VOLVO

# BENEFITS AGREEMENT
# BETWEEN
# NEW RIVER VALLEY TRUCK PLANT
# OF
# VOLVO TRUCKS NORTH AMERICA

## AND

## THE INTERNATIONAL UNION,
## UNITED AUTOMOBILE, AEROSPACE &
## AGRICULTURAL IMPLEMENT WORKERS
## OF AMERICA (UAW)

## AND

## LOCAL 2069 OF INTERNATIONAL UNION, UNITED AUTO-
## MOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT
## WORKERS OF AMERICA (UAW)
## EFFECTIVE
## MARCH 17, 2016 THROUGH MARCH 16, 2021
## FOR
## PRODUCTION AND MAINTENANCE EMPLOYEES

## AND

## SALARIED EMPLOYEES

# 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
## NEW RIVER VALLEY PENSION PLAN

## ARTICLE I - INTRODUCTION

Volvo Group North America, LLC sponsors the Volvo Group North America New River Valley Pension Plan (Pension Plan) to provide you with an important source of income for your retirement years. The Plan pays benefits based on your years of service with the Company, including service with White Motor Corporation. Benefits begin when you retire and continue for the rest of your life. When combined with Social Security and the 401(k) plan, the Pension Plan will help you enjoy a financially secure future.

This booklet describes your pension benefits as negotiated under the collective bargaining agreement between the Union and the Company. If you have any questions after reading this booklet, please contact the Human Resources Department. This booklet describes Pension Plan benefits for Core Group Employees in the Production & Maintenance bargaining unit and all employees in the salary bargaining unit.

**In general, Competitive Employees are not eligible to participate in the Pension Plan. Instead, they are eligible to receive Automatic Company Contributions and Company Matching Contributions under the Voluntary Investment Pretax Plan for Volvo Group North America Union Employees (401(k) Plan). See Appendix D for details. However, if you earned a benefit under the Pension Plan prior to May 31, 2011, you will be entitled to receive that benefit, to the extent it is vested, when you retire. The credited service used to calculate your Pension Plan benefits was frozen as of May 31, 2011. However, service earned after that date will count for purposes of vesting and eligibility to receive Pension Plan benefits.**

**If a Competitive Employee becomes a Core Employee, he/she will resume earning credited service in the Pension Plan on and after the date of transition to Core Employee status and will no longer receive Automatic Company Contributions and Company Match in the 401(k) Plan. In that case, total credited service used to calculate your Pension Plan benefits will equal credited service earned as of May 31, 2011 plus credited service earned after you become a Core Employee.**

## ARTICLE II - ELIGIBILITY

### SECTION 1. Who is Eligible

You are eligible to participate in the Pension Plan if:

- You are at least age 21
- You are covered under a collective bargaining agreement with the Company and the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW) and its Local 2069, and
- You have completed a year of service

For purposes of determining Plan eligibility, a *year of service* is a 12-month period beginning on your date of hire during which you complete at least 750 hours of service with the Company or White Motor Corporation.

You are *not* eligible to participate in the Pension Plan if you **first satisfy the eligibility conditions described above on or after March 17, 2011, or if you** are a temporary or leased employee.

**SECTION 2. When Participation Begins**

If you meet the eligibility requirements during the first six months of the calendar year (January 1 to June 30), you will automatically become a Plan participant on the first day of that year. If you meet the eligibility requirements during the last six months of the calendar year (July 1 to December 31), you will automatically become a Plan participant on January 1 of the following year.

Enrollment in the Pension Plan is automatic; you do not have to complete an enrollment form.

**SECTION 3. Who Pays for the Plan**

The Company pays the full cost of the Plan; you are not required to make any contributions.

## ARTICLE III - YOUR PENSION BENEFITS AT RETIREMENT

**SECTION 1. Normal Retirement Benefits**

You can retire and receive a pension benefit on one of three retirement dates – normal, early, or postponed. Or, you may receive a pension if you become disabled and meet the eligibility requirements described in the Disability Retirement Benefits Section.

You may retire and receive your full pension on your *normal retirement date*. Your normal retirement date is the first day of the month that falls on or after the date you reach age 65, or your fifth anniversary of Plan participation, if later.

Your monthly pension benefit at normal retirement is based on your years of credited service with the Company and White Motor Corporation and the date you retire. The Plan uses the following formula to determine your monthly normal retirement pension benefit.

| | |
|---|---|
| Your monthly benefit factor<br>**Times**<br>your years of credited service<br>***minus***<br>your benefit, if any, payable from another Volvo or White Motor Corporation pension plan that is based on service recognized by this Pension Plan | **Monthly Benefit Factor**<br>***Effective Date of Increase*** / ***Initial Benefit Factor***<br>01/01/201**5** / **$40.25**<br>01/01/201**8** / **$40.50**<br>01/01/201**9** / **$40.75**<br>01/01/20**20** / **$41.00** |

To receive the **$40.50** monthly benefit factor beginning January 1, **2018**, as well as the Benefit Escalation feature described below, you must terminate employment on or after **March 1, 2016 and retire on or after April 1, 2016**. If you terminated employment **before March 1, 2016**, your pension benefit will be based on the prior monthly benefit factor (**$40.25**).

**SECTION 2. Benefit Escalation**

If you retire prior to breaking seniority **during March 2016 or later and retire** during this contract, your pension will be adjusted each year until the end of the contract, to reflect scheduled increases in the plan's Benefit Factor. For example, suppose you retire in **2017**, when the Benefit Factor is $**40.25**. Your pension will be based on the $**40.25** level. Your pension will increase on **January 1, 2018**, to reflect the increase in the Benefit Factor to $**40.50**; and it will increase again on **January 1, 2019**, when the Benefit

Factor increases to $**40.75**; and it will increase again on **January 1, 2020**, when the Benefit Factor increases to $**41.00**. It will remain at this ($**41.00**) level thereafter.

If you break seniority prior to becoming eligible to retire, you will not be eligible for this benefit escalation.

**SECTION 3. Credited Service**

For purposes of calculating your pension, *credited service* means each calendar year during which you complete at least 1,700 hours of service with the Company or White Motor Corporation. If you work fewer than 1,700 hours during a calendar year, you'll receive a fractional year of credited service equal to the total number of hours completed, divided by 1,700, and rounded to the next highest 1/10 of a year. **If you complete at least 1,530 hours during a calendar year, you will receive credit for a full year. For example, suppose you complete 1,540 hours during a year. You would receive 1,540/1,700 = 0.906 years, which would round up to 1.0 year of credited service.** If you are absent from work because of a layoff or while on a Company-approved sick leave, you will be credited with 40 hours of service for each complete calendar week of such absence, provided that you received pay from the Company during that year for at least 170 hours of service, and provided further that if the layoff or sick leave continues beyond the end of that year, no more than 1,530 hours will be credited in that year and the next subsequent year with respect to that absence. If you are part-time, you will be credited for any week of such absence in the same percentage relationship as your regular part-time schedule is to 40 hours per week.

**Salaried Bargaining Employees:**

If you participated in the Volvo Group North America Retirement Plan (the "cash balance plan"), any benefit you are entitled to receive from that plan will be offset from your Pension Plan benefit. Although you may elect to receive your cash balance plan benefit as a lump sum, the offset from your Pension Plan benefit will be determined assuming your cash balance plan benefit started at the same time and under the same form of payment as your Pension Plan benefit.

Under the terms of the cash balance plan, account balances are converted to life annuities (providing a monthly pension benefit), using the cash balance plan's interest rate (the annual rate of interest on high–quality corporate bonds for the month of November which precedes the plan year in which your annuity commencement date occurs). Therefore, the annuity you can receive from the cash balance plan may be higher or lower based on changes in the corporate bond rates. However, the total pension you can receive from the Pension Plan and the cash balance plan won't be affected by interest rate changes: if interest rates decline, causing your cash balance annuity to decline, your net Pension Plan benefit will increase by the same amount – so the total pension won't be affected. Conversely, if your cash balance plan annuity increases because of an increase in interest rates, your net Pension Plan benefit will decrease. Again, the total pension will not be affected (assuming, of course, that you elect to receive your cash balance plan benefit as an annuity).

Similarly, any pension payable from a pension plan sponsored by Volvo or by White Motor Corporation, which is based on service recognized by this Pension Plan, will be offset from your Pension Plan benefit.

*An Example of Your Normal Retirement Pension Benefit*

Assume you retire **during this contract in 2016** at age 65, with 24 years of credited service. Using the formula described previously, here's how your pension benefit is calculated:

| | |
|---|---|
| Monthly Benefit Factor | $ **40.25** |
| times credited service | x 24 |
| | $**966.00** |

This monthly pension is subject to the Benefit Escalation provisions described earlier. For example, on January 1, **2018**, your pension would increase to **$972.00 ($40.50 x 24)**; your pension would increase on **January 1, 2019 to $978.00 ($40.75 x 24);** and your pension would increase on **January 1, 2020 to $984.00 ($41.00 x 24).**

**SECTION 4. Early Retirement Benefits**

You may retire and receive a pension benefit before your normal retirement date, if you meet one of the following age and service requirements:

- You reach age 60 and complete five years of credited service
- You reach age 55 and the sum of your age and years of credited service totals 85 or more
- You complete 30 years of credited service
- You reach age 55, complete 10 years of credited service, and become permanently disabled, or
- You reach age 55, complete 10 years of credited service, and are laid off, provided the layoff is expected to be permanent, as in the case of a plant closing.

Your early retirement pension benefit is calculated in the same way as your normal retirement pension benefit, using your years of credited service at your early retirement date. If you elect to receive payment before age 62, your monthly pension will be reduced to reflect the fact that it will be paid over a longer period. (The chart on the right shows the percentage reduction on a yearly basis.)

| *If you are this age when benefits begin…* | *You will receive this percentage of your benefit…* |
|---|---|
| 61 | 93.3% |
| 60 | 86.7% |
| 59 | 80.8% |
| 58 | 75.2% |
| 57 | 69.4% |
| 56 | 63.9% |
| 55 | 57.9% |

If you retire with 30 or more years of credited service, the early retirement reduction does not apply. Your pension benefit is not reduced for early commencement.

You can also retire early and defer payment of your benefit until age 62. In this case, benefit payments will not be reduced.

***SECTION 5. Special Pension Benefits***

In addition to your regular normal or early retirement pension benefit, you may be eligible for a special Medicare benefit or a supplemental benefit. The Plan also provides a special temporary benefit in the event you become permanently disabled or experience a layoff. See Temporary Benefits.

***Special Medicare Benefit***

If you or a surviving spouse is age 65 or older, you are eligible to receive a special Medicare benefit. This special benefit equals $71.10 and is in addition to your regular pension benefit.

***Supplemental Benefits***

If you retire before age 62 (for reasons other than a permanent disability or layoff), you may be eligible for a monthly supplemental benefit. The amount of the supplemental benefit depends on your years of credited service.

- If you retire with less than 30 years of credited service, your monthly supplemental benefit, when added to your regular early retirement pension, is equal to $64.00 for each year of credited

service. For example, if you terminate employment and retire in **2016** and have 20 years of credited service, your total benefit (regular plus supplemental) would equal $1,280 per month ($64.00 x 20). **The supplemental benefit** will be reduced by 1% for each month (or part of a month) you retire before age 60.

- If you retire with 30 or more years of credited service, your monthly supplemental benefit, when added to your retirement early retirement pension, is equal to $1,925.

To receive a supplemental benefit you must apply for pension benefits within five years of your last day of work with the Company. The supplemental benefit is payable until the first of the month following the earliest of the following dates:

- You reach age 62 and one month
- Your pension ends for any other reason
- You are reemployed by the Company, or
- You die.

The supplemental benefit is not payable if you are discharged for cause.

*Examples of Your Early Retirement Pension Benefit*

*Example 1:*

Assume you terminate employment and retire in **2016** at age 60, with 18 years of credited service, and you elect to receive your benefit immediately. Here's how your early retirement pension benefit would be determined:

| **Your Early Retirement Benefit to Age 62 and One Month** | | | **Your Early Retirement Benefit Beginning After Age 62 and One Month** | |
|---|---|---|---|---|
| Base benefit: $**40.25** x 18 = | $ | **724.50** | Base benefit: $**40.25** x 18 = | $**724.50** |
| Times your early retirement reduction factor (.867) | x | .867 | Times your early retirement reduction factor (.867) | x .867 |
| Regular Early Retirement Benefit = | $ | **628.14** | Regular Early Retirement Benefit = | $**628.14** |
| Plus your supplemental benefit: **($64 x 18 - $628.14)** = | $ | **523.86** | | |
| Total Monthly Benefit = | $1,152.00 | | | |

In this example, your initial early retirement pension would be $1,152.00 per month from age 60 to age 62 and one month. Once your supplemental benefit ends (at age 62 and one month), your early retirement pension would be $**628.14**. However, your benefits would be subject to the Benefit Escalation provisions described previously. The following table shows the amount of your monthly pension:

| Year | Age | Monthly Pension |
|---|---|---|
| **2016-2017** | 60-61 | $64.00 x 18 = $1,152.00 |
| **2018** | 62 | $64.00 x 18 = $1,152.00 (until age 62 and one month)<br>$**40.50** x 18 x .867 = $**632.04** (after age 62 and one month) |
| **2019** | 63 | $**40.75** x 18 x .867 = $**635.94** |
| **2020** and later | 64+ | $**41.00** x 18 x .867 = $**639.85** |

Note: The Supplemental Benefit is payable until age 62 and one month. After age 62 and one month, the pension is determined only using the Basic Benefits formula reduced for early commencement. The early retirement factor used to adjust the Basic Benefit is determined based on age when benefits commence. That factor does not change when the pension is recalculated to reflect Benefit Escalation.

***Example 2:***

**Assume you terminate employment and retire in 2016 at age 59 with 26 years of credited service, and you elect to receive your benefit immediately. Here's how your early retirement pension benefit would be determined:**

| Your Early Retirement Benefit to Age 62 and One Month | | Your Early Retirement Benefit Beginning After Age 62 and One Month | |
|---|---|---|---|
| Base benefit: $40.25 x 26 = | $1,046.50 | Base benefit: $40.25 x 26 = | $1,046.50 |
| Times your early retirement reduction factor (.808) | x .808 | Times your early retirement reduction factor (.808) | x .808 |
| Regular Early Retirement Benefit = | $ 845.57 | Regular Early Retirement Benefit = | $ 845.57 |
| Plus your supplemental benefit: ($64 x 26 - $845.57) x .88 = | + 720.22 | | |
| Total Monthly Benefit = | $1,565.79 | | |

**In this example, your initial early retirement pension would be $1,565.79 per month from age 59 to age 62 and one month. Once your supplemental benefit ends (at age 62 and one month), your early retirement pension would be $845.57. However, your benefits would be subject to the Benefit Escalation provisions described previously. The following table shows the amount of your monthly pension:**

| Year | Age | Monthly Pension |
|---|---|---|
| 2016 | 59 | ($64.00 x 26 - $40.25 x 26 x .808) x .88 + ($40.25 x 26 x .808) = $1,565.79 |
| 2017 | 60 | ($64.00 x 26 - $40.25 x 26 x .808) x .88 + ($40.25 x 26 x .808) = $1,565.79 |
| 2018 | 61 | ($64.00 x 26 - $40.50 x 26 x .808) x .88 + ($40.50 x 26 x .808) = $1,566.42 |
| 2019 | 62 | ($64.00 x 26 - $40.75 x 26 x .808) x .88 + (40.75 x 26 x .808) = $1,567.05 (until age 62 and one month)<br>$40.75 x 26 x .808 = $856.08 (after age 62 and one month) |
| 2020 and later | 63+ | $41.00 x 26 x .808 = $861.33 |

**Note: The Supplemental Benefit is payable until age 62 and one month, and is reduced for early commencement. After age 62 and one month, the pension is determined only using the Basic Benefits formula reduced for early commencement. The early retirement factors used to adjust the Supplemental and Basic Benefits are determined based on age when benefits commence. These factors do not change when the pension is recalculated to reflect Benefit Escalation.**

**SECTION 6. Disability Retirement Benefits**

If you have at least five years of credited service with the Company and become disabled, you are eligible to retire and receive a disability retirement benefit.

Your disability retirement benefit is determined using the normal retirement formula Benefit Factors as of your retirement and your years of credited service as of the date you become disabled; it will *not* be reduced for early payment. In addition, you may be eligible for a special temporary benefit (see below).

Disability retirement benefits begin on the date you elect, which cannot be earlier than:

- the first day of the month that includes the date the required proof of disability is received by the Company,
- the first day of the month following a six-month period of disability, or
- the date the Company receives your application for disability retirement.

Benefits will end if you are no longer disabled.

If you are determined to be totally and permanently disabled under the Company's long-term disability plan **(Appendix B, Article III, Section 5a2) or you receive a Social Security disability award**, you will be deemed to be disabled for purposes of this Plan. A disability cannot result from service in the armed forces of any country, unless you complete at least five years of service after you return to work with the Company.

***Temporary Benefits***

If you retire before age 62 because of a permanent disability or layoff, the plan provides a temporary benefit, which is in addition to your regular early retirement pension benefit. The amount of the monthly temporary benefit is equal to $33.80 for each year of credited service up to 30 years. For example, if you have 20 years of credited service, your temporary benefit would equal $676 per month ($33.80 x 20).

The temporary benefit is payable until the first of the month following the date you reach age 62, or the date you become eligible to receive federal Social Security disability benefits or unreduced federal Social Security benefits for age, if earlier. Temporary benefits will also end if your disability ends, or you die.

You cannot receive a temporary benefit if you are receiving a supplemental benefit.

***An Example of Your Disability Retirement Benefit***

Assume you are age 60, retire **during this contract in 2016** because of a disability, and you are not eligible to receive Social Security benefits. Also assume you have 15 years of credited service. Here's how your disability retirement benefit would be determined:

| **Your Disability Retirement Benefit to Age 62** | **Your Disability Retirement Benefit Beginning After Age 62** |
|---|---|
| Base benefit:<br>$**40.25** x 15 = $ 603.75 | Base benefit:<br>$**40.50** x 15 = $**607.50** |
| ***Plus*** your temporary benefit $33.80 x 15 = $ 507.00 | **Monthly Disability Retirement Benefit Beginning After Age 62** = $**607.50** |
| **Monthly Disability Retirement Benefit to Age 62** = $**1,110.75** | |

In this example, your disability retirement pension would be $**1,110.75** per month from age 60 to age 62. Once your temporary benefit ends (at age 62), your disability retirement pension would be $**607.50**. However, your pension would be subject to the Benefit Escalation provisions described previously. For example, on January 1, **2019** your monthly pension would increase to $**611.25 ($40.75** x 15). The monthly pension would be adjusted in a similar way on January 1, **2020** to $**615.00** ($**41.00** x 15).

If your disability ends, your disability retirement benefits will stop. Your retirement benefits will then be determined as follows:

- *If you return to work*, you will resume earning credited service under the Plan. You do *not* earn pension benefits during your period of disability. When you retire, you will receive the sum of the pension benefits earned both before and after your disability.
- *If your disability ends before you are eligible for early retirement and you are not offered reemployment – or you are offered reemployment but choose not to return within 60 days* – your pension benefit at retirement will be based on your credited service and the monthly benefit factor in effect on the date you became disabled. You will *not* be eligible for any temporary or supplemental benefits.
- *If you are eligible for retirement when your disability ends*, you can continue to receive a monthly pension. Your pension will be adjusted to reflect that temporary benefits end. It may be further adjusted to take into account any special pension benefits, early retirement reduction factors, and supplements, if applicable.

In all three cases, your retirement benefits may be reduced to take into account the amounts paid to you while you were disabled.

The Supplemental Benefits are payable to age 62 and one month. For example, if you turn age 62 in February and age 62 and one month in March, then your final Supplemental Benefit would be paid on April 1. **The Temporary Benefits are payable to age 62. For example, if you turn age 62 in February, then your final Temporary Benefit would be paid on March 1.**

**SECTION 7. Postponed Retirement Benefits**

If you work past your normal retirement date, you will continue to earn credited service until you actually retire. Payment of your pension benefit may begin on the April 1 of the year following the calendar year in which you reach age 70½, even if you remain actively employed. However, if you work past this date, you may elect to postpone the commencement of your pension until you actually retire. In that case, your pension will be actuarially increased (from the April 1 following your 70½ year to your retirement date).

