, each Roth elective contribution does not have to remain in the plan for five years; all that is required is that you maintain a Roth elective contribution account for the five-year period.

Choosing Between Pre-tax and Roth Elective Contributions. **Choosing whether to make elective contributions on a pre-tax or Roth basis should be based on your personal situation. Both types of contributions offer valuable tax benefits. When choosing between pre-tax and Roth elective contributions, you should consider your current marginal income tax rate and your expected marginal tax rate when you retire and receive distributions. In general:**

- **If you expect your marginal income tax rate in retirement to be lower than your current marginal tax rate, pre-tax elective contributions may be the better choice for you.**
- **If you expect your marginal income tax rate in retirement to be higher than your current marginal tax rate, Roth elective contributions may be the better choice for you.**

Example

Suppose that you contribute $10,000 to the Plan on a pre-tax basis. That contribution remains in the Plan for 10 years, and it earns investment income of 5% per year. After 10 years, it grows to $16,289. You withdraw that amount and pay taxes. If your marginal income tax rate in retirement is 24%, you would be left with $12,380.

Now suppose instead that you contribute the same amount - $10,000 less income taxes – as Roth elective contributions. Suppose your marginal income tax rate today is 24%. Therefore, $7,600 is contributed to your Roth account. That contribution remains in the Plan for 10 years, and it earns investment income of 5% per year. After 10 years, it grows to $12,380. You withdraw that amount and, as long as you are at least age 59½, you would not owe taxes on your distribution.

This example illustrates that as long as your marginal tax rate does not change, pre-tax and Roth elective contributions are equivalent. But what if you expect your tax rate to be higher or lower in retirement than it is today? The following table shows the results if your tax rate in retirement is lower (22%), the same (24%) or higher (32%) than it is today (24%). The Company encourages you to consult with your personal tax advisor for guidance on whether to contribute on a pre-tax or Roth basis. Also consider the potential impact of retirement contributions and distributions on your marginal tax rate at the relevant time.

Income Tax Rate in Retirement	22%	24%	32%
Pre-tax Contributions			
a) Initial Contribution	$10,000	$10,000	$10,000
b) Investment Income after 10 years	6,289	6,289	6,289
c) Fund Balance at Retirement = (a) + (b)	16,289	16,289	16,289
d) Taxes on Distribution	3,584	3,909	5,212
e) Net Distribution = (c) – (d)	12,705	12,380	11,077
Roth Contributions			
a) Initial Contribution ($10,000, less taxes @ 24% rate in year of contribution	$7,600	$7,600	$7,600
b) Investment Income after 10 years	4,780	4,780	4,780
c) Fund Balance at Retirement = (a) + (b)	12,380	12,380	12,380
d) Taxes on Distribution	0	0	0
e) Net Distribution = (c) – (d)	12,380	12,380	12,380
Pre-tax net distrib. - Roth net distrib.	325	0	(1,303)
Which is Better (Pre-tax or Roth)?	Pre-tax	Same	Roth

Importantly, when considering whether to contribute on a pre-tax basis or a Roth basis, you should consider the effect of your choice on Company matching contributions (described in Section 3). To receive the maximum Company matching contributions, you must contribute at least 6% of your Pay. If you choose to make Roth elective contributions instead of pre-tax elective contributions, you should make sure that you are able to contribute at least 6% of your Pay on a Roth (after-tax) basis – taking into account the additional taxes that you will pay – so that you get the full Company match.

SECTION 3 Company Contributions

If you were hired or rehired on or after June 1, 2009, the Company makes additional contributions described below on your behalf. Otherwise, you are not entitled to any of these contributions.

Matching Contributions. Each pay period, the Company matches 60% of the first 6% of Pay you contribute as elective contributions (excluding catch-up contributions, contributions of Mack-UAW Profit Sharing Plan payments, if any, and contributions of ratification bonuses or lump sum bonuses).

Catch-up contributions, contributions of Mack-UAW Profit Sharing Plan payments, if any, and contributions of ratification bonuses or lump sum bonuses are not eligible to be matched by Company contributions.

The Company match is made on a per-paycheck basis. This means that if you contribute less than 6% of your Pay in a given pay period, you will miss some or all of the match for that period. Because the IRS limits contributions you may make as elective contributions to your account, you should carefully consider the percentage of Pay that you contribute to the Plan so that you can maximize the matching contributions to your account over the course of the year.

Fixed Contributions. The Company contributes 4% of your Pay for each pay period.

Lump Sum Contributions. Each Plan Year from 2024 to 2028, while you are an eligible employee, the Company contributes a lump sum amount of $1,000 on your behalf, provided you have earned one year of eligibility service as of the January 1st of such Plan Year. Each contribution is credited to your account no later than January 31st of the year for which it is payable.

You earn one year of eligibility service as of the end of the 12-month period that begins with your date of hire if you are credited with 1,000 or more hours of service during that 12-month period. If you are not credited with at least 1,000 hours during your initial 12 months of employment, you will earn a year of eligibility service as of the end of any Plan Year in which you are credited with 1,000 hours of service. You are credited with hours of

service toward a year of eligibility service for any period during which you are absent from work on unpaid leave under the Family and Medical Leave Act of 1993. Hours of service include hours of actual service for performing duties with the Company and hours for which you are paid by the Company during any absences, such as vacation (up to 501 hours for any single absence). In determining hours, employment with certain affiliates of the Company is treated as employment with the Company. Employment as a leased employee is also treated as employment with the Company if you are later hired as an employee of the Company or an affiliate.

SECTION 4 An Example of Your Plan Savings

Here's an example of the advantage of saving on a pre-tax basis as opposed to saving through an ordinary bank account. You should also consider the advantages of saving on a Roth basis (see Section 2) and the favorable impact of matching contributions.

Assume you're married with one child and decide to save 6% of your $40,000 pay, or $2,400, through the Plan. The following chart shows how your pre-tax contributions increase your spendable income.

If you are not eligible to receive a matching contribution (you were hired prior to June 1, 2009), please refer to the first chart in this Section 4.

If you are eligible to receive a matching contribution (you were hired or rehired on or after June 1, 2009), please refer to the second chart in this Section 4.

Employees Hired Prior to June 1, 2009 – No Matching Contribution	Pre-Tax Savings Through the Plan	Saving Outside the Plan
Base Pay	$40,000	$40,000
Pre-Tax Savings	– 2,400	– 0
Taxable Income (before your tax deductions)	$37,600	$40,000
Federal Income Tax*	– **840**	– **1,080**
Post-Tax Savings (6%)	– 0	– 2,400
Spendable Income	$**36,760**	$**36,520**
Immediate Gain Through Tax Savings	$240	$ 0

* Based on estimated federal income tax rates for **2024** assuming you are married, file jointly, take the standard $**29,200** deduction, and have no other income.

As you can see, in this example you would have $240 more in current spendable income by saving 6% of your Pay through the Plan on a pre-tax basis as opposed to saving on a post-tax basis outside the Plan. Remember that taxes are only deferred. You'll be responsible for paying income taxes on your pre-tax savings and any investment earnings when you receive a payout of your Plan account.

Employees Hired or Rehired On or After June 1, 2009 – With Company Contributions	Pre-Tax Savings Through the Plan	Saving Outside the Plan
Base Pay	$40,000	$40,000
Pre-Tax Savings	– 2,400	– 0
Taxable Income (before your tax deductions)	$37,600	$40,000
Federal Income Tax*	– **840**	– **1,080**
Post-Tax Savings (6%)	– 0	– 2,400
Spendable Income	$**36,760**	$**36,520**
Immediate Gain Through Tax Savings	$240	$ 0
Company Contributions (3.6% match + 4% fixed + $1,000 lump sum)	**+ 4,040**	**+ 2,600**
Total Plan Advantage	**$ 4,280**	**$ 2,600**

* Based on estimated federal income tax rates for **2024** assuming you are married, file jointly, take the standard $**29,200** deduction, and have no other income.