# ARTICLE IV - IF YOU LEAVE THE COMPANY BEFORE RETIREMENT

## SECTION 1. Vesting

Vesting means you have a permanent right to receive a pension benefit from the plan, even if you leave the Company before retirement. You become 100% vested in your pension benefit after you have five years of vesting service. In addition, you become 100% vested if you reach your normal or early retirement date.

If you leave the Company before you are vested and you don't return, you will forfeit your benefit.

You earn a year of *vesting service* for each 12-month period after your date of hire during which you:

- Complete at least 750 hours of service for the Company or White Motor Corporation, and
- Are at least 18 years old.

## SECTION 2. Your Deferred Vested Benefit

If you're fully vested and leave the Company before reaching your earliest retirement date, you're eligible to receive a monthly pension based on your years of credited service and the monthly benefit factor in effect when you leave the Company. The Plan uses the normal retirement formula to determine your deferred vested benefit.

You can begin receiving your full pension benefit as of your normal retirement date. Or, you can receive a reduced pension as early as age 60. Also, if your age at your benefit commencement date plus your years of credited service is at least 85, you can receive a reduced pension as early as age 55. This rule applies to all Deferred Vested Participants, regardless of termination date. If you elect to start payments before age 65, your pension will be reduced as follows:

- *If you begin receiving your pension after age 60 but before age 65*, payments will be reduced by .6% for each month (or 7.2% each year) that payments precede your normal retirement date (generally age 65).
- *If you begin receiving your pension after age 55 but before age 60*, payments will be reduced according to the following schedule. (The reductions are listed on a yearly basis.)

| ***If you are this age when benefits begin…*** | ***You will receive this percentage of your benefit…*** |
|---|---|
| 60 | 64.0% |
| 59 | 59.6% |
| 58 | 55.5% |
| 57 | 51.2% |
| 56 | 46.8% |
| 55 | 42.8% |

### *An Example of Your Deferred Vested Benefit*

Assume you terminate in **2016** at age 47 and with 27 years of credited service. When you attain age 58, you can choose to begin your pension because the sum of your age and credited service is 85. Your monthly pension is calculated as follows:

| | | |
|---|---|---|
| Monthly Benefit Factor (**2016**) | $ | **40.25** |
| Times credited service | x | 27 |
| Times early retirement reduction factor | x | 55.5% |
| Monthly pension | $ | **603.15** |

### SECTION 3. When You Have a Break in Service

If you are not vested, a *break in service* can affect the credit you receive for years of service. You have a one-year break in service when you complete fewer than 375 hours of service during a 12-month period.

For purposes of determining a break in service, you can receive credit for hours of service for certain periods during which no duties are performed, such as for military leave. In addition, you're eligible to receive credit for up to 501 hours of service for absence due to:

- Your pregnancy
- The birth of your child
- Placement in connection with the adoption of a child, or
- The need to care for your child during a period immediately following the child's birth or placement.

It's important to notify the Human Resources Department if you plan to take a leave of absence so you can receive proper credit for this time.

### SECTION 4. If You Leave the Company and Are Reemployed

Whether or not a break in service affects your pension benefit depends on your vested status and the length of your absence, as follows:

- If you are vested or you return to work within five years, you will receive credit for service earned before you left for purposes of determining your pension.
- If you are *not* vested and have at least five consecutive one-year breaks in service, you will lose all credit for past years of service. You will rejoin the Plan after you again meet the eligibility requirements.

## ARTICLE V - HOW BENEFITS ARE PAID

### SECTION 1. Normal Forms of Payment

How you receive your pension benefit depends on your marital status and the value of your benefit when you're ready to retire.

*If you are not married on the date your benefit payments are scheduled to begin*, your pension benefit is payable as a single life annuity. A single life annuity provides monthly benefits to you for life. When you die, payments end; no income will be paid to anyone else.

*If you are married on the date your benefit payments are scheduled to begin*, your regular pension benefit is normally payable as a 60% joint and survivor annuity. A 60% joint and survivor annuity provides a reduced monthly benefit to you for your lifetime. After your death, your spouse will receive 60% of your monthly benefit for his or her lifetime. The monthly benefit you receive will be less than a single life annuity because it will be paid over two lifetimes: yours and your spouse's. The amount of the reduction is based on your age and the age of your spouse when benefit payments begin. The joint and survivor benefit is generally equal to 95% of the single life annuity. However, the 95% factor is adjusted if the age difference between you and your spouse is more than five years. Specifically, the 95% factor is increased by ½ of one percent (up to a maximum factor of 100%) for each 12 months in excess of 5 years that your spouse's age exceeds your age; and the 95% factor is decreased by ½ of one percent for each 12 months in excess of 5 years that your spouse's age is less than your age.

If you are receiving disability retirement benefits, your pension benefit is payable as an unreduced 60% joint and survivor annuity until your normal retirement date. As of your normal retirement date, your benefit is payable in one of the forms described above.

### SECTION 2. Optional Forms of Payment

If you are married on the date your benefit payments are scheduled to begin, you may elect to receive your benefit in the form of a single life annuity. You must receive your spouse's written consent and your spouse's consent must be witnessed by a plan representative or a notary public, to elect this option.

Alternatively, you may elect to receive your basic benefit in the form of a 75% joint and survivor annuity. A 75% joint and survivor annuity pays a reduced benefit to you for your lifetime; and after your death, your beneficiary will receive 75% of your monthly benefit for the rest of his or her lifetime. The 75% joint and survivor annuity is equivalent in expected value to a single life annuity.

### SECTION 3. Applying for Your Benefits

Regardless of the form of payment, you must submit a completed benefit application to the Human Resources Department at least 30 but not more than **180** days before your benefit payments are scheduled to begin. Benefits are paid as soon as possible after you (or your spouse) file a claim. As you approach retirement age, you may request more specific information about your payment form and pension benefit.

If a claim for benefits is denied, you have certain rights under the law. For more information, see "Your Rights Under ERISA".

## ARTICLE VI - SURVIVOR BENEFITS

### SECTION 1. If You Die Before Retirement Benefits Begins

If you are fully vested, die before retirement benefits begin, and have been married for at least one year on the date of your death, your spouse will be eligible to receive a survivor benefit from the Plan. Your spouse is eligible for this benefit even if you are no longer working for the Company when you die, as long as you were vested when you left.

The survivor benefit is based on the benefit you earned at the time of your death, as follows:

***Before Eligibility for Retirement***

The amount of your spouse's survivor benefit is 60% of the benefit you would have received if you had terminated employment on the date of death, survived to early or normal retirement, and retired with a 60% joint and survivor annuity benefit.

***After Eligibility for Retirement***

The amount of your spouse's survivor benefit is 60% of the regular benefit you would have received if you had retired on the day of your death with a 60% joint and survivor annuity in effect. Supplemental benefits and temporary benefits are not payable after you die.

***When Payments Begin***

Your spouse may begin receiving survivor benefits as early as the date you would have been eligible to retire. Your spouse has the option to defer payment to a later date; however, payment *must* begin by the date you would have reached age 65.

### SECTION 2. If You Die After Retirement Benefits Begin

If you die after you have started receiving your pension benefit (other than disability retirement benefits), payments may continue to your spouse based on the payment form you elected.

### SECTION 3. If You Die After Disability Retirement Benefits Begin

If you die after you have started receiving a disability retirement benefit, the amount of your spouse's survivor benefit is 60% of the regular benefit you would have received if you had retired on the day of your death with a 60% joint and survivor annuity in effect. Supplemental benefits and temporary benefits are not payable after you die.

# ARTICLE VII - GENERAL INFORMATION

## SECTION 1. How Taxes Affect Your Benefit

Under current tax law, your retirement benefit is not taxable while it remains in the Plan. When you or your beneficiary receives a distribution from the Plan, you are responsible for paying applicable income taxes.

If you receive payment of your benefit in the form of an annuity, you may elect whether or not to have taxes withheld. If you do not return your election form, federal income tax will (if permitted by IRS regulations) be withheld automatically. Withholding is applied as if the payments were wages. If you elect not to have withholding apply, or even if you do elect withholding, you may still owe taxes on the payments. You are responsible for payment of any taxes associated with the payments.

Tax laws change from time to time, and the tax impact of receiving payments from the Plan will vary with your individual situation. Because the Company cannot give tax advice or counsel, you should consult a professional tax advisor or financial expert for specific advice about your circumstances.

## SECTION 2. Maximum Benefit Rules

Current tax law limits the total amount an employee can receive from plans like the Pension Plan. These plans, called *qualified plans*, must meet certain tax requirements.

In general, only very highly paid individuals reach the maximum level of benefits allowed under the Plan. If you are affected by this maximum level, you will be notified.

## SECTION 3. Military Leave

Federal law provides certain protection for employees who return to employment from military leaves of absence. The Pension Plan will provide vesting, eligibility and benefit service credit for military leave to the extent permitted by law. If you are planning to leave employment to enter military service, it is your obligation to provide advance notice to the Company.

## SECTION 4. Qualified Domestic Relations Orders (QDRO)

Benefits payable under the Plan are for the sole use of Plan participants and their beneficiaries. You cannot commute, withdraw, or assign the benefits payable to you to another person. However, benefits will be paid according to a valid Qualified Domestic Relations Order (QDRO). A QDRO is an order from a state court that meets certain legal specifications and directs the Plan Administrator to pay all or a portion of a participant's Plan benefits to a former spouse or dependent.

The Plan Administrator is required to honor any domestic relations order that satisfies the requirements to be a QDRO. However, you will be notified as soon as an attempt is being made to assign your benefits through a court order. Participants and beneficiaries may obtain (without charge) a copy of the Pension Plan's procedures for handling QDROs from the Plan Administrator.

## SECTION 5. Continuance of the Plan

Although the Company intends to continue the Pension Plan for the duration of the collective bargaining agreement, it reserves the right to amend or terminate it at any time and for any reason by action of the Board of Directors, subject to collective bargaining. Of course, the Company cannot change or terminate the Pension Plan without first negotiating that change or termination with the Union. If the Plan ended, you would stop earning benefits. However, you would then have full rights to all benefits you had already earned.

## SECTION 6. Plan Insurance

Plan benefits are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the Plan terminates without enough money to pay all benefits, the PBGC will step in to pay

benefits. Most people will receive all of the benefits they would have received under the Plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits,
- Disability benefits if you become disabled before the plan terminates, and
- Certain benefits for your survivors.

The PBGC guarantee generally does *not* cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates (for **2016**, the maximum life annuity is $**60,000** per year),
- Some or all of the benefit increases and new benefits based on Plan provisions that have been in place for fewer than five years at the time the plan terminates,
- Benefits that are not vested because you have not worked long enough for the Company,
- Benefits for which you have not met all of the requirements at the time the Plan terminates, and
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Pan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, ask the Plan Administrator or contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington, DC 20005-4026 or call 1-202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC is available through the PBGC's website on the Internet at http://www.pbgc.gov.

**SECTION 7. Benefit Restrictions**

Pension plans must meet specified funding thresholds in order to provide continued benefit accruals or to implement amendments improving plan benefits. In general:

- Continued benefit accruals – plan benefits must be frozen if the plan's funded percentage is below 60%
- Benefit improvements – plan amendments improving benefits are generally prohibited unless the plan is at least 80% funded after taking the new amendment into account or the company immediately funds the full cost of the benefit improvement.

When a restriction imposed under this Section no longer applies, the benefit, right, or feature affected by that restriction will be retroactively reinstated.

You will be notified if any of these restrictions apply.

**SECTION 8. Employee Pension Overpayments**

**In circumstances where an employee receives payment(s) which result in an overpayment(s), the employee will be required to repay the overage to the Plan. The overage and interest (30-Year Treasury rate from November of the preceding year), if any, will be recouped in accordance with applicable law.**

**Reasonable steps will be taken to recoup the overpayment from the employee with the Company considering all relevant facts and circumstances.**

## ARTICLE VIII - CLAIMS REVIEW PROCEDURES

### SECTION 1. Claims for Benefits

The law provides that each plan subject to ERISA must set up reasonable rules for filing a claim for benefits. For most Plan benefits, you or your designated beneficiary must file a written claim on the appropriate form; claim forms are available from the Plan Administrator.

For all ERISA plans, the law allows a reasonable amount of time for the Plan Administrator to evaluate a claim and decide whether to pay benefits based on the information contained in the written claim.

### SECTION 2. Decision on a Claim

If a claim for benefits is denied in full or in part, the Plan Administrator will notify you in writing within 90 days after the claim is filed. This time limit may be extended for another 90 days in special cases, if the Plan Administrator provides notice of the reasons for the delay.

Claims for disability benefits **under Article III, Section 4 Early Retirement Benefits)** are decided by **Act-MedicalTec, 2636 Yost Boulevard, Ann Arbor, Michigan 48104**. 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 **Act-MedicalTec** 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 received.

**At such time as it becomes necessary to replace Act-MedicalTec, the parties will mutually agree upon a vendor to provide like services.**

### SECTION 3. Notice of Claim Denial

The notice of denial will include the reasons for the denial, the specific Plan provisions on which the denial is based, a description of any additional information or material required to appeal the denial, the procedure and time limits for filing an appeal so that the Plan Administrator will reconsider its decision, and a statement of your right to sue in court if the claim is again denied after an appeal.

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 joint 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.

**SECTION 4. Appeal Procedure**

If a claim is denied, the claimant may write to the Plan Administrator (or to the joint board in cases of claims for disability benefits) for a review of the claim on appeal. The claimant must request the review on appeal within 60 days after the claim is denied. In cases involving disability, however, the period to file an appeal is extended to 180 days after the date the claim is denied. A claimant who fails to submit an appeal request within the 60 or 180 day period (as applicable) will have no further right to appeal.

As part of the appeal review procedure, the claimant 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 the claimant's representative in the appeal procedure.

The Plan Administrator's or joint board's review of a claim on appeal will take into account all comments, documents, records, and other information relating to the claim submitted by the claimant, without regard to whether such information was submitted or considered in the initial claim determination.

Within 60 days (or 120 days in some cases) after you file your request, the Plan Administrator will notify you of the final decision. If the Plan Administrator denies the claim on appeal (in whole or in part), it will provide the claimant with a notice that advises the claimant of the type of information included in the initial notice of claim denial and 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.

For claims involving disability determinations, the appeal review period is reduced to 45 days (the review period can be extended for up to another 45 days with advance written notice) 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.

When ruling upon both the initial claims and Appeals, the Plan Administrator and the joint board shall have full discretionary authority to determine all questions arising in the administration, interpretation and application of the Plan. A decision on review shall be final and binding. If a claimant fails to file a request for review according to the Plan's claim procedures, the claimant shall have no rights to review and no right to bring action in any court, and the denial of the claim shall be final and binding.

## ARTICLE IX - ADMINISTRATIVE INFORMATION

***Plan Sponsor and Administrator***

Volvo Group North America, LLC
7900 National Service Road, CC/2-5
Greensboro, NC 27409
(336) 393-2000

***Labor Organization***

International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW) and its Local #2069

***Employer Identification Number***

58-2431188

***Name of Plan***

The formal name of the Plan is the Volvo Group North America New River Valley Pension Plan.

***Plan Number***

002

***Plan Type***

The Plan is a defined benefit pension plan that provides retirement, disability, and survivor benefits.

***Plan Year***

The Plan year begins January 1 and ends December 31.

***Agent for Service of Legal Process***

Volvo Group North America, LLC
7900 National Service Road, CC/2-5
Greensboro, NC 27409

Service of legal process may also be made on the Plan's Trustee (see below).

***Trustee of the Pension Plan***

JP Morgan Chase Bank
3 Chase Metro Tech Center, Floor 6
Brooklyn, NY 11245

## ARTICLE X - YOUR RIGHTS UNDER ERISA

As a participant or beneficiary in the Volvo Group North America New River Valley Pension Plan, you have certain rights and protections under federal law, as stated in ERISA, and in regulations issued by the IRS and the U.S. Department of Labor.

ERISA entitles you as a Plan participant to:

- Examine all Plan documents without charge at the Plan Administrator's office, including copies of detailed annual reports, Plan descriptions and a copy of the collective bargaining agreement.
- 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. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**SECTION 1. Annual Report**

If you are a member of the Pension Plan, you have a right to receive a statement each year showing your total accrued retirement benefits and what your benefits under the Plan could be at age 65 if you were to stop working now.

This statement is provided free of charge. If the statement is not provided automatically, you may request it in writing.

**SECTION 2. Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire

you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

**SECTION 3. Enforce Your Rights**

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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If 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.

**SECTION 4. Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest 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.

This booklet is a summary plan description of the Volvo Group North America New River Valley Pension 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.

# APPENDIX B

## WELFARE BENEFIT PROGRAM

## SUMMARY PLAN DESCRIPTION
## TABLE OF CONTENTS

# APPENDIX B
# WELFARE BENEFIT PROGRAM

## ARTICLE I

**SECTION 1. Continuation of Program**

The Welfare Benefit Program which was included as Appendix B to the Collective Bargaining Agreement between the parties dated **March 17, 2011** (hereinafter called the "**2011** Insurance Program") and maintained by the Company for the duration of the **March 17, 2011** Collective Bargaining Agreement shall be amended and restated as herein set forth and maintained for the duration of the **March 17, 2016** Collective Bargaining Agreement of which this Appendix B is a part.

**SECTION 2. Continuation of Benefits**

The **2011** Health and Welfare Benefit Program shall continue in full force and effect in accordance with the conditions, provisions, and limitations thereof until **March 16, 2016**. On and after **March 17, 2016**, the Welfare Benefit Program set forth below will be provided and paid for by the Company ("the **2016** Insurance Program").

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

Such coverage shall 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 health maintenance organization or similar organization; through a preferred provider arrangement; through a self-insured plan; or through a combination of any such methods.

## ARTICLE II

**SECTION 1. Introduction**

Appendix B is furnished to explain in simple language the essential features of the group insurance benefits provided to you and your eligible dependents. This Appendix serves as your summary plan descriptions and describes the features of the following programs:

- Life Insurance
- Optional Life Insurance
- Survivor Income Benefits
- Accidental Death and Dismemberment Insurance
- Optional Accidental Death and Dismemberment Insurance
- Disability Income
- Health Care Coverage
- Cost Containment/Control Provisions

**SECTION 2. Benefit Philosophy**

The most successful benefit systems are those which are developed and maintained under clearly defined goals and objectives and have the full cooperation and support from the covered employees. The key elements of this philosophy are summarized below.

- The benefit system should be reasonably competitive as compared to other Truck and Component manufacturing organizations.

- This degree of competitiveness, however, should also recognize the need for cost constraint and control.
- The system should provide a degree of uniformity.
- The Company will communicate these restructured plans in order to foster employee comprehension and appreciation.
- The system will encourage employee participation, but not at the expense of unreasonable exposure for the employee.

**SECTION 3. General Provisions**

The health and welfare plans (group insurance benefits) described in the following pages provide financial protection for you and your eligible dependents against a wide range of health care related expenses. Coverage for most benefits is provided at no cost to the employee through various providers. Some optional group coverages are also available for you to purchase through payroll deduction.

**SECTION 4. Eligibility**

**a) Production & Maintenace Employees**

**With regard to benefit plans set forth in Article II, Section 1**, you and your eligible dependents are eligible for on the first day of the **third** month following your date of hire (Eligibility Date), **except for Disability Income. Eligibility for Disability Income is the first day of the eighth month following your date of hire (Eligibility Date).**

If you are absent from work on the day you would normally become covered, you will become covered on the day you return to full-time, active work.