As you can see, in this example you would have $240 more in current spendable income by saving 6% of your Pay through the Plan on a pre-tax basis as opposed to saving on a post-tax basis outside the Plan. Also, the Company will contribute $4,040 to your Plan account compared with only $2,600 (4% + $1,000) if you save outside the Plan. Remember that taxes are only deferred. You'll be responsible for paying income taxes on your pre-tax savings, your Company contributions, and any investment earnings when you receive a payout of your Plan account.

SECTION 5 Additional Elective Contributions from Profit Sharing Plan Payments, Ratification Bonuses and Lump Sum Bonuses

In some years, the Company may make a cash payment to you pursuant to the Mack-UAW Profit Sharing Plan. If so, you may make a separate election to contribute 10%-75% of that payment to your Plan Account. Similarly, you may elect to contribute 10% - 75% of any ratification bonus or 10% - 75% of a lump sum bonus. Separate elections are required for each such election. Note that Profit Sharing payments, ratification bonuses and lump sum bonuses are not treated as part of your pay for purposes of your regular elective contribution. A contribution from your Mack-UAW Profit Sharing Plan payment, ratification bonus or lump sum bonus is not matched. A separate election to contribute part of any such payment or bonus you may receive must be made each year. **Any such election may be made on a pre-tax or Roth basis.**

SECTION 6 Rollover Contributions

If you participated in another employer's tax-deferred savings plan, you may be able to roll the money into the 401(k) Plan.

You may roll over or directly transfer certain other types of retirement benefits into the Plan. By doing so, you continue to defer income tax on that money and have the same investment opportunity as the rest of your Plan account.

If you are a current employee, you may roll over into the Plan certain amounts you received from any other retirement plan that meets certain IRS requirements and is therefore subject to special tax rules under Section 401 or Section 403 of the Internal Revenue Code. You may also roll over amounts from an IRA if those amounts were rolled into the IRA from such a retirement plan. The Plan does not accept rollovers from Roth IRAs or rollover of any after-tax amounts. For example, you may be eligible to make a rollover contribution to the Plan if you worked for another employer with a qualified savings plan before joining the Company. You can roll the payout you receive from that plan into the 401(k) Plan. If you are a former employee who has not received a distribution of your entire account under the Plan, you may rollover a lump sum distribution (if available) from a qualified defined benefit plan sponsored by the Company or an Affiliated Company into this Plan.

You may make a rollover contribution by electing a transfer as a direct rollover from the other retirement plan or IRA to the 401(k) Plan. Any amount that is not transferred as a direct rollover must be deposited to the Plan *within 60 days* of receiving the money, as required by the IRS. You can obtain information regarding exceptions for situations where circumstances beyond your control cause you to miss the deadline at https://www.irs.gov/retirement-plans/retirement-plans-faqs-relating-to-waivers-of-the-60-day-rollover-requirement. If you do not elect a direct rollover, you will be subject to a 20% withholding tax on the taxable portion of your distribution. See "How Taxes Affect Your Benefits" for more information about the tax consequences of rolling over money from one plan to another.

Any amounts that you roll over into the Plan (including investment income on those amounts) can be withdrawn by you at any time and for any reason. However, if you take a withdrawal from the rollover account, that withdrawal will be subject to income taxes and, if you are under age 59½, also may be subject to a 10% penalty tax. See "How Taxes Affect Your Benefits" for more information.

SECTION 7 Account Transfers To or From Other Volvo 401(k) Plans

If you transfer to an employment status where you become eligible to participate in another 401(k) plan sponsored by a non-participating affiliate of the Company, you may elect to transfer your current Plan account balance to your new plan. Similarly, if you transfer employment from an employment status where you were a participant in another 401(k) plan sponsored by a non-participating affiliate of

the Company, you also may elect to transfer your account balance under that plan to this Plan. Each type of contribution (e.g., elective pre-tax or Roth, Company, rollover) and attributable earnings that you transfer in this manner will become subject to the Plan's distribution and withdrawal restrictions applicable to such contribution type. However, the transferred amounts will retain the prior plan's vesting schedule if more favorable.

SECTION 8 Tax Deferred Saving

Another big advantage to saving through the Plan is that your investment earnings continue to grow *tax-deferred* as long as the money remains in the Plan. Most other forms of saving tax your investment earnings each year.

Keep in mind, however, that tax-deferred does not mean tax-free. Your Plan account – including the investment earnings – will be taxed as ordinary income in the year it is paid to you. (**See the exception for earnings taken in a qualified Roth distribution described on page 2708**). More information about taxes and the Plan is included under "How Taxes Affect Your Benefits".

Like your pre-tax elective contributions, generally, all of the investment earnings in your account accumulate on a tax-deferred basis until you withdraw the money. Investment earnings on Roth elective contributions, however, will avoid taxation if taken in a qualified Roth distribution.

ARTICLE IV – Investing Under the Plan

SECTION 1 Your Investment Choices

You have a choice of investment funds for investing your account.

The Plan's investment lineup was designed to offer you a variety of options from a wide range of investment categories, without offering an overwhelming number of choices. In addition, every fund is offered in the share class with the lowest available expense ratio (i.e., the lowest fee). The Plan's fiduciaries who are responsible for monitoring the available funds may change the investment line-up to ensure that each available fund is an appropriate investment option for the Plan.

Investors should carefully consider the investment objectives, risks, charges, and expenses of a fund before investing. For a prospectus or an offering statement containing this and other information about any fund in the Plan, please call 1-800-356-9240. Read the prospectus or offering statement carefully before making any investment decisions. Fund performance is not guaranteed; Plan accounts can lose money.

The Plan is intended to be a plan described in Section 404(c) of the Employee Retirement Income Security Act of 1974 ("ERISA") and Labor Regulation 2550.404(c)-1, as amended (referred to as a "404(c) plan"). Section 404(c) may relieve the Plan's fiduciaries of liability for any losses that result from investment instructions given by you or your beneficiaries to invest (or not invest) in particular investment funds, provided the Plan complies with certain requirements of Section 404(c). To qualify as a 404(c) plan, Plan fiduciaries must select appropriate investment funds as alternatives, make available certain information about the Plan's investment choices, and allow participants to direct the investment of account balances in a manner that complies with applicable rules under ERISA. Because you supervise and direct how your Plan account is invested among available investment funds, and because the Plan is designed to comply with certain rules for 404(c) plans under ERISA, fiduciaries of the Plan may be relieved of liability for losses, if any, that occur in your Plan account as a direct result of your investment instructions. A participant or beneficiary will remain responsible for making investment decisions with respect to Plan accounts remaining in the Plan after your termination of employment for any reason.

Should you fail to direct the investment of your account, your Plan account will be invested in the Target Retirement Fund that corresponds with your date of birth on record with the Company, assuming a retirement age of 65 (see the chart on page 11). If your date of birth is not in the Company's records, your Plan account will be invested in the Target Retirement Income Fund. Your Plan account will remain invested in the applicable default investment fund until you make another selection.

On a daily basis, you can change your investment elections. You can reallocate the funds in which your future contributions will be invested in 1% increments. You can make exchanges (transfers) in dollar amounts, percentages (i.e., reallocation), or shares. Again, please read the applicable prospectus for information regarding trading restrictions and fees for individual funds. See **Article VII** for instructions for making investment elections and changes.

This SPD provides general information about the Plan's investment options. It does not intend to provide investment advice. More detailed information about the Plan's investment options is available from Transamerica. For further information on investments, you may wish to consult a trusted, reputable investment advisor.

Choosing a single investment from the "ready-mixed" portfolio choices offers you a one-step approach to diversification ("Option A"). Or, you can mix your own portfolio from among the Plan's other fund choices ("Option B").

Option A: Choose a ready-mixed portfolio

The Target Retirement Funds allow you to:

- Make a single investment choice based on the year you plan to start withdrawing assets, typically at retirement
- Invest in a comprehensive portfolio that is professionally diversified across investment styles
- Have your fund's risk level adjusted to generally become more conservative over time

All of the Target Retirement Funds are diversified across an array of funds that invest in different styles and include a mix of stocks, bonds, and capital preservation investments. Your portfolio will be automatically rebalanced for you on a periodic basis, and your exposure to risk will generally be reduced as you get closer to retirement. Remember that diversification and rebalancing do not guarantee a profit or eliminate risk and you can still lose money in a diversified portfolio.

Each Target Retirement Fund has a different target date indicating when the fund's investors expect to begin withdrawing assets from their accounts, typically at retirement. You can simply select the single fund with the target year that most closely matches the date on which you intend to withdraw money for retirement. The Income Fund is designed for participants who are close to achieving or have already achieved their retirement goals or other savings objectives. Please refer to the prospectus for more details.

When deciding which Target Retirement Fund is right for you, you may wish to consider a number of factors in addition to a fund's target date, including your age, how your fund investment will fit into your overall investment allocation, and whether you are looking for a more aggressive or more conservative allocation.

Each Target Retirement Fund is designed to be used as a single-choice approach to diversification for your Plan account and generally should not be used in combination with any other Target Retirement Fund or the Plan's other investment options. When you invest in a Target Retirement Fund, there is generally no need to change your investment selections in the future unless your time horizon for withdrawing from your account changes.

The underlying funds held by each Target Retirement Fund may invest in international securities, which involve risks such as currency fluctuations, economic instability, and political developments. The funds may also invest some or all of their assets in small and/or midsize companies. Such investments increase the risk of greater price fluctuations.

The funds may also have a significant portion of their assets in bonds. Mutual funds that invest in bonds are subject to certain risks including interest rate risk, credit risk, and inflation risk. As interest rates rise, bond prices fall. Long-term bonds have more exposure to interest rate risk than short-term bonds. Lower-rated bonds may offer higher yields in return for more risk. Unlike bonds, bond funds have ongoing fees and expenses.

To help you decide, simply review the table below.

Most aggressive: Higher risk/longer targeted investment period

If your expected or actual year of retirement is	**Consider**
– 2058–2062	Target Retirement 2060 Fund
– 2053–2057	Target Retirement 2055 Fund
– 2048–2052	Target Retirement 2050 Fund
– 2043–2047	Target Retirement 2045 Fund
– 2038–2042	Target Retirement 2040 Fund
– 2033–2037	Target Retirement 2035 Fund
– 2028–2032	Target Retirement 2030 Fund
– 2024 - 2027	Target Retirement 2025 Fund
– Before 2024	Target Retirement Income Fund

Most conservative: Lower risk/shorter targeted investment period

Target Retirement Funds are ranked according to market and credit risk. Market risk measures how sensitive a fund may be to economic and market changes.

Market risk is generally higher for funds that invest heavily in stocks. Credit risk measures how susceptible a fund's income holdings may be to the nonpayment of principal or interest by the issuer. These rankings are relative only to the listed funds and should not be compared with the rankings of other investments. Moreover, there can be no assurance that any one fund will have less risk or more reward than any other fund.

Option B: Mix your own portfolio

Understand risk and reward factors

If you choose to mix your own portfolio, you will select your own combination of individual funds offered by your Plan to create a diversified portfolio that matches your specific risk tolerance and investment goals. Review your Enrollment Guide or https://www.transamerica.com/portal/volvo for information about the available funds.

An important part of investing is determining how much risk (of losing money) you are willing to accept in exchange for potential reward (of making money). There are a number of factors to weigh when determining a fund's relative risk and potential reward in comparison to other funds offered by your Plan. Specifically, you may wish to consider investment style, company size, and geography.

The importance of rebalancing

Keep in mind that over time different performance gains and losses among your funds can move your portfolio away from your initial diversification strategy. To keep your portfolio on track, you should examine your existing account balance percentages at least once a year and "rebalance" or adjust your holdings to align with your intended strategy.

Your enhanced Plan will offer an automatic rebalancing option that enables you to have your portfolio automatically rebalanced every 3, 6, or 12 months.

Diversification and rebalancing will not necessarily prevent you from losing money; however, they may help reduce volatility and potentially limit downside losses.

Investment style

Funds are managed in different styles. Investment style refers to the way a fund is managed and the types of stocks and bonds in which it invests. There can be no assurance that funds will achieve their investment objectives.

Higher potential risk/higher potential reward

Growth funds seek to maximize the value of your savings over time by investing in the stocks of companies that have a strong potential for providing above-average earnings growth.

Blend funds seek to increase the value of your savings over time by investing in the stocks of companies with strong earnings growth potential as well as those priced below their expected long-term worth.

Value funds seek to increase the value of your savings over time by investing in undervalued, or attractively priced, stocks of well-established companies.

Income funds seek to provide a steady stream of income, which is reinvested in your account, and in some cases a small amount of growth, by investing in bonds issued by governments and corporations and similar income-producing securities.

Capital preservation funds seek to offer price stability and a steady stream of income, which is reinvested in your account, by investing in short-term bonds or contracts issued by creditworthy companies, financial institutions, and government entities.

Lower potential risk/lower potential reward

Company size
Specific to stock funds, company size refers to the total market value or "capitalization" of a company as determined by its outstanding stock shares.

Higher potential risk/higher potential reward

Small-cap funds invest in the stocks of small companies, which often offer innovative products and services. However, because of their small size, such companies may also present volatility and liquidity risks.

Mid-cap funds invest in the stocks of midsize companies, which may have a faster growth rate than large companies but also more stability than small companies.

Large-cap funds invest in the stocks of large companies which, because of their asset size, tend to be the most stable.

Lower potential risk/lower potential reward

Geography

Stocks and bonds are issued by companies and government entities around the world and offer varying degrees of risk and potential reward.

Higher potential risk/higher potential reward

International/global funds invest in stocks issued by companies outside the United States or bonds issued by government entities or companies outside the United States. Global funds invest in securities of issuers worldwide and international funds invest mainly in securities of issuers outside the United States. International and global funds may perform well when U.S. domestic funds do not, but they also involve unique risks such as currency fluctuations, economic instability, and political developments. Additional risks, including illiquidity and volatility, may be associated with emerging market securities.

Domestic funds invest in stocks issued by companies or bonds issued by government entities or companies located in the United States and tend to track the ups and downs of the U.S. economy.

Lower potential risk/lower potential reward

The investment style, company size, and geography illustrations are not intended as investment advice, but rather as a general guide to investment style risk/potential reward profiles. Because blend funds have the flexibility to invest in both growth and value stocks in varying proportions, at any given time they may have a higher or lower risk/potential reward profile than value funds or growth funds. There can be no assurance that any fund will experience less volatility or greater reward than any other fund. Investing in small-cap and mid-cap companies involves increased risk of price volatility compared with investing in large-cap companies.

View sample investor profiles

The profiles below can help you determine how to diversify your own portfolio among your Plan's investment styles based on your goals, risk tolerance, and years to retirement. As you develop your investment strategy, it's important to consider that your retirement (and need for a steady stream of income) may last 20 years or more. So be sure to factor this time into your long-term investment objectives.