**The following information applies to Competitive employees only:**

**When you enroll in Medical benefits your benefit election (including waiver of coverage) will remain in effect throughout the calendar year. 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 certain rules are to be followed.**

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

**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 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) Salaried Employees**

**With regard to benefit plans set forth in Article II, Section 1, you and your eligible dependents are eligible on your date of hire (Eligibility Date), except for Disability Income as prescribed in Article III, Section 1(b).**

**c**) Eligible dependents include:

- the lawful spouse of an employee (including a spouse of a common-law marriage, as recognized by Virginia State Law with legal documentation provided), but not the new spouse of a surviving spouse; 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 yours 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, foster child, or children for whom an Employee is the legal guardian. 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.

Coverage for a dependent will continue through the last day of the month in which dependent is no longer an "eligible dependent" as defined above.

**SECTION 5. Pyramiding of Coverage**

**If an employee and his/her spouse are both employees of the Company, eligible dependents may only be covered by one of the employees. Pyramiding of coverage for eligible dependents is not permitted under the Plan.**

**The spouse/employee with the higher seniority date will be required to cover the eligible dependents, if coverage is elected.**

# ARTICLE III - GROUP INSURANCES

**SECTION 1. Schedule of Benefits**

**a) Production & Maintenance Employees**

The Schedule of Benefits for Company-paid Life and Disability insurances will be based on the following percentages of wages (inclusive of cost of living allowances and general wage increases received during the Agreement):

| Benefit Plan | Hours | Percentage **of Base Pay** |
|---|---|---|
| Life | 2,080 | 111% |
| AD&D | 2,080 | 55.5% |
| Weekly Indemnity | 40 | 60% |
| Extended Disability | | |
| Less than 10 years of service | 173 | 50% |
| Ten or more years of service | 173 | 55% |

Benefit levels for Company-paid Life Insurance, Accidental Death & Dismemberment Insurance, and Disability Income (both Weekly Indemnity and Extended Disability) are based on Basic Rate of Pay. Basic Rate of Pay is determined by multiplying the wage (inclusive of COLA) by the number of straight-time hours in the period (40 hours in a week, 173 in a month, or 2,080 in a year). Benefit level is determined by multiplying the Basic Rate of Pay by the applicable benefit percentage.

All wage increases and cost of living allowances earned during the agreement are used to determine the levels of Weekly Indemnity and Extended Disability coverages. The level of Weekly Indemnity or Extended Disability benefits will remain constant during the duration of your disability.

Both Company-paid and Optional Life Insurance and Company-paid AD&D benefit levels are calculated each year based on your January 1 Basic Rate of Pay.

**b) Salaried Employees**

The Schedule of Benefits for Company-paid Life and Disability insurance will be determined by the following percentages of base pay (exclusive of all cost-of-living allowances, overtime pay, bonuses and other over-base-pay income):

| BENEFIT PLAN | AMOUNT |
|---|---|
| Life Insurance | 200% of annual January 1 Base Pay rounded to the next $ 500 |
| Long Term Disability | 66 2/3% of base pay as of the **date** of disability |

With respect to paid sick leave, benefit payment amounts and duration for Salary Continuation are based on seniority. Benefit amount is determined by multiplying base pay times applicable percentage:

| Seniority | Benefit Percentage | Durational Length |
|---|---|---|
| Less than 2 months | 0% | 0 |
| 2 months to 6 months | 100%<br>50% | 1 week<br>25 weeks |
| 6 months to 12 months | 100% | 2 weeks |

| | | |
|---|---|---|
| | 50% | 24 weeks |
| 1 year to 5 years | 100%<br>60% | ½ month<br>5 ½ months |
| 5 years to 10 years | 100%<br>60% | 1 month<br>5 months |
| 10 years or more | 100%<br>60% | 2 months<br>4 months |

**SECTION 2. Life Insurance**

**Beneficiary**
When you enroll for coverage, you must name a Beneficiary(ies). You may change your Beneficiary at any time. Your primary and contingent beneficiaries, if any, are the same for your Basic Life, Optional Life, Basic AD&D and Optional AD&D amounts. If you do not have a named Beneficiary at the time of your death or if all your Beneficiaries have predeceased you, your life and AD&D insurance amounts will be paid to the executor or administrator of your estate. You are the Beneficiary of your spouse's and/or dependent child's benefits coverage amounts.

**a) Company-paid Life Insurance**
Company-paid Life Insurance coverage is effective for all employees as of their Eligibility Date based on the Schedule of Benefits in Article III, Section 1 as long as they are actively at work. If you are not actively at work on the Eligibility Date, your life insurance coverage will begin when you return to full-time, active employment.

If you become disabled and qualify for benefits under Weekly Indemnity, Extended Disability or Workers' Compensation, your Company-provided Life Insurance will continue, without application for waiver of premium, to the earliest of the following; until 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 Extended Disability.

The Company-paid Life Insurance is term insurance and is without cash, loan or paid-up value. Your coverage amount will increase each calendar year on January 1 reflecting any increase to your basic rate of pay received in the previous calendar year or as of that January 1.

**b) Optional Life Insurance**
If you have reached your Eligibility Date as defined in Article II, Section 4, 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.

**1) 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.

**2) Coverage Amounts**
You may purchase optional life insurance within 31 days of your Eligibility Date according to the following table:

| Production and Maintenance | 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 |

| Salaried Employees | Amount | Rules |
|---|---|---|
| Employee | 1, 2 or 3 times **pay** | Annual base pay rounded to the next $1,000 |
| Spouse | $25,000 increments | Maximum benefit is the greater of the total amount of your Basic and Optional Life or $300,000 |
| Dependent Children | $5,000 or $10,000 | All dependent children are covered by the same amount you elect |

Optional Life Insurance amounts for succeeding calendar years (after your original Eligibility Date) are based on your pay as of January 1 each year.

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

**Coverage amounts over the non-medical limit amount will be effective on the date the insurance company approves your coverage. Please see below.**

**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. Dependent Life**

**elections for your spouse are limited to $25,000. There is no Non-medical Limit for your dependent children.**

**3) 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 Weekly Indemnity, Extended 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 Extended Disability.

**4) Annual Enrollment Periods**
Each November 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 may 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. If you were previously declined for coverage, you must also provide medical information to receive any increase in your optional insurance amount. 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.

**5) 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 | 45% |
| 80 | 35% |
| 85 | 25% |

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.

**6) 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 3. Survivor Income Benefits**

In addition to life insurance, your eligible survivor could also qualify for the following survivor income benefits.

**Your eligible survivor in order of priority is as follows:**

1. Your surviving spouse who was legally married to you for at least one year prior to your death.
2. Your surviving children who are:
    a. Unmarried and under age 21,
    b. Unmarried, between the age of 21 and 25 years, residing with and dependent upon you for support at the time of your death, or
    c. Totally and permanently disabled at any age over 21, residing with and dependent upon you for support at the time of your death.
3. Your parent(s) who was dependent upon you for at least 50% of their financial support.

**a) Transition Benefit**
A monthly income benefit of $300 will be payable to your eligible survivor qualifying for an old age, survivor, or disability benefit under the Federal Social Security program.

A monthly income benefit of $500 will be payable to your eligible survivor not qualifying for an old age, survivor, or disability benefit under the Federal Social Security program.

In the event of more than one eligible survivor, payments will be made in equal shares. Transition benefits will begin the first day of the month following your death and will cease following the 24$^{th}$ payment or until there is no longer an eligible survivor, whichever comes first.

**b) Bridge Benefit <u>(Core Employees only)</u>**
A $500 monthly income benefit is payable to your surviving spouse only. To qualify for this benefit, your surviving spouse must be between the ages of 45 and 60 years of age at the time of your death or your spouse's age, when added to your seniority at the time of death, must total 55 or more. The bridge benefit will begin immediately following the last transition benefit payment.

For any spouse eligible for a mother's or father's Federal Social Security benefit, this bridge benefit will begin following the termination of the Federal Social Security benefit.

Bridge benefits will cease when your surviving spouse remarries, dies, attains age 62, or any lower age at which Widow's or Widower's benefits are payable under Federal Social Security.

Surviving spouses who apply for survivor benefits after January 31, 2005, are entitled to choose either the bridge/transition benefit or the Surviving Spouse pension benefit, but not both.

**SECTION 4. Accidental Death and Dismemberment Insurance**

There are two types of Accidental Death and Dismemberment (AD&D) Insurance – Basic and Optional. AD&D Insurance coverage is effective for employees as of their Eligibility Date as defined in Article II, Section 4 and will be payable in addition to other group life insurance coverage. This coverage is term insurance and is without cash, loan or paid-up value.

**a) Basic AD&D (Production & Maintenance only)**
Benefits from Basic AD&D are payable provided the loss (death or dismemberment) occurs within one year of the date of an accident. In the event of your death from an accident, your Beneficiary will receive the Basic Amount (the AD&D benefit amount shown on the Schedule of Benefits in Article III, Section 1). In the case of a dismemberment, benefits will be payable to you based on the Basic Amount and the Dismemberment Schedule shown below.

**Schedule of AD&D Benefits**

| *Loss** | *Benefit Payable* |
|---|---|
| Life | 100% of coverage amount |
| Both hands, both feet, or sight in both eyes<br>One hand and one foot<br>One hand or foot and sight in one eye<br>Both speech and hearing<br>Quadriplegia | 100% of coverage amount |
| Paraplegia | 75% of coverage amount |
| One hand or one foot<br>Speech or hearing<br>Sight in one eye<br>Hemiplegia | 50% of coverage amount |
| Thumb and index finger of the same hand | 25% of coverage amount |
| *Loss of hand or foot means severance at or above the wrist or ankle joint. Loss of sight, hearing, and speech must be total and irrecoverable. Thumb and index finger loss means severance through or above the metacarpophalangeal joint. Movement of limbs means complete and irreversible paralysis of such limbs. | |

You must be actively at work on the day your coverage begins. If you are not actively at work, your coverage is not effective until you return to your full-time active duties. You do not have to complete any enrollment forms for this coverage. However, you will be asked to complete a beneficiary designation form for these benefits.

**b) Optional AD&D (Production, Maintenance & Salaried Employees)**

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 Volvo, 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 for yourself 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 $25,000 to $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 your coverage 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).

**1) 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 a private passenger 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.)

Private passenger automobile means a validly registered four-wheel private passenger car (or policyholder owned car), station wagon, van, or jeep-type car that is not licensed commercially or being used for commercial purposes. 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.

**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 be reduced 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 by |
|---|---|
| 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. The required premium for your coverage does not reduce even though your coverage amount reduces.

**Exceptions and Limitations**
Benefits are payable for bodily injuries caused solely through violent, external, and accidental means. The maximum 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:

- Disease or sickness, or medical or surgical treatment of sickness or disease
- Infections except those which occur through accidental means
- Injuries sustained while full-time in the armed forces of any country or international authority
- Participation in a riot or engaging in a criminal act
- Intentionally self-inflicted injury, suicide or attempted suicide, whether sane or insane;
- War or act of war, whether declared or undeclared;
- Injury sustained while riding on any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
- Injury sustained while riding on any aircraft:
    - as a pilot, crewmember, or student pilot;
    - as a flight instructor or examiner; or
    - if it is owned, operated or leased by or on behalf of the Policyholder, or any employer or organization whose eligible persons are covered under this policy;
- Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician.

**SECTION 5. Disability Income**

Income protection is provided to all employees in the event of absence due to illness or injury.

**a) Production & Maintenance Employees**

**1) Weekly Indemnity Benefits**
You will be eligible to receive a weekly indemnity income benefit, based on the Schedule of Benefits in Article III, Section 1, provided you are:

- wholly and continuously disabled,
- your disability prevents you from performing any or every duty of your job,
- you are under the continuous care of a licensed **medical professional**, and
- you have provided the Company with satisfactory proof of your disability.

Any weekly indemnity benefits will be reduced by any Workers' Compensation benefits received for the same period.
**Commencement of Benefits:** If your disability is the result of an accident, your weekly benefit will begin on the first day of disability. If your disability is the result of an illness, your weekly benefit will begin on the eighth day of disability. If your disability requires hospitalization, or out-patient surgery**,** your weekly benefit begins on the date of your hospitalization or surgery.

**Duration of Benefits:** Weekly indemnity benefits are payable for your period of disability, as certified by your physician and satisfactory to the Company, equal to the length of your seniority but in no case shall it exceed the 52 week maximum benefit period. After you have been disabled for a period of 26 weeks, you must apply to the Social Security Administration for disability income benefits. Should you be approved for disability benefits from Social Security, your weekly indemnity benefit will be reduced by such Social Security payment. Should your initial application to Social Security be denied, you must appeal that

denial; and if the appeal is denied, legal assistance may be required. The Company-provided disability benefit will remain intact during this Social Security application and appeal process.

**When an employee applies for Company paid disability benefits and prior to approval of a disability income benefit from the Social Security Administration, the employee will be required to sign an agreement to refund the Company for any potential overpayment less any legal fees incurred by the employee during the application process.**

**The overpayment to be repaid by the employee will be the gross amount of company disability payments paid to the employee and reduced by the amount of the Social Security award. Upon approval and receipt of a disability income benefit from the Social Security Administration, the employee will repay any monies owed the Company. The employee's failure to repay the monies within thirty (30) calendar days of the Company's demand for repayment shall result in the suspension and/or termination of health care benefits.**

**Example A: Employee A receives a Company disability benefit of $100 gross per month for 12 months and then receives a Social Security award equal to $300 gross per month. The overpayment to be repaid by the employee is equal to $1,200.**

**Example B: Employee B receives a Company disability benefit of $300 gross per month for 12 months and then receives a Social Security award equal to $100 gross per month. The overpayment to be repaid by the employee is equal to $1,200.**

After 26 weeks of disability, you must complete the application for extended benefits (long-term disability) unless circumstances make it impossible to do so. If you do not provide a complete application for extended disability benefits including any required physician information at least 90 days prior to the expiration of weekly indemnity benefits, your extended disability payments will not begin until all information is provided and your disability benefits have been approved by the insurance carrier.

**Successive Periods of Disability:** If your second absence for disability is within three months of your initial absence for the same or related causes, you will be eligible for the remaining portion of the maximum benefit period without satisfying another waiting period. If your second absence is within three months of your initial absence for unrelated causes, you will eligible for another maximum benefit period and the applicable waiting period will apply. If the successive disability period is separated by three months or more, the second disability will be considered as a new claim regardless of the cause.

**Exceptions and Limitations:**

- For any disability period other than whole weeks, weekly indemnity benefits will be paid on the basis of one-fifth the basic weekly benefit.
- Weekly indemnity benefits shall not be paid for any day you receive holiday pay.
- For disabilities related to mental incapacity, the Company has the option of paying this weekly benefit to an individual or family member acting on your behalf.

**2) Extended Disability Benefits**

In the event of a total disability, which exceeds your maximum benefit period under the weekly indemnity benefit, you will receive a monthly income based on the Schedule of Benefits in Article III, Section 1. This extended disability benefit will be reduced by any other benefits you may be eligible to receive, such as Social Security, Workers' Compensation or Company-sponsored pension benefits.

This extended disability benefit begins the first day following the final weekly indemnity benefit and will continue until: you are no longer disabled, reach your Social Security Normal Retirement Date, die, or reach your maximum benefit period. Your maximum benefit period is based on the number of months you have been employed at the time of your **LTD** disability **award date**, reduced by the period you received weekly indemnity benefits.

For an employee to be deemed totally disabled, he/she must be **totally disabled so as to be unable to engage in any regular employment or occupation with the Company by reason of any medically demonstrable physical or mental condition** at the plant in any job that is contractually available to the employee **provided the employee is 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).** You are responsible **for providing** satisfactory proof of disability to the LTD insurance carrier, including obtaining necessary medical information from your provider/providers to support your disability initially and for any necessary re-certification as required by the carrier. Extended Disability (LTD) payments will be suspended until satisfactory proof is supplied.

**In order to resolve medical disputes concerning the existence or nonexistence of either a total or partial disability in determining an employee's ability or inability to return to work following an absence due to an illness or injury, the following process will be followed:**

**The Company will notify the UAW Benefits Representative and the parties shall meet and discuss the merits of having an Independent Medical Examination (IME) to determine the status and capabilities of the employee. The IME Physician selection process will be by mutual agreement of the Company's Physician and the employee's treating Physician.**

**The Union and the Company will share equally any costs resulting from such examinations and determinations.**

**The parties agree that the Physician performing the IME will be provided with all required medical documentation from both the Company and the employee or his treating physician and will complete a physical capacities form of the employee following the IME. The employee will be responsible for obtaining all medical records as requested by the IME Physician as expeditiously as possible.**

**If the IME results determine that the employee remains disabled, the UAW Benefits Representative will work with the employee and the employee's treating physician to provide supporting documentation to the disability vendor in order to reopen the disability claim.**

**Exceptions and Limitations:** When applying for or receiving this benefit, you may be required to undergo physical examinations from time to time to determine your initial or continuing disability by a physician designated by the carrier.

For any disability related to mental incapacity, the carrier has the option of paying this benefit to an individual or family member acting on your behalf.

Cost-of-living adjustments to Federal Social Security payments or any like benefits will not affect the extended disability benefits initially established.

For any disability period other than a whole month, this benefit will be prorated based on the number of days in that month.

In the event you qualify for extended disability on more than one occasion, regardless of the cause, your maximum period of disability will be reduced by any period you have previously received this benefit.

**b) Salaried Employees**

**1) Salary Continuation**

With respect to paid sick leave, each employee will be entitled to receive salary continuation determined by the Schedule of Benefits in Article III, Section 1 if you are wholly and continually disabled which prevents you from performing any or every duty of your occupation and you are under the continuous care of a **licensed medical professional**. Any salary continuation due will be reduced by any Workers' Compensation benefits received for the same period. To receive benefits for absences lasting more than three days, a doctor's letter explaining the reason for the absence must be provided.

**Duration of Benefits:** Salary Continuation benefits are payable for your period of disability, as certified by your physician and satisfactory to the Company**,** but in no case shall it exceed the six-month maximum benefit period. After you have been disabled for a period of 26 weeks, you must apply to the Social Security Administration for disability income benefits. Should you be approved for disability benefits from Social Security, any long-term disability benefits received from the Company will be reduced by such Social Security payments. Should your initial application to Social Security be denied, and after you have gone through the appeal process, legal assistance may be required. The Company disability benefits will remain intact during this Social Security application and appeal process, but you will be required to sign an agreement to refund the Company for any potential overpayment less any legal fees.

Prior to the end of 26 weeks of salary continuation, you must complete the application for extended benefits (long term disability). You will be contacted by Human Resources. If you do not provide a complete application for extended disability benefits including any required physician information at least 90 days prior to the expiration of salary continuation benefits, your extended disability payments will not begin until all information is provided and your disability benefits have been approved by the insurance carrier.

**Successive Periods of Disability:** If your second absence is within three months of your initial absence and for the same or related causes, you will be eligible for the remaining portion of the maximum benefit period without satisfying another waiting period.

If your second absence is within three months of your initial absence and for unrelated causes, you will be eligible for another maximum benefit period and the applicable waiting period will apply.

If the successive disability period is separated by three months or more, the second disability will be considered as a new claim regardless of the cause.

For any period of salary continuation other than a whole week, benefits will be paid on the basis of one-fifth the weekly benefit. Salary continuation benefits shall not be paid for any days you receive holiday pay.

For disabilities related to mental incapacity, the Company has the option of paying this weekly benefit to an individual or family member acting on your behalf.

**2) Extended Disability Benefits**

In the event of total disability which exceeds your maximum benefit period under the salary continuation plan, you will receive a monthly income based on the Schedule of Benefits in Article III, Section 1. You are responsible to provide satisfactory proof of disability to the LTD insurance carrier, including obtaining necessary medical information from your provider/providers to support your disability initially and for any necessary re-certification as required by the carrier. Extended Disability (LTD) payments will be suspended until satisfactory proof is supplied. This long-term disability benefit will be reduced by any other benefits; you may be eligible to receive such as Social Security, Workers' Compensation or Company-sponsored pension benefits.

**When Benefits Begin:** LTD benefits begin after you have been continuously disabled for six months as a result of injury, illness, or pregnancy. This sixth-month period is called your waiting period. You must be disabled from the same cause throughout your waiting period.

If your disability temporarily ends and you return to work for up to 30 days during your waiting period, your waiting period will be extended by the number of days you were able to work.