Sample investor profiles

● Growth ● Blend ● Value ○ Income ● Capital preservation

GOAL	Maximum growth	Growth	Conservative growth	Income and inflation protection
RISK TOLERANCE	High	High to moderate	Moderate	Moderate to low
TIME HORIZON	20 years or more	10–20 years	5–10 years	5 years or less
TYPICAL ALLOCATION	 30% Growth 30% Blend 30% Value 5% Income 5% Capital preservation	 20% Growth 30% Blend 20% Value 20% Income 10% Capital preservation	 15% Growth 20% Blend 15% Value 35% Income 15% Capital preservation	 10% Growth 10% Blend 10% Value 50% Income 20% Capital preservation

retirement at age 65, historical inflation rates, and risk and potential return relationships of the asset classes shown. No other assumptions have been made. You should not consider these sample profiles to be investment advice, and when applying these profiles to your individual situation, consider your other assets, income, and investments (e.g., the equity in your home, other retirement plan and IRA assets, and your savings) in addition to your Plan account. You may wish to consult a financial advisor to review your specific situation. Call your Plan's toll-free number if you have any questions.

Learn more about your funds

The following profiles outline the investment objective and strategy – including style, company size, and geography – for each of the investments offered by your Plan. There can be no assurance that a fund will achieve its objective. The funds are listed in alphabetical order under each style category; categories are listed according to market and credit risk. Please see page 28018 for more information about investment styles.

Investors should carefully consider the investment objectives, risks, charges, and expenses of a fund before investing. For a prospectus or an offering statement containing this and other information about any fund in the Plan, please call 1-800-356-9240 or visit https://www.transamerica.com/portal/volvo . Read the prospectus or offering statement carefully before making any investment decisions.

SECTION 2 Plan Investment Fees

All of the funds in the Plan's new investment lineup are being offered in the share classes with the lowest available expense ratios. Generally, the share class that has the lowest expense ratio for each fund will have the highest investment return, as compared with the other share classes offered for that fund.

What are expense ratios and share classes?
The operating fees for the funds are assessed as a percentage of the assets invested and are deducted directly from those assets. The expense ratio is used to represent the sum of those operating fees.

Some funds offer different types of shares, known as "classes." Each class invests in the same portfolio of investments and has the same objectives and policies. However, each class has different fees and expenses and therefore different performance results. As mentioned above, the share class with the lowest expense ratio for each fund will generally have the highest investment return, as compared with the other share classes offered for that fund. For information about fund fees and expenses, please refer to each fund's prospectus or offering statement.

How you invest your account is entirely up to you; the Company cannot give investment advice. For more information or a prospectus on any of the funds, please contact Transamerica by phone at 1-800-356-9240 or online at https://www.transamerica.com/portal/volvo .

ARTICLE V – Plan Expenses

SECTION 1 Plan Administrative Fees

In order to offer all of the funds in the share classes with the lowest available expense ratios and still pay for all of the Plan's administrative costs, it will be necessary to implement a per-participant fee. This fee will be deducted quarterly from your account, reflecting administrative expenses for the previous quarter.

SECTION 2 Plan Investment Fees

Plan Investment Fees are described **in Article IV**.

SECTION 3 Other Fees

Fees that may apply to your account (for example, QDRO fees and the administrative fees described above) are listed on a fee schedule that is part of your quarterly account statement.

ARTICLE VI – If You Leave Before Retirement

SECTION 1 Vesting

Vesting means you have a permanent right to the value of your Plan account – including any company contributions made on your behalf and any investment gains or losses on that money.

Vesting determines your right to your Plan account when you leave the Company.

Under the 401(k) Plan, you are always 100% vested in *your* elective contributions and rollover contributions, if any, and the investment gains or losses on that money. You become vested in Company contributions and any investment gains and losses on that money at the rate of 20% for each year of service, as follows:

Years of Service…	***Vested Percentage…***
1	20%
2	40%
3	60%
4	80%
5	100%

You will also become 100% vested in Company contributions if you reach age 65, or die while employed by the Company or while performing qualified military service, or become disabled as determined under the Company's long-term disability plan that applies to you.

SECTION 2 Contributions Following Protected Military Leave

If your employment with the Company is interrupted by a period of military service that lasts less than 5 years and you return to service in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("protected military leave"), you will have the right to make restorative contributions equal to the amount of elective contributions (including catch-up contributions, if applicable) that you could have made for the period of your military leave (based on your eligible Pay immediately prior to such leave). The Company will make any Company contributions to your account to the extent required by law. You are required to notify the Plan Administrator at the commencement of your protected military leave or as soon as possible thereafter.

ARTICLE VII – 401(k) Plan Flexibility

The 401(k) Plan gives you the flexibility to change your decisions to keep pace with your circumstances. You may make the following changes by contacting Transamerica at 1-800-356-9240 or online at https://www.transamerica.com/portal/volvo

*You can change your elections as your circumstances change. You can change your investments simply by calling **Transamerica** or accessing their website.*

- ***Change your contribution percentage.*** You may increase or decrease the amount you contribute to the Plan (as pre-tax **or Roth** elective contributions or a combination) at any time. To change your contribution election, contact Transamerica by phone or online. The change will take effect as soon as administratively possible.
- ***Stop or resume your contributions.*** You may *stop* contributing to or *resume* contributing to the plan at any time. To stop or resume contributions, you must contact Transamerica. Your change will take effect as soon as administratively possible.
- ***Transfer your existing investments or change your investment elections for future contributions.*** You may transfer your existing investments or change your investment elections for *new* contributions going into your account at any time. To transfer your funds or change your investment elections, simply call Transamerica toll-free or visit the Plan's website.
- ***Change your beneficiary designation.*** You may change your beneficiary at any time by accessing the Plan's website or calling Transamerica's toll-free number to request a Beneficiary Designation Form. Remember, however, that if you're married and wish to name someone other than your spouse as your beneficiary, you'll need your spouse's written consent, witnessed by a notary public.

The Plan Administrator may temporarily suspend certain Plan activities in order to facilitate a transfer of assets and/or liabilities to or from the Plan, a change in service providers, or the investment options of the Plan. Actions that may be suspended include, but are not limited to, distributions, withdrawals, loans, investment and contribution elections, and changes in contribution percentages and investment fund allocations. If practicable, you will be notified in advance of any suspension so that you can plan accordingly. In some cases, your transaction requests may be delayed due to administrative time lags in file transfers needed to facilitate such transactions.

ARTICLE VIII – Receiving Your Plan Account

In general, you may request a distribution of your Plan account when you retire or leave the Company and all of its affiliates. Under certain circumstances you may be able to access your money while you are actively working for the Company. The following paragraphs describe how distributions, loans, and withdrawals work.

SECTION 1 Distributions

You or your beneficiary can receive the vested value of your Plan account when you leave the Company and all of its affiliates for any reason, including retirement, disability, or death.

Mack will distribute your Plan savings automatically if you leave the Company and all of its affiliates (for any reason) *and* the value of your Plan account is $1,000 or less. If the vested value of your Plan account is *greater* than $1,000, you can elect to have your account distributed:

- In a lump sum, or
- Monthly, quarterly, semi-annual, or annual installments over a period designated by you. The maximum period you may designate is determined by IRS life expectancy tables.

If you elect to leave your money in the Plan after you leave the Company, periodic minimum required distributions (RMDs) of your account balance will begin the April 1 following the year in which you reach the RMD age. This is your Required Beginning Date. Once you start receiving your RMDs, you should receive them at least annually until all assets in your Account are distributed. The RMD age is shown below. Beginning in 2024, Roth deferral contribution accounts can be disregarded in determining RMDs. If you have any questions about your RMDs, please contact the Plan Administrator.

RMD Age	Date of Birth
70½	Before July 1, 1949
72	On or after July 1, 1949, but prior to January 1, 1951
73	On or after Jan. 1, 1951, but prior to January 1, 1960
75	On or after January 1, 1960

In the event of your death, your beneficiary will receive your benefits in a lump sum as soon as administratively possible. However, if your spouse is your beneficiary and the value of your account is greater than $1,000, he or she can elect to defer payment until the date you would have reached your RMD age.

SECTION 2 Loans

If you wish, you may borrow money from your Plan account. When you repay the loan, you repay your Plan account, with interest. In essence, you pay *yourself* back because you're borrowing *your own money*. The Plan's written loan program is in Appendix A to this SPD. You may also obtain a copy or apply for a loan by calling Transamerica at 1-800-356-9240 or by visiting their website at https://www.transamerica.com/portal/volvo .

Keep in mind that you do not pay income taxes on any money borrowed from your Plan account. In addition, the interest portion of your repayments is *not* tax deductible. You may wish to consult a tax advisor before borrowing from the plan.

SECTION 3 In-Service Withdrawals

Under the Plan's withdrawal feature, you can withdraw money from your Plan account under certain circumstances. The portion of your account available for withdrawal does not include the amount that is reflected on your statement as an outstanding loan balance.

You can withdraw funds from your rollover account at any time and for any reason. If you have an account transferred from the Mack Trucks Inc. Retirement Savings Plan, you may withdraw a portion of that account under certain circumstances. You cannot withdraw elective contributions prior to age 59½, except that elective contributions may be available for hardship withdrawal (explained below under the heading "Hardship Withdrawals").

If your account includes Company matching contributions, you cannot withdraw that money prior to age 59½.

SECTION 4 Age 59½ Withdrawals

Once you reach age 59½, you may withdraw part or all of your vested Plan account at any time.

SECTION 5 Hardship Withdrawals

If you experience certain financial hardships, you can withdraw money from your account.

If you are younger than age 59½, you may withdraw your elective contributions and earnings *only if* you experience financial hardship as defined by the IRS. **Unless you designate otherwise on your withdrawal request, withdrawals will be taken first from pre-tax (not Roth) elective contributions and earnings**. In general, the IRS considers a financial hardship to exist if you

have no other resources reasonably available to meet the need of an immediate and heavy financial burden. This kind of need may include:

- Funds needed to purchase your primary residence;
- Funds needed to prevent your eviction from, or foreclosure on the mortgage of, your primary residence;
- Expenses for the repair of damage to your principal residence, to the extent that such expenses are the type that would qualify for the IRS casualty deduction;
- Funeral expenses for your deceased parents, your spouse, your primary beneficiary under the Plan, and/or your dependents;
- Post-secondary tuition expenses and related educational fees for you, your spouse, your primary beneficiary under the Plan, or your dependents for the next twelve months only,
- Expenses and losses (including loss of income) incurred by you on account of a disaster declared by the Federal Emergency Management Agency (FEMA), provided that your principal residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance with respect to the disaster; and
- Unreimbursed medical expenses (incurred or to be incurred) for yourself, your spouse, your primary beneficiary under the Plan, or your dependents, to the extent that such expenses are the type that would be tax deductible by you.

The following rules apply to hardship withdrawals:

- The amount of the withdrawal cannot be greater than your financial need, although it can include amounts you may need to pay any applicable income taxes and penalties.
- Before obtaining a hardship withdrawal, you must exhaust all loans and other distribution options available under this and any other plan sponsored by the Company or an affiliate.

For *all* withdrawals, including Hardship withdrawals, you must contact Transamerica at 1-800-356-9240.

You are responsible for paying ordinary income taxes on the taxable amount of your withdrawal in the year you receive the distribution. A penalty tax of 10% – *in addition* to ordinary income tax – also may apply if you make the withdrawal before reaching age 59½. Hardship withdrawals may not be rolled over. (See "How Taxes Affect Your Benefit" for information about withholding and penalty taxes.)

SECTION 6 Relief for Special Circumstances

From time to time, federal law provides temporary relief related to natural disasters or national emergencies. Affected individuals will be notified when such relief is available and how to exercise their rights and responsibilities, consistent with the Plan terms. For example, effective April 13, 2020, the Plan offered special distribution rights to participants who certified that they qualified for relief available to individuals impacted by COVID-19. These distributions were available for vested amounts of up to $100,000 without regard to the Plan's withdrawal or partial distribution restrictions, subject to special tax and rollover rules. In addition, all RMDs (see page 28826) for 2020 were waived for participants and beneficiaries, unless such distributions were requested.

ARTICLE IX – Account Information

SECTION 1 Quarterly Statements

Plan account statements are available on the Plan's website, https://www.transamerica.com/portal/volvo . If you have an email address on file, you will receive notification when your quarterly statement is available online. Your quarterly statement shows the following:

Once each quarter, you can receive a statement showing the status of your plan account. Keep your statements in a safe place so you can keep track of the growth of your 401(k) savings.

- The amount of pre-tax elective contributions you made
- **The amount of Roth elective contributions you made**
- The amount of matching **and other Company contributions** credited to your account
- The percentage of your total contribution that you are allocating to each investment fund
- Opening and closing balances for each investment fund
- Any loans you have taken or payments you have made, including loan balances
- Any withdrawals you have made, and
- The amount of fees you have paid.

You may view your account balance online each day at https://www.transamerica.com/portal/volvo . To receive a quarterly statement by mail you must contact Transamerica at 1-800-356-9240 and request a mailed statement.

SECTION 2 Voice Response System and Web Site

Current information about your account is available daily through a toll-free number at 1-800-356-9240 or online at https://www.transamerica.com/portal/volvo . These Plan access features are available 24 hours a day, seven days a week. You may also speak with a Plan representative at that number between 8:30 am and 6:30 pm Eastern Time, on any business day.

Information about your account is available 24 hours a day by calling Transamerica at 1-800-356-9240 or by logging onto https://www.transamerica.com/portal/volvo .

SECTION 3 Protecting Your Account

Transamerica has pledged to reimburse losses through no fault of your own due to unauthorized activity in your Plan account maintained on the

Transamerica recordkeeping system, subject to specified requirements and conditions. You should become familiar with your responsibilities under this policy and ensure that you undertake the recommended actions in order to benefit from this coverage. To learn more, visit https://www.transamerica.com/why-transamerica/security **and** https://cdn.brandfolder.io/86JM1UOD/as/35hj28hb84jcj4wkbt8b92h/Customer_Security_Policy_Flyer.pdf.

If you think your Plan account has been compromised, call Transamerica immediately at 800-797-2643. It will promptly review your claim and help you take measures to protect from further loss. You will be required to complete a notarized affidavit of fraud and to identify items of unauthorized activity as part of the claim process. You may be asked to professionally clean your hard drive, sign a release, file a police report, or take other actions reasonably necessary to assist in assessing the losses. Most notably, Transamerica reserves the right to deny your claim if you fail to notify it within 60 days after the suspicious activity occurs. This means that, among other recommended safeguards, you need to monitor your account diligently.

ARTICLE X – How Taxes Affect Your Benefits

Generally, you are not taxed on your savings while the money remains in the 401(k) Plan, but you'll have to pay income taxes when you receive a distribution.

The 401(k) Plan enjoys certain tax advantages because it is intended to be a long-term savings program for retirement. For example, under current federal income tax law, your money is not taxable while it is held in the Plan. You will owe income taxes on your distribution when you receive payment of your benefits. **However, the special rules for Roth elective contributions, including earnings on such contributions, are described on page 2708.**

Prior to receiving a distribution, you will receive a detailed notice that describes many of the tax rules that apply. A general description of the rules is provided in this section of the SPD. Before deciding how to receive your Plan distribution, you should review the detailed tax notice and seek the advice of your attorney or investment advisor.

In addition to ordinary income taxes, you also may owe a 10% penalty tax depending on when and under what circumstances you receive a distribution. The 10% penalty tax will *not* apply in these situations:

- Your account is paid to you after age 59½
- Your account is paid to you after you retire from the Company during or after the year in which you reach age 55
- Your account is distributed in approximately equal installments over your life expectancy (even if you leave the Company before age 55)
- Your account is paid because you become disabled or die
- Your account is used to pay medical expenses eligible to be deducted on your year-end federal income tax return
- Payment is directed to another person by a qualified domestic relations order
- You direct the Plan Administrator to transfer your entire account to an IRA or another *qualified* employer-sponsored plan, or
- **Your account attributable to Roth elective contributions (including earnings) is received in a Qualified Roth distribution described on page 2708.**

When you are eligible to receive a distribution from the Plan, you have several choices:

- You can elect that the Plan directly roll over your eligible rollover distribution (generally, a lump sum or payments made over a period of less than 10 years, excluding a hardship distribution) to another eligible retirement plan or IRA (other than a SIMPLE IRA or Coverdell Education Savings Account). In this

elective contributions can't exceed 75% of your Pay. All elective contributions can be made on a pre-tax or Roth basis or a combination.