**Definition of Total Disability:** To receive LTD benefits, your disability must continue to meet the plan's definition of *total disability.* The definition changes after you have been disabled for 24 months.

- During your waiting period and for the first 24 months you receive LTD benefits, *total disability* means you are continuously unable to perform all of the material and substantial duties of your regular occupation and require the regular care and attendance of a physician.
- After 24 months of LTD, *total disability* means you are continuously unable to perform with reasonable continuity, all of the material and substantial duties of any occupation or

employment for which you are reasonably qualified by education, training, physical, and mental capacity or experience.

**Maximum Payment Period:** If you become disabled before age 60, your monthly LTD benefits will continue until you reach age 65, retire, or are no longer disabled (whichever is sooner). If you become disabled at age 60 or older, your maximum payment period will be defined as follows:

| If you become disabled at… | You'll receive benefits for… |
|---|---|
| Age 60 | 60 months |
| Age 61 | 48 months |
| Age 62 | 42 months |
| Age 63 | 36 months |
| Age 64 | 30 months |
| Age 65 | 24 months |
| Age 66 | 21 months |
| Age 67 | 18 months |
| Age 68 | 15 months |
| Age 69 or over | 12 months |

**Coordination with Other Disability Plans:** Your LTD benefits are coordinated with other disability benefits for which you are eligible. LTD benefits are reduced by any amount you receive from the following sources:

- Workers' Compensation benefits, including any benefits payable under an occupational disease law, compulsory benefits act or law, or other similar act or law.
- Social Security disability benefits you receive because of disability or retirement.
- Any local, state, provincial, or federal government disability or retirement plan or law, including compulsory state benefit plans, and
- Any benefits you receive under any Volvo pension plan.

Please note that any disability benefits you receive from any individual policy will *not* reduce your Volvo LTD benefits.

**Social Security Adjustment:** Because your LTD benefits depend on your other sources of disability income, you must apply for Social Security disability benefits as soon as you become disabled to ensure that you receive the maximum benefit for which you qualify. In determining your LTD benefit, the insurance carrier will reduce your monthly payment benefits by your Social Security benefits, if any. If you are not eligible for Social Security benefits, your LTD benefits will not be adjusted for Social Security.

**Cost of Living Freeze:** LTD benefits are reduced by other disability benefits in effect on the date your LTD benefit payments begin (see above). Any future increases in your other sources of benefits will not affect your monthly payments from the LTD plan. Instead, you will receive an increased total disability income.

**Continuous period of Disability:** If you receive LTD benefits, return to work, and become totally disabled again, the LTD Plan will consider this as one continuous period of disability if both periods of disability are:

- The result of the same or related cause, and
- Separated by six months or less.

This means that if you become disabled again after returning to work, within six months, you do not have to satisfy another waiting period before receiving benefits from the LTD Plan. To qualify for a successive period of disability benefit, you must experience more than a 20% loss of your pre-disability earnings.

**Exclusions:** The LTD Plan does not cover disabilities caused by:

- War or riot
- Your committing or attempting to commit an indictable offense
- Intentional self-inflicted injuries, or
- A pre-existing condition that was treated within the three months before you were covered under this Plan if you apply for LTD benefits within the first 12 months you were eligible for coverage.

In addition, you must be under the care of a licensed physician to receive LTD benefits.

**When Coverage Ends:** The eligibility for Salary Continuation and LTD benefits ends on the earlier of the date:

- Your employment with Volvo ends,
- Your eligibility for benefits with Volvo ends,
- The Plan is terminated, or
- You are no longer an eligible employee.

**c) If You Die While Receiving Extended Disability Benefits**

**If you die while you are receiving extended disability benefits from this plan, your survivors are entitled to receive a one-time death benefit, which is an amount equal to three times the covered persons last monthly benefit. If you do not have a surviving spouse, your surviving children under age 25 wil receive your benefit. If you have no eligible survivors, payment will be made to your estate.**

**d) Filing a Claim:**
If you become ill or injured, you should notify your supervisor and Human Resources. Human Resources will provide you with the appropriate salary continuation forms. You must complete the form and submit it to Human Resources along with an Attending Physician's Statement explaining the nature of your disability. If you are able to predetermine your disability – such as pregnancy or elective surgery – you should submit your Attending Physician's Statement to Human Resources as soon as possible.

*Long Term Disability benefits are not paid automatically-you must apply for them.*

To receive LTD, you must provide the insurance carrier with written application of your disability during your waiting period or as soon as reasonably possible. Human Resources will provide you with the necessary forms for filing during the waiting period.

If you do not provide a complete application for extended disability benefits including any required physician information at least 90 days prior to the expiration of salary continuation benefits, your extended disability payments will not begin until all information is provided and your disability benefits been approved by the insurance carrier.

The insurance carrier has the right to examine anyone who files a claim for LTD benefits as often as is reasonably required.

Remember, you must also contact your Social Security office to apply for Social Security Disability benefits.

If a claim for benefits is denied, you have certain rights under the law. For more information, see the Claim Denial section and your Rights under ERISA.

**e) Medicare Enrollees**

**Effective March 17, 2016, an employee receiving Long-Term Disability or Workers Compensation Benefits for at least six months (6), 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 $120 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 the Special Medicare Benefit under the Pension Plan. Payment of the applicable amount provided under this Subsection (j) will be made concurrent with a monthly Long Term Disability Benefit payment and for the same period of disability.**

**If you or your spouse are eligible for medicare due to disability, Medicare is primary to Volvo's medical plan if you are not currently working.**

**SECTION 6. Health Care Benefits**

The health care plan for all employees and their eligible dependents is a Point of Service (POS) health plan. This plan requires that employees and each of their eligible dependents chose a primary care physician upon enrollment. That primary care physician is responsible for each member's care including authorizing referrals to specialist providers and coordinating any other prior authorizations as needed. Employees or future retirees who live outside the state of Virginia or certain other employees/future retirees that have received a waiver from Anthem because of access limitation issues, do not have to select a primary care physician. **Effective 1/1/2017 the Plan will transition to a PPO plan and will no longer require referrals to specialist providers.**

Coordination of benefits with any other group insurance plan, Workers' Compensation, or no-fault automobile insurance will apply in order that benefits received do not exceed 100% of actual expense.

Employees have the option each Annual Enrollment period in November to review and update any eligible dependents and their information such as date of birth, other employment, other insurance coverage, etc., that is needed by the Claim Administrator in order to properly administer claims.

You should be aware that the new privacy security requirements of the Health Insurance Portability and Accountability Act (HIPAA), though providing you privacy protection, also create greater difficulty in accessing individual protected health information (PHI) to solve claim disputes. Therefore, the first steps of claims resolution is for you or your covered dependents to make an attempt to work with the Claims Administrator (insurance company) or your health care providers to resolve any disputes you may encounter.

**a) Anthem Blue Cross and Blue Shield Medical Plan**

**1) Introductory Information**

This member booklet fully explains your health care benefits and how you can maximize them.

***Important phone numbers***:
Member Services:

**1-844-855-1942**

***Hours of Operation:***
Monday-Friday
8:00 a.m. to **10**:00 p.m. ET
**Saturday 10:00 a.m. to 4:00 p.m.**

**24/7 Nurseline:**
**1-866-670-6654**

Visit us on-line at:
*www.anthem.com*

**2) Key Words**

There are a few key words you will see repeated throughout this booklet. We've highlighted them here to make the booklet easier to understand. In addition, we have included a Definitions section that lists the various words referenced. A defined word will be italicized each time it is used.

***We, us, our, Anthem***
Anthem Blue Cross and Blue Shield.

***Covered persons***
You and enrolled eligible dependents.

***Outpatient***
When you receive care in a hospital outpatient department, emergency room, professional provider's office, or your home.

***Inpatient***
When you are a bed patient in the hospital.

***You***
The enrolled employee

***Your health plan***
Your employer's health care plan through which benefits described in this booklet are available.

***Co-payment***
The fixed dollar amount you pay for some covered services.

***Coinsurance***
The percentage of the allowable charge you pay for some covered services.

**3) Table of Contents / Health Plan**

**4) Summary of Benefits**

This chart is an overview of your benefits for covered services.

***What will I pay?***

This chart shows the most you pay for deductibles and out-of-pocket expenses for covered services in one year of coverage.

| | In-Plan | | Out-of-Plan | |
|---|---|---|---|---|
| | Employee | Family | Employee | Family |
| Calendar year deductible | $200* | $400* | $400* | $800* |
| Out-of-pocket Maximum | $750 | $1,500 | $3,000 | $6,000 |

* Physician co-pays, emergency room visits, therapy visits, and prescription drug co-pays do not count towards the deductible**.**

| | Co-payment | In-Plan Coinsurance | Out-of-Plan Coinsurance |
|---|---|---|---|
| **Ambulance Travel** No calendar year limit (ground ambulance) | $0 | 10% | 10% |
| **Dental services (accidental)** | $0 | 10% | 30% |
| **Diabetic equipment and education** | $0 | 10% | 30% |
| **Diagnostic tests** for specific conditions or diseases at a doctor's office, emergency room, or outpatient hospital department | $0 | 10% | 30% |

| | Co-payment | In-Plan Coinsurance | Out-of-Plan Coinsurance |
|---|---|---|---|
| **Dialysis treatments** | | | |
| Facility | $0 | 0% | 30% |
| Doctor's Office | $0 | 0% | 30% |
| **Doctor visits** on an outpatient basis | | | |
| Primary Care Physicians | $15 | 0% | 30% |
| Specialty Care Providers | $30 | 0% | 30% |
| **Early intervention services (through age 3)** | **Co-payment/coinsurance is determined by service received** | | |
| **Emergency room visits (for true emergencies)** | | | |
| Facility services<br>Co-payment waived if admitted | $75 per visit | 0% | 0% |
| Professional provider services | $0 | 0% | 0% |
| **Emergency room visits (for non-emergencies)** | | | |
| Facility services | $0 | 10% | 30% |
| Professional provider services<br>Out of network providers may also bill you for any charges over the maximum allowed amounts. | $0 | 0% | 30% |

| | Co-payment | In-Plan Coinsurance | Out-of-Plan Coinsurance |
|---|---|---|---|
| **Hearing aids**<br>Limited to **$1000/every 12 months** | $0 | 0% | 0% |
| **Hearing examinations**<br>Limited to 1 every 24 months | $0 | 20% | 30% |
| **Home care services**<br>No calendar year visit limit for home health services | $0 | 10% | 30% |

| | | | |
|---|---|---|---|
| **Home private duty nurses services** | | | |
| No calendar year limit | $0 | 20% | 30% |
| **Hospice Care Services** | $0 | 10% | 30% |
| **Hospital services** | | | |
| *Inpatient treatment* | | | |
| Facility Services | $0 per stay | 10% | 30% |
| Professional provider services | $0 | 10% | 30% |
| *Outpatient treatment* | | | |
| Facility services | $0 | 10% | 30% |
| Professional provider services | $0 | 10% | 30% |
| **Infusion services - outpatient services** (see note at end of summary of benefits) | | | |
| Facility services | $0 | 0% | 30% |
| Professional provider services | $0 | 0% | 30% |
| Home services | $0 | 0% | 30% |
| Infusion medications | | | |
| Outpatient settings | $0 | 10% | 30% |
| Home settings | $0 | 0% | 30% |

| | **Co-payment** | **In-Plan Coinsurance** | **Out-of-Plan Coinsurance** |
|---|---|---|---|
| **Maternity** | | | |
| Professional provider services | | | |
| Prenatal and postnatal follow-up care | $0 | 10% | 30% |
| Delivery | $0 | 10% | 30% |
| Hospital services for delivery room, anesthesia, nursing care for newborn | $0 Per stay | 10% | 30% |
| **Diagnostic tests** | $0 | 10% | 30% |
| **Medical equipment (durable), appliances, formulas, supplies, and medications** No calendar year limit for medical equipment (durable) | $0 | 10% | 30% |
| **Mental health or substance abuse treatment** | | | |
| ***Inpatient treatment*** Facility services | $0 per stay | 10% | 30% |

| | Co-payment | In-Plan Coinsurance | Out-of-Plan Coinsurance |
|---|---|---|---|
| Professional provider services | $0 | 10% | 30% |
| ***Outpatient facility-based treatment*** (Includes partial day) | | | |
| Facility services | $0 | 10% | 30% |
| Professional Provider services | $0 | 10% | 30% |
| Outpatient office-based treatment | $15 | 0% | 0% |
| **Shots (injections)** at a doctor's office, emergency room or outpatient hospital department | $0 | 10% | 30% |
| **Skilled nursing facility stays** | | | |
| 730-day per stay limit; with 90-day reinstatement | | | |
| Facility services | $0 per stay | 10% | 30% |
| Professional provider services | $0 | 0% | 30% |

| | Co-payment | In-Plan Coinsurance | Out-of-Plan Coinsurance |
|---|---|---|---|
| **Spinal manipulations** and other manual medical interventions | | | |
| 36 visits per calendar year limit | $10 | 0% | 30% |
| **Surgery** | | | |
| ***Inpatient*** | | | |
| Facility services | $0 per stay | 10% | 30% |
| Professional provider services | | | |
| Primary Care Physicians | $0 | 10% | 30% |
| Specialty Care Providers | $0 | 10% | 30% |
| ***Outpatient*** | | | |
| Facility services | $0 per visit | 10% | 30% |
| Professional provider services | | | |
| Primary Care Physicians | $0 | 10% | 30% |
| Specialty Care Providers | $0 | 10% | 30% |
| **Therapy - outpatient services** (See note at end of benefit summary) | | | |
| ***Cardiac rehabilitation therapy*** | | | |
| Hospital services | $0 | 0% | 30% |
| Professional provider services | $0 | 0% | 30% |
| ***Chemotherapy*** | | | |
| Hospital Services | $0 | 0% | 30% |
| Professional provider Services | $0 | 0% | 30% |

| | Co-payment | In-Plan Coinsurance | Out-of-Plan Coinsurance |
|---|---|---|---|
| ***Occupational therapy visits*** | | | |
| Hospital services | $10 | 0% | 30% |
| Professional provider services | | | |
| Primary Care Physicians | $10 | 0% | 30% |
| Specialty Care Providers | $10 | 0% | 30% |
| ***Physical therapy visits*** | | | |
| Hospital services | $10 | 0% | 30% |
| Professional provider services | | | |
| Primary Care Physicians | $10 | 0% | 30% |
| Specialty Care Providers | $10 | 0% | 30% |
| ***Radiation Therapy*** | | | |
| Hospital services | $0 | 0% | 30% |
| Professional provider services | $0 | 0% | 30% |

| | Co-payment | In-Plan Coinsurance | Out-of-Plan Coinsurance |
|---|---|---|---|
| ***Respiratory therapy*** | | | |
| Hospital services | $0 | 0% | 30% |
| Professional provider services | $0 | 0% | 30% |
| **Speech therapy visits** | | | |
| Hospital services | $10 | 0% | 30% |
| Professional provider services | | | |
| Primary Care Physicians | $10 | 0% | 30% |
| Specialty Care Providers | $10 | 0% | 30% |
| **Vision correction** after surgery or accident | $0 | 10% | 30% |
| **Wellness Services*** | | | |
| Primary Care Physicians | $0 | 0% | 30% |
| Specialty Care Providers | $0 | 0% | 30% |
| Immunizations | | | |
| Primary Care Physicians | $0 | 0% | 30% |
| Specialty Care Providers | $0 | 0% | 30% |
| Screening tests | $0 | 0% | 30% |

* If wellness services are received from out-of-network providers, the services will be subject to the calendar year deductible. Screenings received for diagnostic purposes (as billed by the in or out-of-network provider or facility) are not considered to be wellness services, and therefore will also be subject to the diagnostic benefits shown earlier in the **Summary of Benefits**.

Note: Please see Hospital Services section for payment amounts that apply to inpatient therapy.

| ***Prescription Drug Benefits*** *(for all covered persons including Medicare Eligible retiree Participants (as defined in Section 12) who have not enrolled in Medicare Part D and who retire under this agreement))* | |
|---|---|
| Actives and future retirees (retiring 3/17/08 or later with seniority dates preceding 2/1/05) | **Co-payment** |
| **Prescription drugs and diabetic supplies** | |
| **Retail pharmacy** | |
| covered drugs for up to a 30-day supply | |
| Generic drugs | $8 |
| Brand name drugs | $25 |
| *Targeted brand | $45 |
| **Anthem Rx Direct** | |
| covered drugs for up to a 90-day supply | |
| Generic drugs | $16 |
| Brand name drugs | $50 |
| *Targeted brands | $90 |

*Targeted brands are; Aciphex, Allegra, Allegra-D, Clarinex, Clarinex-D, Nexium, Prevacid, Prilosec, Protonix Zyrtec, Zyrtec-D, Xyzal and Zegerid.

Coverage will be provided for the following over-the-counter medications: Prilosec OTC, Zantac, Claritin and Zyrtec. The employee co-pay for these medications is $8 for a 30 day supply or $16 for a 90 day supply.

Diabetic supplies including glucometers are not subject to any drug co-payment. Glucometers are limited to one every 24 months.

Prescriptions for Viagra are limited to 15 pills when filled at a retail pharmacy and 45 pills when filled through the Anthem Rx Direct program. Please contact Anthem's customer service for procedures necessary to receive full limit each month.

**5) <u>Competitive</u> Employee Contributions* for Health Care**

| | **Weekly Contributions** |
|---|---|
| Employee Only | $16 |
| Employee Plus One | $24 |
| Family | $36 |

***Contributions will be taken on a pre-tax basis.***

**Coverage during Temporary or Permanent Lay Off:** If an employee is laid off, health coverages will continue to the end of the month following the month that the layoff commences. During this period, employees are not required to pay weekly contributions, nor will they be required to make them up. If coverage terminates, normal COBRA rules and payment conditions will apply.

**Wellness Incentives:**

The Health For Life wellness program is the cornerstone in promoting and achieving our culture of health within the Volvo organization. The Health For Life program for UAW employees incorporates the following key features-

**Contribution Credit – <u>Competitive Employees</u>**

A**<u>n</u>** $**<u>8</u>** per week reduction in employee health plan contributions upon attainment of all of the following:

- completion of the annual Health Risk Assessment (HRA) survey
- completion of the annual biometric screening that measures blood pressure, cholesterol, glucose and Body Mass Index (BMI) and

- annual written attestation that you do not use tobacco or the timely completion of a tobacco cessation program

The HRA and biometric screenings will be performed on-site on an annual basis.

**The** Wellness Contribution Credit will be offset against required weekly contributions for all Competitive Employees through **the first calendar year of employment**. Effective January 1, **of the following year**, to continue receiving the Contribution Credit, employees must meet the Wellness criteria described above **each year**. **Each summer you will have the opportunity to qualify for the contribution credit that is effective the following January 1st.**

**Core employees will receive $100 for completion of the Wellness criteria decribed above.**

**Cash Incentives – Healthy People Rewards***

Based on the biometric screening results referred to above, employees can earn up to $150 in cash annually if they meet the following criteria:

- blood pressure less than or equal to 130/85
- total cholesterol less than or equal to 200, and
- BMI less than or equal to 27.5

For each criterion that is achieved, the employee will receive $50 cash each December.

***Core, Competitive, and Salaried employees are eligible to participate in the Healthy People Rewards program***

**6) How your health plan works**

*Your health plan* provides a wide range of health care services within a special network of health care *providers* and *facilities. You* will receive benefits based on where *you* receive health care services and the limits stated in the Summary of Benefits. *Your health plan* is a self-funded employee welfare benefit plan sponsored by your employer. The cost of your coverage, which includes the plan benefits and administrative expenses, is borne by your employer. Your employer has entered into an administrative services contract with *Anthem* to carry out certain functions with respect to claims operation.

**Carry your ID card**

Your Anthem Blue Cross and Blue Shield ID card identifies *you* as a *covered person* and contains important health care coverage information. When *you* show your ID card to your doctor, hospital, pharmacist, or other health care *provider,* they will file your claims for *you* in most cases. Carrying your card at all times will ensure *you* always have this coverage information with *you* when *you* need it.

**Covered providers and facilities**

*Your health plan* covers certain care administered by providers and *facilities.* To ensure benefits, *providers* and *facilities* must be licensed in the state where they operate to perform the service *you* receive and the service must be covered by *your health plan.* Certain services are covered by the plan and rendered by other covered medical suppliers, such as suppliers of *medical equipment (durable),* private duty nursing services, *prescription drugs,* ambulance services, etc.

A *provider* may delegate to his employee the responsibility for performing a covered service. *Your health plan* will cover this care if we determine that a bona fide employer-employee relationship exists, based on information given by the *provider.* Under these circumstances:

- both the *provider* and the delegated employee must be licensed/certified to render the service;
- the service must be performed under the direct supervision of the *provider* since the *provider* is primarily responsible for the patient's care; and
- the *provider* who is directly supervising the service must bill for the service.

Because the service of the delegated employee is a substitute for the *provider's* service, *your health plan* will not pay a supervisory or other fee for the same service performed by both the *provider* and his delegated employee.

**Primary care physicians and specialty care providers**

*Your health plan* covers care provided by *primary care physicians* and *specialty care providers.* When *you visit* your PCP, the PCP will either address any medical concerns *you* have at the time of your *visit* or refer *you* to a *specialty care provider* for treatment.

Medical care is available through your PCP 24 hours a day, 7 days a week. All PCPs provide coverage through a backup physician who will coordinate your care in the event your PCP is unavailable. If *you* need care after regular office hours, *you* may contact your on-call PCP or backup physician. For instructions on how to receive care, call your PCP or Service Operations.

In order to receive *the in-plan benefits, you* and your family members will need to have all of your medical care coordinated through the PCP *you* have selected. However, *you* will always have the option of visiting the *provider* of your choice without a *referral* from your PCP and receiving the reduced *out-of-plan benefits.*

**Helpful tip:** PCP referrals do not guarantee payment.

**Selecting or changing your primary care physician**

Building a personal relationship with your PCP is an important part of health care. *You* will need to select a PCP from a directory of *primary care physicians* in order to receive the highest level of benefits. Each covered family member may select a different PCP. If *you* do not select a PCP upon enrollment, or if the PCP *you* selected is no longer in the network, then *out-of-plan benefits* will automatically apply. If *you* do not select a PCP upon enrollment, *you* may do so at a later date. If *you* wish to change your PCP for any reason, *you* may select another PCP from the directory of *primary care physicians.* If your PCP leaves the network, *you* will receive a letter of notification asking *you* to select another PCP.

To select or change your PCP, submit a change form or call Member Services. Changes in PCP will be made manually, effective on the date notification is given of the change, in cases involving a physician no longer participating with the carrier, retiring sooner than the first of the month or leaving practice for any other reason. A request for a retroactive change to your PCP cannot be honored. The acceptance of the PCP change is subject to the availability of the newly selected PCP. Please know that *Anthem* cannot guarantee the continued availability of a particular network *provider.*

**Helpful tip:** You may call Member Services for information regarding the qualifications of providers in the PPO Network. Qualifications include: medical school attended, residency completed, and board certification status.

**The referral process**

**Effective 1/1/2017, designation of a Primary Care Physician and Primary Care referrals for specialty care will no longer be required.**

In order to receive the highest level of benefits from *your health plan, you* need to seek care from your PCP or have a *referral.* Your PCP will manage your care by determining what specific treatment is necessary.

If your PCP recommends that *you* receive services from another *provider, you* will receive a PCP *referral* authorization. The decision to refer *you* to another *provider* is at the sole discretion of your PCP. Your PCP will refer *you* to a *specialty care provider* within the *PPO network.* The *referral* may authorize specialty care for a one-*visit* consultation, an assigned number of *visits,* or an unlimited number of *visits* during a specified period of time (up to one year). Your PCP may also authorize certain *medical equipment (durable)* purchases and urgent care services (urgent care is not life threatening).

**Referrals to Non-Network Providers**

- **Primary care physicians within the network will refer patients to network specialists whenever possible.**
- **Referrals to non-network participating providers must be preauthorized and will be paid at the participating providers benefit level which will not subject employees to balance billing.**
- **Note that referrals to non-participating providers are pre-authorized according to provider contractual arrangements with the claims administrator. For all out of network covered services, initial payment is made using the participating fee schedule. However, if a provider refers to a non-network provider, any subsequent non-network balance billing will be paid by the plan for covered services (except required co-pays) by exception with verification of proper notification of the referral to the claims administrator by the PCP.**

**To obtain a referral**

*You* need to obtain a *referral* from your PCP before receiving care from any other *provider.* Your PCP will make the *referral* arrangements on your behalf by notifying *Anthem* of the *referral* by phone or electronically. *Referrals* will automatically be valid for a 120-day period beginning with the date referred unless otherwise specified by your PCP. In most cases, your health plan will process your referral immediately upon receipt of the request from your PCP, but no later than 2 working days from your PCPs request for the referral. A written confirmation will be mailed to you within 2 working days of the date the referral is processed.

**Standing referrals for special conditions and cancer pain management**

If *you* have an ongoing *special condition* as determined by Anthem that causes *you* to see a *specialty care provider* often, *you* may receive a standing referral. *Your* PCP will refer *you* to *a specialty care provider,* for treatment of the ongoing *special condition.* The standing referral will allow the *specialty care provider* to treat *you* without obtaining further referrals. The *specialty care provider* may authorize *referrals,* procedures, tests, and other medical services related to the *special condition.*

If *you* have been diagnosed with cancer, *you* may receive a standing referral to a board-certified physician in pain management or an oncologist for cancer treatment. The board-certified physician in pain management or oncologist will consult on a regular basis with *your* PCP and any oncologist providing care to *you* concerning the plan of pain management. The board-certified physician in pain management or oncologist cannot authorize referrals or other health care services.

**When referrals are not required**

While *you* may seek the following kinds of care without a *referral, you* should go to a *KeyCare PPO network provider* to ensure that *you* receive the highest level of benefits from *your health plan:*

- *outpatient* radiation therapy, chemotherapy, dialysis treatments, and infusion therapy services;
- *outpatient* diagnostic services;
- *outpatient* oral surgery services or covered services in conjunction with a dental accident;
- *outpatient* gynecological covered services (other than surgical services);
- routine vision exams;
- maternity care (routine or complicated);
- outpatient mental health and substance abuse services;
- covered services for an *emergency;* and
- services by your PCPs backup physician.

**How to find a provider in the network**

There are four ways you can find out if a provider or facility is in your network:

- Refer to your health plan's directory of network providers at www.anthem.com, which lists doctors and health care facilities that participate in your health plan's network, as well as information about the standards of care in area hospitals.
- Call Anthem's Member Services to request a list of doctors and health care facilities that participate in your health plan's network, based on specialty and geographic area.
- Check with your doctor or health care facility.
- Ask your group administrator.

All network providers have a process in place to help you access urgent medical care 24 hours a day, 7 days a week. If you require urgent medical care after your doctor's normal business hours call his/her office and you will be directed to needed care.

**When you do not use your primary care physician**

If *you* decide to seek treatment from someone other than your PCP for a non-*emergency* health condition without first obtaining a *referral, you* will receive *out-of-plan benefits.* After *you* satisfy a calendar year out-of-network *deductible, you* are responsible for your *coinsurance,* a percentage of the *allowable charge* as stated in the Summary of Benefits. If the *provider* or *facility* participates in any *Anthem* PPO network or other Blue Cross Blue Shield company's PPO network, they will accept the *allowable charge* as payment in full for their services. However, *providers* and *facilities* that do not participate in any *Anthem* or Blue Cross Blue Shield company's PPO network may bill *you* for the difference between their charge and the *allowable charge.*

**Helpful tip:** Covered services received during the last three months of the calendar year that are applied to a covered person's deductible, may also apply to the deductible required for the following calendar year.

**The advance approval process**

Network *providers* are required to obtain prior authorization in order for *you* to receive benefits for certain services. Prior authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. *Anthem* may determine that a service that was initially prescribed or requested is not *medically necessary* if you have not previously tried alternative treatments which are more cost effective.

Your health plan will make coverage decisions on services requiring advance approval (for example, home care services, etc.), within 15 days from the receipt of the request. Your health plan may extend this period for another 15 days if we determine it to be necessary because of matters beyond our control. In the event that this extension is necessary, you will be notified prior to the expiration of the initial 15-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, your health plan will make its decision within 2 working days of its receipt of the medical information needed to process the advance approval request.

For *urgent care claims,* coverage decisions will be completed and *we* will respond to *you* and your *provider* as soon as possible taking into account your medical condition, but not later than 72 hours from receipt of the request. If insufficient information is submitted in order to review the claim, *we* will ask *you* or your *provider* for the information needed within 24 hours of the receipt of your request, and make *our* decision within 48 hours of receiving the information. If the requested information is not received within 48 hours of *our* request, *we* will make *our* decision within 96 hours from the date of *our* request.

Once your health plan has made a coverage decision on services requiring advance approval, you will receive written notification of the coverage decision. In the event of an adverse benefit determination, the written notification will include the following:

- Information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of your health plan's appeal procedures and applicable time limits; and
- in the case of an *urgent care claim,* a description of the expedited review process applicable to such claims.
- the availability of, and contact information for, the U.S. Department of Labor's Employee Benefits Security Administration that may assist you with the internal or external appeals process.

If all or part of a *pre-service* or *urgent care claim* was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol, or criterion that your health plan relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, you are entitled to receive, upon request and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to your medical condition.

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

In addition, *we* may select certain qualifying *providers* to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. *We* may also exempt your claim from medical review if certain conditions apply.

Just because *Anthem* exempts a process, *provider* or claim from the standards which otherwise would apply, it does not mean that *Anthem* will do so in the future, or will do so in the future for any other *provider,* claim or member. *Anthem* may stop or modify any such exemption with or without advance notice.

*You* may determine whether a *provider* is participating in certain programs by checking *your health plan's* on-line *provider* directory or contacting customer service number on the back of your ID card.

**Approvals of care involving an ongoing course of treatment**

*Network providers* must follow certain procedures to ensure that if a previously approved course of treatment needs to be extended, the extension is requested in time to minimize disruption of needed services. If you are receiving care from a non-network provider and need to receive an extension of a previously approved course of treatment, you will be required to ask for the extension. You should request the extension at least 24 hours prior to the end of the authorized timeframe to avoid disruption of care or services. We will notify you of our coverage decision within 24 hours of your request.

If *we* make a determination to reduce or terminate benefits for all or any part of a previously approved course of treatment prior to its conclusion, this will be considered an adverse benefit determination. If the reduction or termination was not a result of a health plan amendment or health plan termination,we will notify *you* in advance of the reduction or termination in sufficient time for you to file an internal appeal prior to the reduction or termination.

**In an emergency or if specialty care is not reasonably available in the network**

If *you* have an emergency medical condition*,* go to the nearest appropriate *provider* or medical *facility.* Emergencies do not require a *referral* for *outpatient* care, nor must the *provider* be in the network for *you* to receive the highest level of benefits. Please contact your PCP within 48 hours so that he may be

involved in coordinating any ongoing treatment. For *urgent care situations you* should contact your PCP before *you* seek care. A *referral* from your PCP is required for urgent care or benefits will be paid at the *out-of-plan benefit* level. If specialty care is required and it's not available from a *provider* within the network, your PCP can call *Anthem* in advance of your receiving care to have the *out-of-network* services authorized for the highest level of benefits.

**For coverage overseas**
If *you* plan to travel outside the United States, call *Anthem* Member Services and ask for the names of the participating hospitals in the area *you* will be visiting. If *you* need *inpatient* hospital care while you're overseas, show your ID card at the admissions office. The participating hospital will bill the plan through *Anthem* for covered expenses. *Anthem* will send benefits payments to the hospital directly. If *you* go to a non-participating hospital or receive *outpatient* care, *you* will usually have to pay the bills and submit the claims for reimbursement. However, if possible *we* will work out direct payment with the *providers.*

**Allowable charge**

| Providers or facilities | Allowable charge |
|---|---|
| *providers* rendering in-plan services | the network allowance or *provider's* charge, whichever is less |
| | |
| *providers* rendering out-of-plan services | the participating allowance or *provider's* charge, whichever is less |
| network and participating *facilities* | the negotiated allowance or the *facility's* charge, whichever is less |
| non-participating *facilities* located in Virginia | *Anthem's* non-participating allowance or the *facility's* charge, whichever is less |
| non-participating *facilities* located outside of Virginia | the amount *Anthem* determines to be reasonable for the services rendered |
| non-provider, non-*facility* service | the amount *Anthem* determines to be reasonable for the services rendered |

In the *allowable charge* chart, the allowance for covered services and the reasonable charge for covered services are determined by *Anthem* and other Blue Cross Blue Shield companies at their sole discretion.

Another Blue Cross Blue Shield company may pay a claim on our behalf to a *facility* that participates in one of its networks. When this occurs, the *allowable charge* will be the lower of the billed charges of the *facility* or the negotiated price that the Blue Cross Blue Shield company passes on to us. The negotiated price may be a simple discount of billed charges, an estimated final price that reflects future settlement with the *facility,* or an average expected savings from the *facility* or network. The estimated or average price may have been adjusted to correct for over- or under-estimation of past prices or non-claim transaction costs.

If *Anthem's* negotiated compensation cannot be determined at the time the claim for the covered service is processed, *Anthem* will use the value of the last known negotiated compensation derived from its most recent settlement with the *facility.*

**Allowable charge for surgical services**
Surgical services performed by a *provider* are covered services. *Your health plan* will not pay separately for pre- and post-operative services.

If more than one surgical procedure is performed during the same operation, we will calculate the *allowable charge* for all of the services combined by adding:

- the *allowable charge* for the service with the highest *allowable charge;* plus
- 50% of the *allowable charge* for each of the additional surgical services if they had been performed alone.

This is the most *your health plan* will pay during a single operation, unless extraordinary circumstances exist.

**Assistant at surgery**
Services of a physician who actively assists the operating surgeon to perform a covered surgical service are covered services. However, when two or more surgeons provide a covered surgical service that could have been performed by one surgeon, the *allowable charge* will not be more than that available to one surgeon.

**Anesthesia**
When surgical services require anesthesia, anesthesia services rendered by a second physician are covered services. However, when the physician performs both the surgical service and the anesthesia service, the *allowable charge* for the anesthesia services will be 50% of what it would have been if a second physician had performed the anesthesia service.

**Hospital Admission Review**
All hospital *stays,* skilled nursing home *stays,* or treatment in partial day mental health or substance abuse programs must be approved before each admission. Your PCP can perform admission review on your behalf. If a specialist calls for *you,* the PCP must first authorize the admission. For hospital admissions outside of Virginia, you must make sure the preadmission review takes place. If *you* are admitted to the hospital as a result of an emergency, your hospital *stay* should be reviewed by *Anthem* within 48 hours of admission. The emergency room doctor, a relative, or a friend can call for Hospital Admission Review.

Before *you* are admitted to the hospital for medical care or surgery, *you, your physician,* or someone *you* authorize must call the Member Services telephone number located on your identification card.

If your *provider* is calling on your behalf, the telephone number for *providers* is 800-533-1120. *You or your provider* should have the following information available:

- your Anthem Blue Cross and Blue Shield identification number (shown on your ID card);
- your doctor's name and phone number;
- the date *you* plan to enter the hospital and length of *stay;* and
- the reason for hospitalization.

*Your health plan* will respond to a request for hospital admission within 2 working days after receiving all of the medical information needed to process the request, but not to exceed 15 days from the receipt of the request. *We* may extend this period for another 15 days if *we* determine it to be necessary because of matters beyond *our* control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 15-day period.

In cases where the hospital admission is an *urgent care claim*, a coverage decision will be completed within 24 hours. Your physician will be notified verbally of the coverage decision within this timeframe.

Once a coverage decision has been made regarding your hospital admission, *you* will receive written notification of the coverage decision. In the event of an *adverse benefit determination*, the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of *your health plan's* appeal procedures and applicable time limits; and
- in the case of an urgent care claim, a description of the expedited review process applicable to such claims; and
- the availability of, and contact information for, the U.S. Department of Labor's Employee Benefits Security Administration the may assist *you* with the internal or external appeals process.

If all or part of a hospital admission was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol, or criterion that *your health plan* relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, *you* are entitled to receive, upon request and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to your medical condition.

Hospital admissions for covered radical or modified radical mastectomy for the treatment of breast cancer shall be approved for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours. Hospital admissions for a covered laparoscopy-assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy shall be approved for a period of no less than 48 hours.

The length of *stay* for maternity admissions is determined according to the Newborn's and Mother's Health Protection Act. This federal law allows for 48 hours for vaginal delivery or 96 hours for caesarian section. Admissions for maternity care do not, initially, require Hospital Admission Review. However, if complications develop and additional days are necessary, Hospital Admission Review is required. *We* request that your doctor contact *Anthem* to establish eligibility and waiting periods. This will also assist in the assignment of the Future Moms program.

**Admissions to hospitals located outside of Virginia**
If *you* are admitted to a hospital outside of Virginia, *you* must make sure that someone on your behalf (a hospital physician, an administrative person, or family member) initiates the Hospital Admission Review process. This applies in all cases, whether *you* live, work, or travel outside of Virginia. If approval is not obtained for an *inpatient stay* and the *stay* is later determined by *Anthem* not to be *medically necessary, you* may have to pay the entire hospital bill in addition to any charges for services provided while *you* were an *inpatient.*

**Individual case management**
In addition to the *covered services* listed in this booklet, *your health plan* may elect to offer benefits for an approved alternate treatment plan for a patient who would otherwise require more expensive covered services. This includes, but is not limited to, long term *inpatient* care. *Your health plan* will provide alternate benefits at its sole discretion. It will do so only when and for so long as it decides that the services are *medically necessary* and cost effective. The total benefits paid for such services may not exceed the total that would otherwise be paid without alternate benefits. If *your health plan* elects to provide alternate benefits for a *covered person* in one instance, it will not be required to provide the same or similar benefits for any *covered person* in any other instance. Also, this will not be construed as a waiver of *your health plan's* right to enforce the terms of *your health plan* in the future in strict accordance with its express terms.

Also, from time to time *your health plan* may offer a *covered person* and/or their *provider* or *facility* information and resources related to disease management and wellness initiatives. These services may be in conjunction with the *covered person's* medical condition or with therapies that the *covered person* receives, and may or may not result in the provision of alternative benefits as described in the preceding paragraph.

## 7) What is covered

*Your health plan* covers only those medical services that are *medically necessary.* Just because the service is prescribed by a *provider* does not mean the service is *medically necessary.* In addition, *your health plan* requires that services be safely performed in the least costly *setting.*

See the Summary of Benefits for payment levels and limits for the covered services. For details of the specific coverage provided as well as what is not covered, see applicable summary. All of the following services, except as noted, must be rendered by covered *facilities* or *providers.*

**Ambulance travel**

*Medically necessary* ambulance services are a *covered service* when one or more of the following criteria are met:

- *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.
- For ground ambulance, *you* are taken:
  - From your home, the scene of an accident or medical emergency to a hospital;
  - Between hospitals, including when *we* require *you* to move from an *out-of-network* hospital to an *in-network* hospital;
  - Between a hospital and a *skilled nursing facility* or other approved facility.
- For air or water ambulance, *you* are taken:
  - From the scene of an accident or medical emergency to a hospital;
  - Between hospitals, including when we require *you* to move from an *out-of-network* hospital to an *in-network* hospital
  - Between a hospital and an approved *facility*.

Ambulance services are subject to medical necessity reviews by *us*. When using an air ambulance for non- *emergency* transport, *we* reserve the right to select the air ambulance provider. If you do not use the air ambulance provider we select, 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, *we* 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.

**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 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 you 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.

**Dental services (All Members/All Ages)**

**Preparing the Mouth for Medical Treatments**
Your plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. *Covered services* include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

**Treatment of Accidental Injury**
Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an accidental injury under this plan. Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered.