Legal Contribution Limitations. The Internal Revenue Service (IRS) imposes the following limits on how much money can be contributed on your behalf each year:

- Regular elective contributions (including amounts attributable to separate elections based on a profit sharing plan payment or a bonus, as described in Section 5 of this Article) cannot exceed an annual dollar limit **($23,000 in 2024**).
- The maximum amount that can be contributed to your account each year – in the form of your elective contributions (excluding catch-up contributions) and company contributions – cannot exceed a dollar amount (**$69,000 in 2024**) or 100% of your compensation, whichever is less.
- Your Pay that can be taken into account each year is subject to a limit ($**345,000 in 2024**).
- In some cases, highly-compensated employees may be restricted from making certain contributions to the Plan so that the Plan can comply with these and other IRS guidelines. You will be notified if you are affected by these restrictions.
- If you are age 50, or will reach age 50 by the end of the year, you can contribute an additional amount each year in excess of the foregoing limits ($**7,500 in 2024**) by making a separate election. These additional contributions are called "catch-up" contributions. You can make catch-up contributions only if you reach, or you expect to reach, one of the legal limits on contributions for the year. Your catch-up contributions plus your other elective contributions based on your Pay can't exceed 75% of your Pay each pay period. Your total elective contributions (including catch-up contributions) can't exceed **$30,500 in 2024**.

These limits are adjusted from time to time by the government for changes in the cost of living. Note that the limits on your elective contributions apply each year with respect to the aggregate amount of such contributions that you make into any tax-qualified retirement plan (including contributions to a plan maintained by another unrelated employer). To request a corrective distribution from the Plan if you exceed the limits in any year, you must contact the Plan Administrator by March 15th of the following year.

How Pre-tax Elective Contributions Work. Pre-tax elective contributions are deducted from your paycheck *before* federal – and, in most locations, state and local – income taxes are withheld. As a result, your taxable income is reduced, so you pay less in taxes. You *will* pay taxes on this money, including any investment earnings, when you receive your account balance at retirement (or earlier, if you withdraw the money).

ARTICLE XI – Claims Information

SECTION 1 Filing a Claim

You must apply to receive benefits from the Plan. To apply for benefits, you must contact Transamerica by calling 1-800-356-9240. If you die, your beneficiary must contact the Human Resources Department. Benefits are paid as soon as possible after you or your beneficiary file a claim. If you defer receiving your benefits after you leave the employment, keep the Company informed of any address changes so you can continue to receive information about your Plan account.

*There are specific procedures for filing claims and settling disputes. See **Article XII**.*

SECTION 2 Benefit Denial and Appeal

If all or part of your claim for benefits is denied, or if there is a dispute regarding your right to participate in the Plan, the Plan Administrator will notify you in writing of the specific reason or reasons for the denial of your claim or the decision with respect to your participation. The notice will reference the appropriate Plan provision or provisions on which the denial or decision is based, include a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and inform you of your right to sue in federal court if your claim is denied on appeal.

The notice will also describe how claims are reviewed and outline the steps for requesting review of your claim. Usually the written notice will be issued within 90 days of receipt of your claim. However, due to special circumstances, some cases may require an additional 90 days to review. You will be notified if additional time is required for review of your claim.

If you or your beneficiary disagrees with the decision of the Plan Administrator, you have 60 days after receiving the notice of denial to request a review of your case by the Plan Administrator. As part of the appeal review procedures, you or your beneficiary will be allowed to:

- submit additional documents, records, and information relating to the claim;
- request access to and receive copies (free of charge) of all Plan documents, records, and other information affecting the claim;
- appeal the denial in writing; and
- have someone act as your representative in the appeal procedure.

The Plan Administrator's review of a claim on appeal will take into account all comments, documents, records, and other information relating to the claim

submitted in connection with the appeal, without regard to whether such information was submitted or considered in the initial claim determination.

The Plan Administrator will usually give its final decision within 60 days after receipt of your request for review. However, some cases may require an additional 60 days to review due to special circumstances. You will be notified if additional time is required to review your claim. You will be notified by mail of the Plan Administrator's final decision and the specific reasons for the decision. If the Plan Administrator denies the claim on appeal (in whole or in part), the notice will inform you (or your beneficiary) of the right to receive (upon request and free of charge) copies of all documents, records, or other information that were submitted to the Plan, considered by the Plan, or generated in the course of making the benefit determination and your right to sue in federal court.

The Plan Administrator has full discretion and authority to determine all claims under the Plan. Any action or determination in the review procedure will be final, conclusive, and binding on all participants and beneficiaries and their representatives.

ARTICLE XII – Other Important Facts About the Plan

SECTION 1 Circumstances Which Could Affect Your Benefit

Benefits may be denied, lost or suspended, or you may not qualify or be eligible for benefits, under the following circumstances:

- You are not eligible to participate in the Plan
- If a benefit under the program cannot be paid because you or your beneficiary cannot be found, the benefit will be forfeited in certain circumstances. If the payee is located at a later date, benefits which were due but could not be paid will be paid in a single sum and the right to future benefits will be reinstated in full.
- If you receive a benefit payment in excess of the amount which you are owed, the excess will be returned to the Plan. Subject to certain restrictions, the Plan Administrator may do this by either (1) reducing future Plan payments owing to you until the excess is recovered or (2) requiring you to repay the excess to the Plan.
- If a Company contribution is made by reason of a mistake of fact, the Company can recover the contribution.
- If a tax deduction for a Company contribution is disallowed, the Company contribution can be returned to the Company.

Other circumstances which could affect the amount of your benefit include:

Limitations on Contributions. Federal law limits the amount of contributions that may be made to the Plan. If these limitations affect you, you will be notified.

Military Leave. It's your responsibility to notify the Company as soon as possible if you are going to go on military leave. If you leave work for a qualified military leave, you may make additional contributions when you return to work to make up for the period when you were on leave (provided you return to work for the Company within the time period prescribed by federal law for protection of your reemployment rights). You will receive service credit while on qualified military leave.

Plan Insurance. Unlike your benefit in the Pension Plan, your Plan benefit is not insured by the Pension Benefit Guarantee Corporation (PBGC) because your benefit is determined solely based upon contributions to the Plan and gains and losses thereon.

Assignment of Benefits. Your Plan benefit is not assignable or alienable. Your creditors cannot claim your account to satisfy debts. However, a court may order all or a portion of your account be paid to an "alternate payee" (such as a former spouse, minor children, etc.) under a Qualified Domestic Relations Order. The

Plan Administrator determines whether a domestic relations order is qualified pursuant to certain procedures under the Plan. You or your beneficiary can obtain, without charge, a copy of these procedures from the Plan Administrator. You should contact the Plan Administrator when you become aware of any court proceedings that may affect your benefits so that appropriate action may be taken.

In addition, if you commit a crime against the Plan, a court may order, or a legal settlement between you and a governmental agency may provide, that all or a portion of your benefit will be paid to the Plan.

SECTION 2 Interpretation of the Plan

The Plan Administrator has full authority to interpret the provisions of the Plan and this SPD. While the SPD is intended to be complete and accurate, remember that it is only a summary of the Plan's provisions. In interpreting this SPD, the Plan Administrator will rely on the governing Plan document. In the event of any conflict between this SPD and the Plan document, the Plan document will always control. The explanations in the SPD cannot alter, modify, or otherwise change the controlling Plan document, nor can any rights accrue by reason of any statements or omissions in the SPD.