Treatment must begin within 60 days of the injury, or as soon after that as possible to be a *covered service*
under this plan.

**Hospitalization for Anesthesia and Dental Procedures**
Your plan includes coverage of general anesthesia and hospitalization services for children under the age of 5, *covered persons* who are severely disabled and *covered persons* who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the *covered person's* treating physician that such services are required to effectively and safely provide dental care.

**Diabetic equipment and education**
*Your health plan* covers medical supplies, equipment, and education for diabetes care for all diabetics. This includes coverage for the following:

- insulin pumps;
- home blood glucose monitors, lancets, blood glucose test strips, syringes, and hypodermic needles and syringes (when purchased from a participating pharmacy, through the prescription drug plan, no coinsurance or co-pays are required); and
- *outpatient* self-management training and education performed in-person; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional.

Diabetic education may be received from pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to perform this service.

Screenings for gestational diabetes are covered under Wellness services.

**Diagnostic tests**
Your benefits include coverage for the following procedures when ordered by your doctor to diagnose a definite condition or disease because of specific signs and/or symptoms:

- radiology (including mammograms), ultrasound, or nuclear medicine;
- laboratory and pathology services or tests; and
- diagnostic EKGs, EEGs; and

- advanced diagnostic imaging services.

Observation, diagnostic examinations, or diagnostic laboratory testing that involves a hospital *stay* is covered under *your health plan* only when:

- your medical condition requires that medical skills be constantly available;
- your medical condition requires that medical supervision by your doctor is constantly available; or
- diagnostic services and equipment are available only as an *inpatient.*

*Outpatient* diagnostic imaging tools can be the key to identifying underlying health problems, but unnecessary imaging may contribute to patient safety issues: increased radiation exposure and false positive findings that may result in additional unnecessary testing and potential surgical procedures. To help ensure that *you* are receiving services that are safe and appropriate, we have made available a health services review process for physicians ordering these services. Health services review is a process performed in advance of receiving an outpatient advanced diagnostic imaging service. The purpose is to review for safety, appropriateness, and medical necessity, and to determine whether the service meets coverage guidelines. If your doctor orders one of the following tests for *you*, we suggest that you ask your doctor to initiate a health services review by contacting *Anthem*:

- magnetic resonance angiography (MRA);
- magnetic resonance imaging (MRI);
- magnetic resonance spectroscopy (MRS);
- computed tomographic angiography (CTA);
- positron emission tomography (PET) scans;
- computed tomography (CT) scans;
- single photon emission computed tomography (SPECT) scans; and
- nuclear cardiology.

**Helpful tip**: While there is no penalty if the health services review is not performed in advance of receiving the service, the advantage of the front-end review is that *you* and your doctor know beforehand whether the service is appropriate, medically necessary, and meets coverage guidelines. If advance approval is not obtained and the service is later determined not to be *medically necessary, you* may have to pay for the service.

Medical supplies and other services that may be required and provided in conjunction with a diagnostic test are not considered part of the diagnostic test. Therefore, if a *facility* or *provider* bills a separate charge for such services or supplies, benefits for such services or supplies will be provided as described in the **Summary of benefits** for such services and supplies and not as part of the diagnostic test.

**Dialysis**

*Your health plan* covers dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis.

**Doctor visits and services**

Your health plan covers:

- *visits* to a doctor's office or your doctor's *visits* to your home;
- *visits* to an urgent care center;

- *visits* to a hospital *outpatient* department or *emergency* room; and
- *visits* for shots needed for treatment (for example, allergy shots).

**Early intervention services**

*Your health plan* covers early intervention services for covered dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services ("the Department") as eligible for services under Part C of the Individuals with Disabilities Education Act. These services consist of:

- speech and language therapy;
- occupational therapy;
- physical therapy; and
- assistive technology services and devices.

Early intervention services for the population certified by the Department are those services listed above which are determined to be *medically necessary* by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without affecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not *medically necessary.*

**Emergency room care**

Benefits are available in a hospital emergency room for services and supplies to treat the onset of symptoms for an emergency, which is defined below.

**Emergency (emergency medical condition)**

"Emergency," or "*emergency medical condition*" means a medical condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient's mental or physical health in serious danger or, for a pregnant woman, placing the woman's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be emergencies by us.

**Emergency care**

"Emergency care" means a medical exam done in the emergency department of a hospital, and includes services routinely available in the emergency department to evaluate an emergency condition. It includes any further medical exams and treatment required to stabilize the patient. "Stabilize" means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

If you are experiencing an emergency please call 911 or visit the nearest hospital for treatment.

*Medically necessary* services will be covered whether *you* get care from an in-network or *out-of-network* provider. Emergency care *you* get from an *out-of-network* provider will be covered as an in-network service, but you may have to pay the difference between the *out-of-network* provider's charge and the *maximum allowed amount*, as well as any applicable *coinsurance*, *copayment* or *deductible*.

The *maximum allowed amount* for emergency care from an out-of-network provider will be the greatest of the following:

1. The amount negotiated with in-network *providers* for the emergency service;

2. The amount for the emergency service calculated using the same method *we* generally use to determine payments for *out-of-network* services but substituting the in-network cost-sharing for the *out-of-network* cost-sharing; or
3. The amount that would be paid under Medicare for the emergency service.

If *you* are admitted to the hospital from the emergency room, be sure that you or your doctor calls *us* as soon as possible. *We* will review your care to decide if a hospital stay is needed and how many days *you* should stay. See "Hospital admission review" in the **How your program works** section for more details. If *you* or your doctor do not call *us*, *you* may have to pay for services that are determined to be not *medically necessary*.

Treatment *you* get after your condition has stabilized is not emergency care. If *you* continue to get care from an *out-of-network provider, covered services* will be covered at the out-of-network level unless *we* agree to cover them as an authorized service

**Foot Care**

*Your health plan* provides the following foot care coverage.

- Elastic support stockings, with written prescription from a physician.
- 50% of one pair of orthopedic shoes not forming part of a brace.
- No more frequently than once every 36 months, the purchase of one pair of orthopedic shoe inserts as prescribed by a network or pre-approved orthopedic or podiatry physician. This coverage is for active employees only.

**Home care services**

*Your health plan* covers treatment provided in your home on a part-time or intermittent basis. This coverage allows for an alternative to repeated hospitalizations that will provide the quality and appropriate level of care to treat *your* condition. To ensure benefits, *your* doctor must provide a description of the treatment *you* will receive at home. *Your* coverage includes the following home health services:

- *visits* by a licensed health care professional, including a nurse, therapist, or home health aide; and
- physical, speech, and occupational therapy (services provided as part of home health are not subject to separate visit limits for therapy services).

These services are only covered when your condition confines *you* to your home at all times except for brief absences.

**Home private duty nurse's services**

*Your health plan* covers the cost of medically skilled services of a currently licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in your home when the nurse is not a relative or member of your family. Your doctor must certify to *us* that private duty nursing services are *medically necessary* for your condition, and not merely custodial in nature.

**Hospice care services**

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 the following:

- 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. Coverage includesshort-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute *inpatient* care for the *covered person* in order to provide the *covered person's* primary caregiver a temporary break from care giving responsibilities.

- 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 pain management and 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, bothers and sisters.

Your doctor and hospice medical director must certify that *you* are terminally ill and likely have less than six months to live. Your doctor 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 us upon request.

Benefits for *covered services* beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a member in hospice. These additional *covered services* will be covered under other parts of this plan.

**Hospital services**
*Your health plan* covers the hospital and doctors' services when *you* are treated on an *outpatient* basis, or when *you* are an *inpatient* because of illness, injury, or pregnancy. (See Maternity for an additional discussion of pregnancy benefits.) *Your health plan* covers *medically necessary* care in a semi-private room or intensive or special care unit. This includes your bed, meals, special diets, and general nursing services.

In addition to your semi-private room, general nursing services and meals, *your health plan* covers the *maximum allowed amount* for *medically necessary* services and supplies furnished by the *hospital* when prescribed by your doctor or *provider.*

The hospital must meet the American Hospital Association's standards for registration as a hospital. Remember that your share of the cost of covered services will change if *you* use a doctor, *facility,* or other health care *provider* that is outside your network.

While *you* are an *inpatient* in the hospital, *your health plan* covers the *medically necessary* services rendered by doctors and other covered *providers.*

**Helpful tip:** All inpatient hospital stays must be approved before each admission (see Hospital Admission Review section).

**Private room**
*Your health plan* will cover the private room charge if *you* need a private room because *you* have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your *inpatient* benefits would cover the hospital's charges for a semi-private room. If *you* choose to occupy a private room, *you* will be responsible for paying the daily differences between the semi-private and private room rates in addition to your *co-payment* and *coinsurance* (if any).

**Infusion services**
*Your health plan* covers infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition,

which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.

**Helpful tip:** Infusion services may be received at multiple sites of service, including facilities, *professional provider offices*, ambulatory infusion centers and from home infusion *providers*. Benefits may vary by place of service, and where you choose to receive covered services may result in a difference in your *copayment* and/or *coinsurance*. Please see the Infusion services section on the **Summary of Benefits** for a description of the benefits by place of service.

**Maternity**

***Prenatal and newborn care***

If *you* (or your covered dependent) become pregnant, *your health plan* provides several coverage features. Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered by *your health plan.*

**Helpful tip:** Notify the Volvo HR Service Center at 1-800-344-8339 or via email at hrsc@volvo.com within 31 days to add your baby to your medical coverage.

Your benefits include:

- use of the delivery room and care for normal deliveries;
- home setting covered with nurse midwives;
- anesthesia services to provide partial or complete loss of sensation before delivery;
- hospital services for routine nursery care for the newborn during the mother's normal hospital *stay;*
- prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
- initial examination of a newborn and circumcision of a covered male dependent;
- services for interruption of pregnancy; and
- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

Your **Summary of Benefits** may contain one *copayment* which covers all prenatal and postnatal *visits* for each pregnancy. In most cases, this will be a more favorable benefit than paying the specialist *copayment* for each prenatal and postnatal *visit*. If, for any reason, your per-pregnancy *copayment* exceeds the total *copayment you* would have paid if *you* had paid your specialist *copayment* for each prenatal and postnatal *visit*, *Anthem* or your *provider* will reimburse *you* the difference between the per-pregnancy *copayment* and the total per *visit* specialist *copayments you* would have paid for all prenatal and postnatal *visits* during any one pregnancy.

**Future Moms**

*You* (or your covered dependent) are eligible to participate in *Future Moms.* This program is designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery. A *Future Moms* consultant is assigned to women identified as having greater risk of premature delivery. The consultant (a nurse or health educator) works with the mother and her doctor during the pregnancy to determine what may be needed to help achieve a full-term delivery. As soon as pregnancy is confirmed, sign up for the program by calling 800-828-5891. *You* will receive:

- a kit containing educational material on how to get proper prenatal care and identify signs of premature labor;
- a risk appraisal to identify signs of premature labor; and

- after delivery, a birth kit, and child care book.

**Medical equipment (durable)**
*Your health plan* will cover the rental (or purchase if that would be less expensive) of *medical equipment (durable)* when prescribed by your doctor. Also covered are maintenance and necessary repairs of *medical equipment (durable)* except when damage is due to neglect.

Coverage includes the following types of equipment, **in addition to those listed in the approved Medicare Schedule for Durable Medical Equipment:**

- nebulizers;
- hospital type beds;
- wheelchairs;
- traction equipment;
- walkers;
- crutches; and
- **insulin pumps**

**Medical devices and appliances**
*Your health plan* covers the cost of fitting, adjustment, and repair of the following items when prescribed by your doctor for *activities of daily living:*

- prosthetic devices and components;
- orthopedic braces;
- leg braces, including attached or built up shoes attached to the leg brace;
- molded, therapeutic shoes for diabetics with peripheral vascular disease;
- arm braces, back braces, and neck braces;
- head halters;
- catheters and related supplies;
- orthotics; and
- splints.

A prosthetic device is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, leg, foot, or eye. Coverage is also included for the repair, fitting, adjustments, and replacement of a prosthetic device. In addition, componenets for artificial limbs are covered. Componenets are the materials and equipment needed to ensure the comfort and functioning of the prosthetic device.

**Medical formulas**
*Your health plan* covers special medical formulas, which are the primary source of nutrition for *covered persons* with inborn errors of amino acid or organic acid metabolism, metabolic abnormality, or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

**Medical supplies and medications**
Medical supplies are covered under *your health plan* if they are prescribed by a covered *provider.* Examples of medical supplies include:

- hypodermic needles and syringes;
- oxygen and equipment (respirators) for its administration;
- prescription medications provided by your doctor; and
- prescription medications infused through IV therapy in the physician's office or *outpatient facilities.*

Certain medical supplies may be covered under the *prescription drug* card feature of *your health plan* when purchased by you and supplied directly to *you* by a pharmacy. If so, these supplies will be listed and covered under Prescription Drugs.

**Mental health or substance use disorder treatment**

Accessing your mental health services and substance abuse disorder services (treatment of alcohol or drug dependency) is easy. In fact *you* have a dedicated department available to *you* simply by calling 800-991-6045. *You* can select any mental health and substance use disorder *provider* listed in your *provider* directory (see www.anthem.com) . Or if *you* are unsure of which *provider* to see, call 800-991-6045 and the representative will be able too match *you* with a *provider* who seems best suited to meet your needs.

***Inpatient treatment***

*You* have coverage *for inpatient* care for mental health services and substance use disorder services. Your coverage includes individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, and convulsive therapy treatment. Coverage for *inpatient* mental health services and substance use disorder services is subject to the Hospital Admission Review provisions of *your health plan*. Please see Hospital Admission Review in the **How your health plan works** section for additional information. Please note that *inpatient* services for substance use disorder treatment must not be merely custodial, residential, or domiciliary in nature and must be provided in a hospital or substance use disorder treatment *facility* which is licensed to provide a continuous, structured, 24-hour-a-day program of drug or alcohol treatment and rehabilitation including 24-hour-a-day nursing care.

***Partial day services***

*You* also have coverage for "partial day" mental health services and substance use disorder services. Obtaining authorization in advance is recommended. A partial day program must be licensed or approved by the state and must include either a day or evening treatment program, which lasts at least 6 or more continuous hours per day for mental health or substance use disorder, or an intensive *outpatient* program, which lasts 3 or more continuous hours per day for treatment of alcohol or drug dependence.

***Outpatient treatment***

Your coverage includes treatment for outpatient mental health and substance use disorder services. Obtaining authorization in advance is recommended.

**Medication management**

*Visits* to your physician to make sure that medication *you* are taking for a mental health or substance use problem is working and the dosage is right for *you* are covered.

**Prescription drugs administered by a medical provider**

*Your* 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, 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 *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 the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" benefit. Also, if *prescription drugs* are covered under the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" benefit, they will not be covered under this benefit.

**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 we can decide if the *drug* is *medically necessary*. *We* may also set quantity and/or age limits for specific *prescription drugs* or use recommendations made as part of *our* Medical Policy and Technology Assessment Committee and/or *pharmacy and therapeutics* process.

**Prior authorization**
Prior authorization may be needed for certain *prescription* drugs to make sure proper use and guidelines for *prescription drug* coverage are followed. *We* will contact your provider to get the details we need to decide if prior authorization should be given. *We* will give the results of our decision to both you and your provider.

If prior authorization is denied you have the right to file a grievance as outlined in the **Important information** section of this booklet.

For a list of *drugs* that need prior authorization, 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 *drug* or related item on the list does not guarantee coverage under *your* plan. *Your provider* may check with *us* to verify *drug* coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which *brand* or *generic* drugs are covered under the Plan.

**Therapeutic substitution**
Therapeutic substitution is an optional program that tells *you* and *your* doctors about alternatives to certain prescribed *drugs*. *We* may contact *you* and *your* doctor to make *you* aware of these choices. Only *you* and *your* doctor can determine if the therapeutic substitute is right for *you*. *We* have a therapeutic drug substitutes list, which *we* review and update from time to time. For questions or issues about therapeutic *drug* substitutes, call Member Services at the phone number on the back of *your* identification card.

**Prescription drug benefit at a retail or home delivery (mail order) pharmacy**
*Your* plan also includes benefits for *prescription drugs you* get at a retail or mail order *pharmacy*. *We* use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of retail *pharmacies*, a home delivery (mail order) *pharmacy*, and a specialty *pharmacy*. The PBM works to make sure *drugs* are used properly. This includes checking that prescriptions are based on recognized and appropriate doses and checking for *drug* interactions or pregnancy concerns.

Note: Benefits for *prescription drugs*, including *specialty drugs*, which are administered to *you* in a medical setting (e.g., doctor's office, home care visit, or *outpatient* facility) are covered under the "Prescription drugs administered by a medical provider" benefit. Please read that section for important details.

**Prescription drug benefits**
As described in the "Prescription drugs administered by a medical provider" section, *prescription drug* benefits may depend on reviews to decide when *drugs* should be covered. These reviews may include prior authorization, step therapy, use of a *prescription drug* list, therapeutic substitution, day/supply limits, and other utilization reviews. *Your* in-network pharmacist will be told of any rules when *you* fill a prescription, and will be also told about any details *we* need to decide benefits.

**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 *you* must get them from a licensed *pharmacy*.

Benefits are available for the following:

- Prescription legend *drugs* from either a retail *pharmacy* or the PBM's home delivery *pharmacy*;
- Specialty drugs;
- Self-administered *drugs*. These are *drugs* that do not need administration or monitoring by a *provider* in an office or facility. Injectable and infused *drugs* that need *provider* administration and/or supervision are covered under the "Prescription drugs administered by a medical provider" benefit;
- Oral chemotherapy drugs when administration or monitoring by a *provider* or in an office or a facility is not required;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Special food products or supplements when prescribed by a doctor if *we* agree they are *medically necessary*;
- Flu shots (including administration). These will be covered under the "Preventive care" benefit.
- Immunizations required by the "Preventive care" benefit.
- Immunizations administered by a licensed pharmacist as allowed by law.
- *Prescription drugs* that help *you* stop smoking or reduce *your* dependence on tobacco products.These drugs will be covered under the "Preventive care" benefit;
- *Compound drugs when a commercially available dosage form of* a *medically necessary* medication is not available, all the ingredients of the compound drug are FDA-approved and 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.
- FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a prescription for a *member* age 18 or older. These products will be covered under the "Preventive care" benefit;
- *Prescription drugs* used to treat sexual or erectile dysfunctions or inadequacies.

We will not deny prescription drugs (or inpatient or IV therapy drugs) used in the treatment of cancer pain on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.

Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Additionally, benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

Please see "Experimental/investigative" in the **Definitions** section for additional information about the exception criteria and requirements for these coverage situations.

**Important note:** If *we* determine that *you* may be using *prescription drugs* in a harmful or abusive manner, or with harmful frequency, your selection of in-network pharmacies may be limited. If this happens, *we* may require *you* to select a single in-network pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if *you* use the single in-network pharmacy. *We* will contact *you* if we determine that use of a single in-network pharmacy is needed and give *you* options as to which in-network pharmacy *you* may use. If *you* do not select one of the in-

network pharmacies *we* offer within 31 days, *we* will select a single in-network pharmacy for *you*. If *you* disagree with our decision, *you* may ask us to reconsider it as outlined in the "Grievance/Appeal Process" section of this booklet.

**Where you can get prescription drugs**

**In-network pharmacy**
*You* can visit one of the local retail *pharmacies* in our network. Give the pharmacy the prescription from your doctor and your identification card and they will file your claim for *you*. *You* may receive up to a 30-day supply of medicine for an original prescription or refill for up to one year. *You* will need to pay any *copayment* that applies when *you* get the drug. If *you* do not have your identification card, the pharmacy will charge *you* the full retail price of the prescription and will not be able to file the claim for *you*. *You* will need to ask the pharmacy for a detailed receipt and send it to us with a written request for payment.
To find a pharmacy that participates in the retail pharmacy network *you* should:

- refer to *your health plan's* directory of network *providers* at www.anthem.com, which lists pharmacies that participate in the retail pharmacy network;
- check with your local pharmacy to see if they participate in the retail pharmacy network; or
- call *Anthem's* Member Services.