The Plan Administrator's decisions regarding the interpretation of the Plan document and SPD and all questions that may arise thereunder as to the status and rights of participants and others, are conclusive and binding on all persons. The Plan Administrator may, however, appoint and delegate some of its interpretation and decision-making authority to other individuals. The Plan documents are available for review in the Human Resources Department during normal business hours.

ARTICLE XIII – Administrative Information

Plan Name
The official name of the plan is the *Mack-UAW 401(k) Plan.*

Plan Type
The Plan is a defined contribution plan with a 401(k) feature.

Plan Sponsor and Plan Administrator
The Plan Sponsor and Plan Administrator is:
Mack Trucks, Inc.
8003 Piedmont Triad Pkwy (27409)
P.O. Box 26115
Greensboro NC 27402-6115

Plan Trustee
The Trustee is State Street Bank and Trust Company
1 Iron Street
Boston, MA 02110

Employer Identification Number (EIN)
22-1582040

Plan Number
012

Plan Year
The Plan year is January 1 to December 31

Agent for Service of Legal Process
For disputes arising under the Plan, service of legal process can be made upon the Plan Administrator or the Plan Trustee.

Plan Effective Date
The Plan's original effective date was January 1, 1999. This SPD describes the terms of the Plan as in effect on February 1, 2024.

ARTICLE XIV – Your Rights Under ERISA

As a participant in the *Mack-UAW 401(k) Plan*, you are entitled to certain rights and protections under federal law as stated in the Employee Retirement Income Security Act of 1974 (ERISA). ERISA entitles you as a plan participant to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all Plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable amount for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Quarterly Statements
If you are a member of the Plan, you have a right to receive a quarterly statement at no charge to you. If the statement is not provided automatically, you may request it in writing.

Obligations of Fiduciaries
In addition to creating rights for Plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the Plan. These individuals are called fiduciaries. They have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries.

Provisions for Legal Action
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 or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, you can take steps to enforce the rights outlined above. For instance, if you request materials 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 Plan Administrator.

If your claim for benefits 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 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, you should contact the Plan Administrative Committee. If you have any questions about this statement of your rights under ERISA or to obtain certain publications about your rights and responsibilities under ERISA, contact the Employee Benefits Security Administration, U.S. Department of Labor, by telephone at the toll free number 1-866-444-3272, electronically at www.askebsa.dol.gov, or by mail to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

ARTICLE XV – A Final Note

The Company intends to continue the 401(k) Plan indefinitely, but reserves the right to discontinue or change the Plan at any time and for any reason by action of its Board of Directors or its delegate. (Of course, the 401(k) Plan is part of the collective bargaining agreement, and any amendment or Plan termination during the contract would be subject to the collective bargaining process.) If the Company terminates the Plan for any reason, the assets in the Plan will be used for the exclusive benefit of Plan members and beneficiaries. If the Plan terminates or partially terminates, you will receive a distribution of your plan account according to the terms of the official Plan document.

This booklet is a Summary Plan Description of the Mack-UAW 401(k) Plan. It highlights the main provisions of the Plan but is subject to the terms of the legal Plan document. Where this description and the official Plan document vary in the description of the Plan, the Plan document is the final authority.

This description of the 401(k) Plan is not an employment contract or any type of employment guarantee.

Appendix A

Mack-UAW 401(k) Plan Loan Program

1. Applicability and Effective Date

This loan program has been approved by the Committee, effective as of December 31, 2017 with respect to the Plan. The loan program applies to any outstanding loan as of the effective date and to any loans issued on or after that date. The Committee may revise this loan program at any time. However, in no event will any change to the loan program impair your rights under the terms of an existing promissory note or under any loan that is outstanding immediately prior to the effective date of the change, except as may be required to comply with ERISA or other applicable law.

2. Plan Website and Contact Information

To model or apply for a loan (as described in Item 4 below), to check the balance on an existing loan, or to find other information or ask a question regarding this loan program, you can log into your account on the Plan website or call a Plan representative, as follows:

Website:	https://www.transamerica.com/portal/volvo
Telephone:	800-356-9240
Address:	4333 Edgewood Rd NE Mail Drop 0001 Cedar Rapids, IA 52499

3. Eligibility Criteria

You are eligible to apply for a loan from the Plan if you meet all of the following conditions:

- You are actively employed by a participating employer.
- You have a vested (i.e., nonforfeitable interest) in your Plan account.
- You meet the loan minimum described in Item 6.
- You do not have any other outstanding loans from any Plan sponsored by a participating employer, and you paid off any prior loan at least ten days prior to your application for a new loan. (A previously defaulted loan is disregarded for this purpose.)
- You have sufficient compensation, net of other deductions, to cover the required loan repayments described in Item 10.

Note that you are not eligible to apply for a loan if you have terminated employment or have taken a leave of absence with insufficient compensation

to cover the loan repayments. If you already have a loan outstanding, you must first repay that loan before requesting a new loan (see Item 0) for instructions to pre-pay a loan in full). As described in Item 6, the highest outstanding loan balance in the previous twelve months will reduce the maximum amount available for a new loan. You may not refinance an existing loan.

4. Application Process

If you meet the eligibility criteria, you may initiate a loan by going to the Plan website (under Transactions) or by calling a Plan representative (see Item 2). You can model a loan using any variable data, such as loan amount, loan term, etc. that meet the parameters in this loan program. Once you have modeled your desired loan, you can submit a loan request by calling a Plan representative, using the website, or printing and submitting a completed paper application. You can request expedited check delivery (for a fee) or direct deposit.

After you make a formal loan request, you will be notified if your loan has been approved. In that case, you will receive a check in the amount of the loan request, a loan note and security agreement, and the amortization schedule. You will be responsible for communicating any errors or discrepancies in a timely manner by calling a Plan representative (see Item 2). By endorsing and cashing the check, you will acknowledge that you have received, read, and understood the foregoing documentation regarding loan terms. See Item 13 regarding the application fee.

5. Cancelling a Loan

A loan request may be cancelled up until the close of business for the New York Stock Exchange ("NYSE"), which is normally 4:00 pm Eastern Standard Time, on the day that you requested the loan. If your request is submitted after the close of business on the NYSE or on a weekend or holiday, you have until the close of business on the following business day to cancel the loan. Please contact a Plan representative (see Item 2).

6. Loan Amount

When you model a loan, you will see the loan amount available to you, which is limited as follows, based on your vested account balance:

Vested Account Balance	**Maximum Loan Amount**
Less than $2,000	No loan available*
$2,000 - $100,000	50% of vested balance**
Over $100,000	$50,000***

* The minimum loan amount is $1,000, and you cannot take a loan for more than 50% of your vested account.

** Amounts held in a Roth Contribution Account, if any, are included in determining 50% of your vested account; however, none of the loan proceeds will be taken from such amounts.

*** $50,000, reduced by the highest outstanding loan balance in aggregate from all Plans sponsored by the Company or an affiliate.

7. Loan Term Duration

The repayment period of any general purpose loan can be no more than five years. The repayment period of a primary residence loan can be up to ten years, provided you submit a Residence Verification Form. The repayment period you choose must be in one month increments.

8. Interest Rate

The interest rate for a loan will be the Prime Rate (as listed in The Wall Street Journal on the 3rd business day of the month in which you request the loan), plus 1%. The interest will remain fixed throughout the duration of the loan. However, in no event can the interest rate exceed 6% during a period of military service leave started while a loan is outstanding (see Item 17).

9. Loan Accounting

The disbursement of monies from your account to fulfill the loan are taken pro rata from all available investment options held in your account. This means that the portion of your account attributable to the loan will not experience investment gains or losses, but interest you pay on the loan will be credited to your account. The outstanding loan will be reflected in your account until it is fully repaid or offset (see Item 15).

10. Loan Repayments

Generally, a loan must be repaid in substantially equal installments by payroll deduction from each paycheck. The Committee will automatically reamortize your loan if your payroll frequency changes. Repayments start as soon as administratively possible after the date the loan check is issued. Please review your pay stub to confirm that repayments are being deducted properly. Errors or other failures that delay your loan repayments could subject you to severe adverse tax consequences (see Item 15).

Even though loan repayments are made with after-tax dollars, they are credited back to the account source from which the loan proceeds were redeemed. Repayments are reinvested in accordance with your investment instructions for new contributions.

See Item 16 regarding the accelerated due date for repayment in full if you terminate employment. See Item 17 if you take a leave of absence without pay or with reduced pay.

11. Prepayments

Partial or full pre-payment of your outstanding balance is permitted. A pre-payment will reduce the remaining loan term.

12. Transfers to Other Plans

If you transfer to one of the following plans, your loan will automatically transfer to the new plan. Any transferred loan is treated as being outstanding for purposes of applying for a new loan.

- Volvo Group North America Voluntary Investment Pretax Plan
- Voluntary Investment Pretax Plan for the Volvo Group North America Union Employees
- Arrow Truck Sales, Inc. 401(k) Retirement Plan
- Volvo Investment Plan
- Volvo Penta Marine Products, LLC Retirement Savings Plan
- Prevost Car, Inc. (a Division of Prevost Car (US) Inc.) 401(k) Retirement Savings Plan

13. Fees

The following fees are deducted from your account and disclosed on your quarterly account statement for the period in which the fee is deducted.

- Application Fee: $35

  A one-time, nonrefundable fee is charged for application processing. This fee will not be refunded if you cancel a loan after the request has been processed, but before cashing or depositing loan check that has already been issued.

- Annual Maintenance Fee: $15

  An annual loan account fee is charged each year until the loan is repaid, offset, or goes into default. This fee is prorated and deducted each quarter.

- Expedited Delivery Fee: $50

  A one-time, nonrefundable fee is charged if you elect expedited delivery of your loan check.

14. Security

Your loan will be secured by the assignment of the portion of your vested account balance equal to the amount of your loan. No other security will be required or accepted.

15. Default

If you fail to make a scheduled repayment when due, you will receive a written notice of your right to cure this failure by making up missed payments (with interest) or repaying the loan in full. You will have until the last business day of the calendar quarter following the calendar quarter in which your last payment was received to cure all missed payments and interest for the quarter in which you first missed payments. If you do not cure your loan by this deadline, your loan will default. This will result in a deemed distribution for federal income tax purposes. This means that the deemed distribution amount will be taxed and reported to the IRS as if it was actually received by you. The amount of the deemed distribution equals the entire outstanding balance of the loan (including accumulated unpaid interest) at the time of the default.

Because a deemed distribution is not an actual distribution, the defaulted loan remains outstanding on the Plan's books and continues to accrue interest until the loan offset for purposes of determining the maximum amount of a future loan (see Item 6). You are not taxed on any interest accruing after the default. A defaulted loan is not treated as being outstanding for purposes of your right to apply for a new loan (see Item 3).

The Plan will offset the default amount against your account at the time you are eligible for an actual distribution or non-hardship withdrawal from the Plan. If the offset occurs at a later date, it will not result in additional tax consequences to you.

16. Termination of Employment

If you terminate employment with an outstanding loan, you must repay your loan in full by the earlier of:

- the last business day of the calendar quarter following the calendar quarter in which you terminated employment, or
- the date your account is distributed to you.

If you do not repay your loan in full by that time, the Committee will offset the unpaid loan balance and interest against your account. The offset amount will be taxed and reported to the IRS like an actual distribution to you, unless you rollover an amount equal to the loan offset to another employer's plan or to an IRA by the tax return deadline for filing your taxes for the year in which you terminated employment. However, a prior deemed distribution that is offset at termination will not be taxed again. If you receive an actual distribution from your account at the same time as the offset, the Plan must apply the 20% mandatory income tax withholding to both the offset amount and the actual amount received as an eligible rollover distribution, but the total amount

required to be withheld is limited to the amount deducted from your account, excluding the offset.

***Example**:*
Jill terminates employment with an account balance of $10,000, which includes a $3,000 balance on an outstanding loan. Jill requests a lump sum distribution of her entire account balance. The plan offsets the $3,000 unpaid loan balance, and pays the remaining $7,000 to Jill. Although the plan distributes only $7,000 in actual cash, the plan must withhold 20% of the entire distribution of $10,000. Thus, the plan will withhold $2,000, Jill will receive a check for only $5,000 ($7,000 cash distribution less $2,000 withheld), and the plan will report a distribution of $10,000. Jill can elect an indirect rollover in the amount of $10,000 within 60 days after the distribution if she has other resources to make up for the $3,000 loan offset and $2,000 in withholding.

17. Suspension of Repayments

Non-Military Leave: If you take a leave of absence (for reasons other than protected military leave, including an absence due to lay off or disability) without pay or with insufficient pay to cover your loan repayments, the Committee will automatically suspend your loan repayments during your absence for up to a maximum of 12 months (or until the end of the maximum loan term described in Item 7, if earlier).

The Plan will take the following actions after your suspension ends:

- If you return to active employment:
  (a) The Plan will resume repayments in the original repayment amount via payroll deduction; and
  (b) Loan repayments will be suspended while a Participant is on authorized non-military leave, not longer than one year, either without pay from the Employer or at a rate of pay (after applicable employment tax withholding) that is insufficient to cover the loan repayments. The suspension will not cause the loan to be treated as a Deemed Taxable Distribution, as long as (i) loan repayments resume upon the completion of such leave, or, if earlier, after the first year of leave; (ii) the payments resume in substantially level payments which are not less in amount than the amount required under the terms of the original loan; and (iii) the loan (including interest that accrues during the leave of absence) is fully paid by the Latest Permissible Term of a Loan.
- If you fail to return to work due to termination of employment, see Item 16.

Military Leave: All of the above provisions regarding a leave of absence apply if you take a protected military leave, except that the Plan will automatically extend your suspension to the end of your protected leave, your

loan term will be extended by the duration of your leave, and your repayments will be reamortized over the remainder of your extended loan term. This provision applies for absences due to active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, or an absence to determine fitness for duty.

The term "**uniformed services**" means:

- US armed forces,
- Army and Air National Guards (when engaged in active duty for training, inactive duty training or full-time National Guard duty),
- Commissioned corps of the Public Health Service, and
- any other category of persons designated by the President in time of war or emergency.

18. Refinancing

Refinancing is not permitted, except in circumstances authorized by the Committee and administered in a nondiscriminatory manner to correct administrative errors related to Plan loans.

19. Death

If you die with an outstanding loan, the entire loan balance and any unpaid interest will be offset against your remaining vested account as soon as administratively practicable following your death.

Your Truth In Lending Disclosure Statement, together with this Loan Program, is your permanent record of the terms of your loan. Keep it with your financial records. Your regular participant statement will show how much you have repaid on a loan, and how it has been reinvested.

2023 CALENDAR

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OCTOBER

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2024 CALENDAR

JANUARY

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2025 CALENDAR

JANUARY

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2026 CALENDAR

JANUARY

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FEBRUARY

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JUNE

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JULY

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2027 CALENDAR

JANUARY

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FEBRUARY

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JUNE

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JULY

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AUGUST

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SEPTEMBER

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OCTOBER

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NOVEMBER

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DECEMBER

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2028 CALENDAR

JANUARY

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FEBRUARY

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APRIL

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JUNE

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JULY

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AUGUST

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

SEPTEMBER

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

OCTOBER

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

NOVEMBER

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

DECEMBER

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						