*You* must have used 75% of your prescription before it can be refilled. However, in the following circumstances, *you* can obtain an additional 30-day supply from your pharmacist:

- you've lost your medication;
- your medication was stolen; or
- your physician increases the amount of your dosage.

***Generic and brand name drugs***
A generic drug is a copy that is the same as a brand-name drug in dosage, safety, strength, how it is taken, quality, performance, and intended use. The Food and Drug Administration (FDA) requires that all drugs be safe and effective. Since generics use the same active ingredients and are shown to work the same way in the body, they have the same risks and benefits as their brand-name counterparts. Laws do not allow a generic drug to look like the brand-name drug so colors, flavors, and certain other inactive ingredients may be different.

Generic drugs are less expensive because generic manufacturers don't have the investment costs of developing a new drug. New drugs are developed under patent protection. As patents near expiration, manufacturers can apply to the FDA to sell generic versions. Once generic drugs are approved, there is greater competition, which keeps prices down.

Your prescription drug program covers allowable charges up to the cost of the drug. The following details how the generic drug program works:

- if *you* purchase a generic drug, *you* are responsible for the generic co-payment;
- if there is no generic available *you* are responsible for the brand co-payment.

**Specialty pharmacy**
If *you* need a *specialty drug*, *you* or your doctor must order it from the PBM's specialty *pharmacy*. *Specialty drugs* are high cost, biotech drugs, usually injected or infused and used for the treatment of acute or chronic diseases. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at retail drug stores. We keep a list of *specialty drugs* that may be covered based upon clinical findings from the *pharmacy and therapeutics (P&T) process*, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's specialty *pharmacy* has dedicated patient care coordinators to help *you* take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about *specialty drugs*.
When *you* use the PBM's specialty *pharmacy* a patient care coordinator will work with *you* and your doctor to get prior authorization and to ship your *specialty drugs* to *you* or your doctor's office. Your patient care coordinator will also tell *you* when it is time to refill your prescription. The PBM's specialty pharmacy will be the sole specialty drug pharmacy network, and specialty drugs will be covered only when obtained through the Specialty Pharmacy.

*You* can get the list of covered specialty drugs by calling Member Service at the phone number on the back of your identification card or check our website at www.anthem.com.

**Home delivery pharmacy**
The PBM also has a home delivery *pharmacy* which lets *you* get a 90-day supply of certain *drugs* by mail if *you* take them on a regular basis. *You* will need to contact the PBM to sign up when *you* first use the service. *You* can mail written prescriptions from *your* doctor or have *your* doctor send the prescription to the home delivery *pharmacy*. *Your* doctor may also call the home delivery *pharmacy*. *You* will need to send in any *copayments*, *deductible*, or *coinsurance* amounts that apply when *you* ask for a prescription or refill.

A *maintenance medication* is a drug *you* take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If *you* are not sure if the prescription drug you are taking is a *maintenance medication,* please call Member Service at the number on the back of your identification card or check our website at www.anthem.com for more details.

**Out-of-network pharmacy**
*You* may also use a *pharmacy* that is not in our network. *You* will be charged the full retail price of the drug and *you* will have to send your claim for the drug to us. (*Out-of-network pharmacies* won't file the claim for *you*.) *You* can get a claims form from us or the PBM. *You* must fill in the top section of the form and ask the *out-of-network pharmacy* to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, *you* must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the out-of-network pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the drug;
- Cost of the drug;
- Quantity (amount) of each covered drug or refill dispensed.

*You* must pay the full price of the drug. Reimbursement to you is based on the *maximum allowed amount* as determined by our normal or average contracted rate with network *pharmacies* on or near the date of service.

***When you may need to file a claim***
*You* may need to file your own claim if:

- your prescription is filled by a non-participating pharmacy;
- you need to have a prescription filled before you receive your card; or
- you have a prescription that requires special prior approval, but you need the prescription filled immediately.

Contact *Anthem's* Member Services if *you* need a Direct Member Reimbursement Claim Form or if *you* have any questions about your drug program and related procedures.

***To file a claim, follow these 3 steps:***

- complete the Direct Member Reimbursement Claim Form. If possible, ask the pharmacist to complete the pharmacy section of the form and sign;
- pay for the prescription; and
- mail your claim form to the address on the back of the form within 15 months of purchasing the prescription.

***Shots (Injections)***

*Your health plan* covers therapeutic injections (shots) that a *provider* gives to treat illness (e.g., allergy shots) or pregnancy-related conditions. Also included is allergy serum for allergy shots. In addition, *you* have coverage for immunizations and self-administered injections. Some injections may be administered by pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to perform this service.

**Skilled nursing facility stays**

Your coverage includes benefits for skilled nursing home *stays.* Coverage for your *stay* requires prior approval. Your doctor must submit a plan of treatment that describes the type of care *you* need. The following items and services will be provided to *you* as an *inpatient* in a skilled nursing bed of a *skilled nursing facility:*

- room and board in semi-private accommodations;
- rehabilitative services; and
- drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies.

Your *health plan* will cover the private room charge if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your inpatient benefits would cover the skilled nursing facility's charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your *copayment* and *coinsurance* (if any).

Custodial or residential care in a *skilled nursing facility* or any other facility is not covered except as rendered as part of Hospice care.

**Spinal manipulation and other manual medical interventions**

*Your health plan* covers spinal manipulation services (manual medical interventions) and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations such as massage and myofascial release.

**Surgery**

***General surgery***

Surgery charges are covered when treatment is received at an *inpatient, outpatient* or ambulatory surgery *facility,* or doctor's office. Your health plan will not pay separately for pre- and post-operative services.

**Morbid obesity treatment**

*Your health plan* covers treatment of morbid obesity through gastric bypass, or other methods recognized by the National Institutes of Health (NIH). Coverage is restricted to surgical procedures and does not include weight control dietary supplements. According to the NIH guidelines, gastric bypass surgery is effective for the long-term reversal of morbid obesity for a patient who:

- weighs at least 100 pounds over or twice the ideal body weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables;

- has a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- has a body mass index of 40 kilograms per meter squared, without such comorbidity.

As used above, body mass index equals weight in kilograms divided by height in meters squared. Coverage does not include weight control dietary supplements or weight loss medications, unless such supplements are recognized by the National Institutes of Health as effective treatment for the long-term reversal of morbid obesity for *covered persons* meeting the requirements specified above.

**Reconstructive breast surgery and mastectomy**
Mastectomy, or the surgical removal of all or part of the breast, is a covered service. Also covered are:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the *covered person.*
- Reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to reestablish symmetry between two breasts.

**Oral surgery**
**Important note:** Although this plan covers certain oral surgeries, many oral surgeries (e.g.removal of wisdom teeth) are not covered.

*Benefits are limited to certain oral surgeries including*:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Maxillary or mandibular frenectomy when not related to a dental procedure.
- Alveolectomy when related to tooth extraction.
- Orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone and is *medically necessary* to attain functional capacity of the affected part.
- Oral/surgical correction of accidental injuries as indicated in the “Dental Services” (All Members/All Ages)” section.
- Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures.
- Treatment of non-dental lesions, such as removal of tumors and biopsies
- Incision and draingage of infection of soft tissue not including odontongenic cysts or abscesses.

**Organ and tissue transplants, transfusions**
*Your health plan* covers organ and tissue transplants and transfusions. When a covered human organ or tissue transplant is provided from a living donor to a *covered person*, both the recipient and the donor may receive the benefits of the health plan.

> **Helpful tip:** Certain organ or tissue transplants are considered *experimental/investigative* or not *medically necessary.* You may wish to contact Member Services or have your *provider* initiate the pre-authorization process to determine if a specific transplant will be covered.

Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose

chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of *experimental/investigative* services.

To maximize your benefits, *you* need to call our 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.

**Therapy**

*Your health plan* covers the following therapies when the treatment is *medically necessary* for your condition and provided by a licensed therapist:

***Cardiac rehabilitation therapy***

*Your health plan* includes benefits for cardiac rehabilitation which is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

***Chemotherapy***

*Your health plan* covers the treatment of disease by chemical or biological antineoplastic agents.

***Occupational therapy***

*Your health plan* covers occupational therapy, which is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.

***Physical therapy***

*Your health plan* covers physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. Your coverage includes benefits for physical therapy to treat lymphedema.

***Radiation therapy***

*Your health plan* covers radiation therapy including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high-energy particle sources.

***Respiratory therapy***

*Your health plan* covers respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

***Speech therapy***

*Your health plan* covers speech therapy, which is treatment for the correction of a speech impairment, which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment.

**Vision correction after surgery or accident**

*Your health plan* covers the cost of prescribed eyeglasses or contact lenses only when required as a result of surgery, or for the treatment of accidental injury. Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if:

- prescribed to replace the human lens lost due to surgery or injury;
- "pinhole" glasses are prescribed for use after surgery for a detached retina; or
- lenses are prescribed instead of surgery in the following situations:
    - contact lenses are used for the treatment of infantile glaucoma;

- corneal or scleral lenses are prescribed in connection with keratoconus;
- scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or
- corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism

**Wellness services**

*Your health plan* covers preventive care services for children, adolescents and adults. Preventive care services generally include check-up visits, developmental assessment and guidance, screening tests, intervention counseling/education services, immunizations and other services to prevent the development of disease, or allow the detection of medical conditions in advance.

Services are covered as preventive care for children, adolescents and adults with no current symptoms or prior history of the medical condition associated with the screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition, but instead benefits will be considered under the diagnostic services benefit.

Additionally, a routine preventive screening may identify abnormalities or problems that require immediate intervention or additional diagnosis. If this occurs, and your *provider* performs additional necessary *covered services*, these services will generally be covered as diagnostic and/or surgical services and not as preventive care services. Also, covered screenings that *you* undergo because *you* have a personal or family history of a particular condition are not generally covered as preventive care services. *Deductibles, copayments* and *coinsurance* amounts applicable to diagnostic and/or surgical services may be different from those applicable to preventive care services. Please see the Diagnostic tests and Surgery sections on the **Summary of Benefits** for more information.

The preventive care services in this section meet the requirements outlined under federal and state law. Preventive care services covered by *your health plan* that meet these requirements are not subject to cost shares (for example, *deductible*, *copayment*, and/or *coinsurance* amounts) when services are received from in-network *providers*. That means *Anthem* pays 100% of the *maximum allowed amount*. Cost shares will apply when services are received from *out-of-network providers*. These services fall under four broad categories as shown below:

1. services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
- breast cancer;
- cervical cancer;
- colorectal cancer;
- high blood pressure;
- type 2 diabetes mellitus;
- cholesterol;
- child and adult obesity.

2. immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. 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

4. additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
- breastfeeding support, supplies, and counseling. Standard benefits for breast pumps are limited to one pump per pregnancy;

- gestational diabetes screening for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes;
- testing for Human Papillomavirus (HPV) every three years for women who are 30 or older and at high risk, regardless of pap smear results;
- annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women;
- screening and counseling for interpersonal and domestic violence;
- well woman visits.

5. counseling services related to nutrition, and to smoking and tobacco use cessation.

You may call Member Services at 800-451-1527 for additional information about these services. You may also visit the federal government websites:

http://www.healthcare.gov/center/regulations/prevention.html;
http://www.ahrq.gov/clinic/uspstfix.htm; or
http://www.cdc.gov/vaccines/recs/acip/.

In addition to the Federal requirements above, preventive coverage also includes the following covered services at intervals no less frequent than required by state law:

- Routine screening mammograms;
- Routine prostate specific antigen testing and digital rectal exams.

**Helpful tip:** If in the course of a colonoscopy screening procedure a polyp or other abnormality is identified, biopsied and/or removed, the service will be considered diagnostic and/or surgical, rather than screening. This may result in a possible difference in your *deductible* (if any), *co-payment* and/or *coinsurance.* Please see the Diagnostic tests and Surgery sections on the Summary of Benefits and earlier in this section for a complete description of these benefits.

**8) What is not covered (Exclusions)**

This list of services and supplies that are excluded from coverage by *your health plan* will not be covered in any case.

**A**

Your coverage does not include benefits for **acupuncture** or **Applied Behavioral Analysis (ABA) therapy.**

**B**

Your coverage does not include benefits for **biofeedback therapy.**

**C**

Your coverage does not include benefits for:

- over the counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, under pads, and ice bags; or
- benefits for, or related to, **cosmetic surgery or procedures,** including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. *We* will not consider the patient's mental state in deciding if the surgery is cosmetic.

**D**

Your coverage does not include benefits for the following **dental** services:

- treatment of natural teeth due to diseases;
- treatment of natural teeth due to accidental injury occurring on or after your *effective date* of coverage, unless treatment was sought within 60 days after the injury and *you* submitted a treatment plan to *Anthem* for prior approval;
- dental care, treatment, supplies, or dental x-rays;
- damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered;
- extraction of either erupted or impacted wisdom teeth;
- oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures;
- dental implants;
- appliances for temporomandibular joint pain dysfunction; or
- periodontal care, prosthodontal care, or orthodontic care.

Your coverage does not include benefits for **donor** searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood related family members (parent, child, sibling).

**E**

Your coverage does not include benefits for services or supplies primarily for **educational**, vocational, or self-management training purposes, except as otherwise specified in this benefit booklet or when received as part of a covered wellness services visit or screening.

Your coverage does not include benefits for **experimental/investigative** procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer. The criteria for deciding whether a service is experimental/investigative or a clinical trial cost for cancer is set forth in Exhibit A**.**

**F**

Your coverage does not include benefits for **family planning** services. These include:

- services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;
- any services or supplies provided to a person not covered under your health plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple);
- drugs used to treat infertility**;** or
- services to reverse voluntarily induced sterility

Your coverage does not include benefits for palliative or cosmetic **foot** care including:

- flat foot conditions;
- support devices, fittings, castings and other services related to devices of the feet; (Please see Foot Care for what is covered under *your Health Plan)*.
- subluxations of the foot;
- corns (except as treatment for patients with diabetes or vascular disease);
- bunions (except capsular or bone surgery);
- calluses (except as treatment for patients with diabetes or vascular disease);
- care of toenails (except as treatment for patients with diabetes or vascular disease);
- fallen arches;
- weak feet;

- chronic foot strain; or
- symptomatic complaints of the feet.

**G**

Your coverage does not include services for surgical treatments of **gynecomastia** for cosmetic purposes.

**H**

Your coverage does not include benefits for **health club memberships**, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Your coverage does not include benefits for the following **home** care services:

- homemaker services;
- maintenance therapy;
- food and home delivered meals; or
- custodial care and services.

Your coverage does not include benefits for the following **hospital** services:

- guest meals, telephones, televisions, and any other convenience items received as part of your *inpatient stay;*
- care by interns, residents, house physicians, or other *facility* employees that are billed separately from the *facility;* or
- a private room unless it is *medically necessary.*

**I**

Your coverage does not include benefits for **immunizations** required for travel and work, unless such services are received as part of the covered preventive care services as defined in this booklet.

**M**

Your coverage does not include benefits for **medical equipment (durable), appliances and devices, and medical supplies** that have both a non-therapeutic and therapeutic use. These include:

- exercise equipment;
- air conditioners, dehumidifiers, humidifiers, and purifiers;
- hypoallergenic bed linens;
- whirlpool baths or hot tubs;
- handrails, ramps, elevators, and stair glides;
- telephones;
- adjustments made to a vehicle;
- changes made to a home or place of business; or
- repair or replacement of equipment you lose or damage through neglect.

Your coverage does not include benefits for *medical equipment (durable)* that is not appropriate for use in the home.

Your coverage does not include benefits for services and supplies if they are deemed not **medically necessary** as determined by Anthem at its sole discretion. Nothing in this exclusion shall prevent *you* from appealing Anthem's decision that a service is not *medically necessary.*

However, if *you* receive *inpatient* or *outpatient* services that are denied as not *medically necessary,* or are denied for failure to obtain the required pre-authorization or *primary care physician referral,* the following professional provider services that you receive during your *inpatient stay* or as part of your *outpatient* services will not be denied under this exclusion in spite of the medical necessity denial of the overall services:

For ***inpatients***

1. services that are rendered by professional providers who do not control whether *you* are treated on an *inpatient* basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.
2. services rendered by your attending provider other than *inpatient* evaluation and management services provided to *you. Inpatient* evaluation and management services include routine visits by your attending provider for purposes such as reviewing patient status, test results, and patient medical records. *Inpatient* evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your attending provider.

For ***outpatients*** - services of pathologists, radiologists, and anesthesiologists rendering services in an (i) *outpatient* hospital setting, (ii) *emergency room,* or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist, or anesthesiologist assumes the role of attending physician.

Your coverage does not include benefits for the following ***mental*** **health services and substance abuse services:**

- *inpatient* stays for environmental changes;
- cognitive rehabilitation therapy;
- educational therapy;
- vocational and recreational activities;
- coma stimulation therapy;
- services for sexual deviation and dysfunction;
- treatment of social maladjustment without signs of a psychiatric disorder;
- remedial or special education services; or

**N**

Your coverage does not include benefits for **nutrition** counseling and related services, except when provided as part of diabetes education or when received as part of a covered wellness services visit or screening.

Your coverage does not include benefits for **nutritional and/or dietary supplements**, except as provided under *your health plan* as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

**O**

Your coverage does not include benefits for care of **obesity** or related services to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.

The exception to this exclusion is for morbid obesity as set forth in the **"Surgery"** paragraph of the **"What is covered"** section.

Your coverage does not include benefits for **organ** or tissue transplants, including complications caused by them, except as outlined in other sections of this book.

**P**
Your coverage does not include benefits for **paternity testing.**

Your ***prescription drug*** benefit does not include coverage for:

- over the counter drugs; This exclusion does not apply to over-the-counter drugs when coverage is required under federal law when recommended by the U.S. Preventive Services Task Force and when *you* receive a prescription from a physician;
- any per unit, per month quantity over the plan's limit;
- drugs used mainly for cosmetic purposes;
- drugs that are experimental, investigational, or not approved by the FDA
- cost of medicine that exceeds the *maximum allowable amount* for that prescription;
- drugs for weight loss;
- therapeutic devices or appliances;
- injectable *prescription drugs* that are supplied by a *provider* other than a pharmacy;
- charges to inject or administer drugs;
- drugs not dispensed by a licensed pharmacy;
- drugs not prescribed by a licensed *provider;*
- any refill dispensed after one year from the date of the original prescription order;
- medicine covered by Workers' Compensation, Occupational Disease Law, state or government agencies; or
- medicine furnished by any other drug or medical service.

Your coverage does not include benefits for **private duty nurses** in an inpatient setting, unless medically necessary.

**R**
Your coverage does not include benefits for rest cures, custodial, **residential,** or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether *you* receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic services.

Your coverage does not include benefits for care from a **residential treatment center** or other non-skilled settings, except to the extent such setting qualifies as a substance abuse treatment facility licensed to provide a continuous, structured, 24-hour-a-day program of drug or alcohol treatment and rehabilitation including 24-hour-a-day nursing care.

Certain residential treatment facilities, like the Life Center of Galax, will be covered for **pre-approved**, partial-day treatment programs. Facilities like Mount Regis and Saint Albans are currently approved for inpatient, intensive out-patient, and partial-day treatment programs. Please remember that facility contracts are subject to change and that Mental Health and Substance Abuse treatment is always subject to pre-admission review requirements for your protection.

**S**
Your coverage does not include benefits for **services or supplies** if they are:

- ordered by a doctor whose services are not covered under *your health plan;*
- care of any type given along with the services of an attending *provider* whose services are not covered;
- benefits for charges from stand-by physicians in the absence of *covered services* being rendered;
- not listed as covered under *your health plan;*
- not prescribed, performed, or directed by a *provider* licensed to do so;

- received before the *effective date* or after a covered person's coverage ends;
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms;
- for travel, whether or not recommended by a physician;
- services prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law or self;
- provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not *you waive* your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted;
- provided under a U. S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government;
- received from an employer mutual association, trust, or a labor union's dental or medical department;
- for injuries or illnesses incurred as a result of your commission of, or attempt to commit, a crime; or
- for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

Your coverage does not include benefits for **services** for which a charge is not usually made. This includes services for which *you* would not have been charged if *you* did not have health care coverage.

Your coverage does not include benefits for:

- amounts above the *maximum allowed amount* for a service; or;
- biofeedback, neurofeedback, and related diagnostic tests.

Your coverage does not include benefits for surgeries for **sexual dysfunction.** In addition, your coverage does not include benefits for services for **sex transformation.** This includes medical and mental health services.

Your coverage does not include benefits for the following **skilled nursing facility** *stays:*

- treatment of psychiatric conditions and senile deterioration; or
- *facility* services during a temporary leave of absence from the *facility;* or a private room, unless it is *medically necessary.*

Your coverage does not include benefits for services related to **smoking cessation** programs not affiliated with *us*.

Your coverage does not include benefits for **spinal manipulations** or other manual medical interventions for an illness or injury other than musculoskeletal conditions.

**T**

Your coverage does not include benefits for non-interactive ***telemedicine services.*** Non-interactive telemedicine services include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

Your coverage does not include benefits for the following **therapies**:

- physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services;
- group speech therapy;

- group or individual exercise classes or personal training sessions; or
- recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

**V**
Your coverage does not include services for treatment of varicose **veins** or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Your coverage does not include benefits for the following **vision** services:

- services for radial keratotomy and other surgical procedures to correct nearsightedness and / or farsightedness. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics;
- sunglasses of any type;
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer; or
- any other vision services not specifically listed as covered.

**W**
Your coverage does not include benefits for **weight loss programs,** whether or not they are pursued under medical or physician supervision, unless specifically listed as covered under *your health plan.* This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to *medically necessary* treatments for morbid obesity.

Your coverage does not include benefits for services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer.

### 9) Claims and Payments

*Your health plan* considers the charge to be incurred on the date a service is provided. This is important because *you* must be actively enrolled on the date the service is provided. Also, the dates of service will affect your *deductible* (if any) and other minimums described in the **Summary of Benefits** and in this section.

**Calendar year deductible**
Your benefits include a calendar year *deductible* for covered services that *you* receive *in-plan* and *out-of-plan.* Before *we* will make payments for covered services (either in or out of plan) *you* must first satisfy the calendar year *deductible.* See the **Summary of Benefits** section of this booklet for the amount of your calendar year *deductible.*

Covered services received during the last three months of the calendar year that applied to a *covered person's deductible,* may also apply to the *deductible* required for the following calendar year.

**Limits on your out-of-pocket expenses**
*Your health plan* protects *you* from large out-of-pocket expenses by limiting the amount *you* spend out of your own pocket each year. Once the limit on *your health plan* is reached, almost all other covered expenses are paid in full for the rest of the calendar year.

**What you will pay**

***In-plan limit***
*Deductibles, copayments* and *coinsurance* for services by *providers* and *facilities* within your network count toward your in-plan, out-of-pocket expense limit. When your in-network, out-of-pocket expense limit is reached, *co-payments* and *coinsurance* for in-network services will no longer apply for the rest of the calendar year. Two special situations when expenses will also count toward this limit are:

- when *you* receive services from medical suppliers for whom there is no network (e.g. private duty nurses), your out-of-pocket expenses count towards this limit; and
- when specialty care is not available within the network and *Anthem* authorizes the highest level of benefits, any *copayments* and *coinsurance* for these covered services count toward this limit.

***Out-of-network limit***
*Deductibles* and *coinsurance* for *covered services* by *providers* and *facilities* who are not part of your PPO network, but who participate in an *Anthem* or Blue Cross and Blue Shield Company's network, count toward your out-of-network, out-of-pocket expense limit. If *you* reach your *out-of-network*, out-of-pocket expense limit, *you* will no longer pay *coinsurance* for out-of-network services for the rest of the calendar year.

**Helpful tip:** The in-network and out-of-network out-of-pocket expense limits are separate, and amounts applied to one do not apply to the other.

***What does not count toward these limits***
The following amounts do not count toward your out-of-pocket expense limit, and *you* will always be responsible for these expenses, regardless of whether *you* have met your out-of-pocket expense limit.

- amounts above the *maximum allowed amount* (these amounts are not the patient's responsibility when services are rendered by a network or participating *provider* or *facility);*
- amounts above health plan limits;
- co-payments and coinsurance for prescription drugs under your prescription drug benefit;
- *deductible* amounts carried forward from the prior calendar year;
- expenses for supplies or services not covered by *your health plan;* or
- *deductible, co-payments,* and *coinsurance* for dental services provided by your Volvo Dental plan.

**How Anthem pays a claim**

How we pay a claim takes into account the *maximum allowed amount* for the service, the network status of the *provider* or *facility* where *you* receive services, and your member cost share under *your health plan's* benefit design. Each of the components is explained in the sections that follow. For the purposes of these sections, *providers* also includes *facilities*.

***Maximum allowed amount***
This section describes how we determine the amount of reimbursement for *covered services*. Reimbursement for services rendered by *in-network* and *out–of-network providers* is based on *your health plan's* maximum allowed amount for the *covered service* that you received. Please see the BlueCard section for additional information.

The *maximum allowed amount* for *your health 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 health 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 non- participating *providers*, 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, we* 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 *our* determination of the *maximum allowed amount. Our* application of these rules does not mean that the *covered services you* received were not *medically necessary.* It means *we* have 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.

"Per diem amount" means an all inclusive fixed payment amount for each day of admission in an *inpatient facility.*

**Maximum allowed amount for multiple procedures**
When multiple procedures are performed on the same day by the same physician or other healthcare professional, *we* 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.

**Assistant at surgery**
Services of a physician who actively assists the operating surgeon to perform a covered surgical service are *covered services.* However, when two or more surgeons provide a covered surgical service that could have been performed by one surgeon, the *maximum allowed amount* will not be more than that available to one surgeon.

**Provider network status**
The *maximum allowed amount* may vary depending upon whether the *provider* is an in-network *provider* or an *out-of-network provider*.

An in-network *provider* is a *provider* who is in the *PPO network*, the managed network for this specific health plan. For *covered services* performed by an in-network *provider*, the *maximum allowed amount* for *your health plan* is the rate the *provider* has agreed with *Anthem* to accept as reimbursement for the *covered services*.

*Providers* who are not in the *PPO network*, but contracted for other products with us are considered non-network participating *providers.* While your cost share may be higher because these *providers* are not in-network, these non-network participating *providers* have agreed to accept the *maximum allowed amount* established by the *provider's* contract as payment in full for those *covered services*. Choosing an in-network *provider* will likely result in lower out-of-pocket costs to *you.*

Because in-network providers and non-network participating 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 Member Services for help in finding an in-network *provider* or visit www.anthem.com.

*Providers* who have not signed any contract with us and are not in any of *our* networks are out-of-network providers. For covered services *you* receive from an *out-of-network* provider, the *maximum allowed amount* for *your health plan* will be one of the following as determined by *Anthem*:

1. an amount based on *our* non-participating *provider* fee schedule/rate, which we have established in *our* discretion, and which *we* reserve the right to modify from time to time, after considering one or more

of the following: statewide average reimbursement amounts that *Anthem* previously has paid for similar claims in the state of Virginia, reimbursement amounts accepted by like/similar *providers* contracted with *Anthem,* reimbursement rates accepted by providers under the last network contract in effect with *Anthem*, 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

2. 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 and/or method of reimbursement used by the CMS, *Anthem* will update such information, no less than annually; or
3. 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
4. an amount negotiated by us or a third party vendor which has been agreed to by the provider.This may include rates for services coordinated through case management; or
5. an amount based on or derived from the total charges billed by the out-of-network provider.

A per diem amount may be used in calculating the *maximum allowed amount* for *inpatient facility* services. When calculating these amounts, the charges for non-covered services are subtracted from the per diem amount.

Member Services is also available to assist you in determining *your health plan's maximum allowed amount* for a particular service from an *out-of-network* provider. In order for us 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 Member Services 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*.

Certain *covered services* such as medical supplies, ambulance, early intervention services, *home care services*, private duty nursing, medical equipment, and medical formulas, may be rendered by persons or entities that are not *providers*. There may or may not be networks established for these persons or entities. The *maximum allowed amount* for services from these persons or entities will be determined in the same manner as described above for *providers.* For *prescription drugs* and diabetic supplies rendered by a pharmacy, the *maximum allowed amount* is the amount determined by *us* using prescription drug cost information provided by *our* pharmacy benefits manager.

**Member cost share**

For certain *covered services* and depending on your plan's benefit 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).*

Your cost share amount and out-of-pocket limits may vary depending on whether *you* received services from an in-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 **Summary of Benefits** in this certificate for your cost share responsibilities and limitations, or call Member Services to learn how this plan's benefits or cost share amounts may vary by the type of *provider you* use.

*Anthem* 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 an in-network or *out-of-network provider.* Both services specifically excluded by the terms of your policy/plan and those received after benefits have been exhausted are non-*covered services.* Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits. The *maximum*

*allowed amount* for *inpatient facility* services may be based on a per diem amount. When calculating these amounts, the charges for non-*covered services* are subtracted from the per diem amount.

In some instances, *you* may only be asked to pay the lower in-network cost sharing amount when *you* use an *out-of-network provider.* For example, if *you* go to an in-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 an in-network hospital or *facility, you* will pay the in-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.

In some instances, because of the negotiated arrangement with network *facilities* and *providers,* our *maximum allowed amount* may be higher than the *facility* or *provider* billed charge for the *covered services.* In these cases, any *coinsurance* amount that *your health plan* imposes will be based off the lower billed charges.

**Helpful tip:** The following examples are illustrative only, and are not intended to reflect the actual member cost share amounts reflected in the **Summary of Benefits**.

Example: Your plan has a *coinsurance* cost share of 10% for in-network services, and 30% *out-of-network* after the in- or *out-of-network deductible* has been met. *You* undergo a surgical procedure in an in-network hospital. The hospital has contracted with an *out-of-network* anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- the out-of-network anesthesiologist's charge for the service is $1200. The maximum allowed amount for the anesthesiology service is $950; your coinsurance responsibility is 10% of $950, or $95 and the remaining allowance from us is 90% of $950, or $855. You may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the deductible has been met, your total out-of-pocket responsibility would be $95 (10% coinsurance responsibility) plus an additional $250, for a total of $345.
- you choose an in-network surgeon. The charge was $2500. The maximum allowed amount for the surgery is $1500; your coinsurance responsibility when an in-network surgeon is used is 10% of $1500, or $150. We allow 90% of $1500, or $1350. The in-network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total out-of-pocket responsibility would be $150.
- you choose an out-of-network surgeon. The out-of-network surgeon's charge for the service is $2500.The maximum allowed amount for the surgery service is $1500; your coinsurance responsibility for the out-of-network surgeon is 30% of $1500, or $450 after the out-of-network deductible has been met. We allow the remaining 70% of $1500, or $1050. In addition, the out-of-network surgeon could bill you the difference between $2500 and $1500, so your total out-of-pocket charge would be $450 plus an additional $1000, for a total of $1450.

**Authorized services**

In some circumstances, such as where there is no in-network *provider* available for the *covered service*, we 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 a circumstance, *you* must contact us in advance of obtaining the *covered service*. *We* 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 *us* until after the *covered service* is rendered. If *we* authorize a *covered service* so that *you* are responsible for the in-network cost share amounts, *you* may still be liable for the difference between the *maximum allowed amount* and the *out-of-network provider's* charge. Please contact Member Services for authorized services information or to request authorization.

Example: *You* require the services of a specialty *provider*, but there are no in-network *providers* for that specialty in your state of residence. *You* contact *us* in advance of receiving any *covered services*, and

*we* authorize *you* to go to an available *out-of-network provider* for that *covered service* and we agree that the in- network cost share will apply.

Your plan has a $45 *copayment* for *out-of-network providers* and a $25 *copayment* for in-network *providers* for the covered service. The *out-of-network provider's* charge for this service is $500. The *maximum allowed amount* is $200.

Because *we* have authorized the in-network cost share amount to apply in this situation, *you* will be responsible for the in-network *copayment* of $25 and *Anthem* will be responsible for the remaining $175 of the $200 *maximum allowed amount*.
Because the *out-of-network* provider's charge for this service is $500, *you* may receive a bill from the *out-of- network provider* for the difference between the $500 charge and the *maximum allowed amount* of $200. Combined with your *in-network copayment* of $25, your total out-of-pocket expense would be $325.

**Network and participating providers and facilities**
If you go to a network or participating *provider* or *facility*, we will pay the *provider* or *facility* directly. If *coinsurance* or a *copayment* is applicable to covered services rendered by a network or participating *facility* or *provider*, or if any applicable *deductible* is not met, any such amounts may be collected at the time of service.

**Non-participating providers and facilities**
If you go to a non-participating *provider* or *facility*, we may choose to pay *you* or anyone else responsible for paying the bill. *We* will pay only after *we* have received an itemized bill or proof of loss and all the medical information we need to process the claim. *We* will not pay a non-participating *provider* more than we would have paid a participating *provider* for the same service.

In the event that payment is made directly to *you*, you have the responsibility to apply this payment to the claim from the non-participating *provider*.

***When you are Eligible for Medicare***
If you (or your spouse) become eligible for Medicare while you are an active employee, you should check with the Social Security Administration to see if it is necessary for you to enroll in Medicare Part B to avoid any possible future penalties for not enrolling when first eligible. While you are working, the Volvo Medical Plan will remain primary for you and your spouse and Medicare would be your secondary coverage. If you become disabled and qualify for Social Security Disability benefits, Medicare will be primary once you qualify for Medicare.

***When you must file a claim***
Network *providers* file claims on your behalf. *You* may have to file a claim if *you* receive care from a *provider* or *facility* that does not participate in *Anthem's* network.

*You* will have to file a claim if *you* receive care billed by someone other than a doctor or hospital, or if the *provider* cannot file a claim for *you.* To file a claim follow these 3 steps:

1. Call 800-358-1551 to order a claim form or get one from Human Resources.
2. Please include the completed and signed claim form and any itemized bills for *covered services*. Each itemized bill must contain the following:
    - name and address of the person or organization providing services or supplies;
    - name of the patient receiving services or supplies;
    - date services or supplies were provided;
    - the charge for each type of service or supply;

- a description of the services or supplies received; and
- a description of the patient's condition (diagnosis).

In addition, private duty nursing bills must include the professional status of the nurse (for example, RN for registered nurse), the attending physician's written certification that the services were *medically necessary,* and the hours the nurse worked.

3. Send the completed claim form and any itemized bills for covered services to:

   Anthem Blue Cross and Blue Shield
   P. O. Box 27401
   Richmond, VA 23279

***Timely filing of claims***

Written proof of loss must be furnished within 90 days after the date of service. A proof of loss is not complete unless it is properly filed and contains all information that *Anthem* needs to process the claim. Failure to furnish the proof of loss within this time frame will not invalidate or reduce any claim if the proof of loss is given as soon as reasonably possible. However, no claim will be paid if we receive the proof of loss more than 24 months after the date of service, except in the absence of legal capacity of the *covered person.*

**When your claim is processed**

Once a claim has been processed, if your portion of the bill is anything other than zero or equal to a flat *copayment* amount, a paper copy of the Explanation of Benefits (EOB) statement will be mailed to *you* to explain your responsibility. In the event that your portion of the bill is zero or equal to a flat *copayment* amount, the paper copy will not be mailed, but will available to *you* online at www.anthem.com. If *you* do not have access to the Internet, *you* may contact Member Services to arrange for a printed copy.

In processing your claim, *your health plan* may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the "**When you must file a claim**" paragraph of this section will be processed within 30 days of receipt of the claim. *We* may extend this period for another 15 days if *we* determine it to be necessary because of matters beyond *our* control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 30-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, *we* will make *our* decision within 2 working days of *our* receipt of the medical information needed to process the claim.

*Your health plan* may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by *you* or your *provider* furnishing the additional information. *You* or your *provider* must submit the additional information to *us* within either 15 months of the date of service or 45 days from the date *you* were notified that the information is needed, whichever is later. Once your claim has been processed by *your health plan, you* will receive written notification of the coverage decision. In the event of an *adverse benefit determination,* the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of *your health plan's* appeal procedures and applicable time limits; and
- the availability of, and contact information for, the U.S. Department of Labor's Employee Benefits Security Administration that may assist *you* with the internal or external appeals process.

If all or part of a claim was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that *your health plan* relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, *you* are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to your medical condition.

**10) Right of recovery provision**

Immediately upon paying or providing any benefit under this plan, *your health plan* shall be subrogated to all rights of recovery a *covered person* has against any party potentially responsible for making any payment to a *covered person* due to a *covered person's* injuries or illness, to the full extent of benefits provided or to be provided by the plan.

In addition, if a *covered person* receives any payment from any potentially responsible party as a result of an injury or illness, *your health plan* has the right to recover from, and be reimbursed by, the *covered person* for all amounts this plan has paid and will pay as a result of that injury or illness, up to and including the full amount the *covered person* receives from all potentially responsible parties. The *covered person* agrees that if he/she receives any payment from any potentially responsible party as a result of an injury or illness, he/she will serve as a constructive trustee over the funds. Failure to hold such funds in trust will be deemed a breach of the covered person's fiduciary duty to the plan.
Further, *your health plan* will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a *covered person* receives from a third party, the third party's insurer or any other source as a result of the *covered person's* injuries. The lien is in the amount of benefits paid by *your health plan* for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a *covered person* due to a *covered person's* injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The *covered person* acknowledges that this plan's recovery rights are a first priority claim against all potentially responsible parties and are to be paid to *the plan* before any other claim for the *covered person's* damages. This plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the plan will result in a recovery to the *covered person* which is insufficient to make the *covered person* whole or to compensate the *covered person* in part or in whole for the damages sustained. It is further agreed that the plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the *covered person* to pursue the *covered person's* damage claim.

The terms of this entire right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the *covered person* identifies the medical benefits the plan provided. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The *covered person* shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the *covered person* to notify the plan within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the *covered person.* The *covered person* shall provide all information requested by the plan or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against the *covered person.*

The *covered person* shall do nothing to prejudice the plan's recovery rights as herein set forth. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the *covered person* and this plan agree that the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The *covered person* agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. Upon receiving benefits under this plan, the *covered person* hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

**11) After coverage ends**

The *covered person's* coverage ends on the last day of the month during which eligibility ceases.

Examples of when a *covered person's* eligibility may cease include:

- when *you* leave your job with the employer.
- when a child (other than a handicapped child) reaches the end of the month in which the child turns 26.
- in the case of a handicapped dependent, when the child is no longer handicapped.
- in the case of your spouse, when *you* and your spouse divorce.

**12) Anthem's relationship to providers**

The choice of a health care *provider* is solely the *covered person's. Providers* are neither *Anthem* employees nor agents. *We* can contract with any appropriate *provider* or *facility* to provide services to *you. Our* inclusion or exclusion of a *provider* or a covered *facility* in any network is not an indication of the *provider's* or *facility's* quality or skill. *We* make no guarantees about the health of any *providers. We* do not furnish covered services but only make payment for them when received by *covered persons.*

*We* are not liable for any act or omission of any *provider,* nor are *we* responsible for a *provider's* failure or refusal to render covered services to a *covered person.*

**13) Assignment of payment**

A *covered person* may not assign the right to receive payment for covered services. Prior payments to anyone, whether or not there has been an assignment of payment, shall not waive or otherwise restrict, Anthem's right to direct future payments to a *covered person* or any other entity. This provision does not apply to dentists and oral surgeons.

Once covered services are rendered by a provider, Anthem will not honor requests not to pay the claims submitted by the provider. Anthem will have no liability to any person because it rejects the request.

**14) Member's Rights and Responsibilities**

***Making the Most of Your Coverage***

As a member you have certain rights and responsibilities when receiving your health care. *You* also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving *you* access to our network providers and the information *you* need to make the best decisions for your helath and welfare.

These are your rights and responsibilities:

**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. This is no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and
- Federal laws and our privacy policies.
- 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:
    - our company and services.
    - our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal* about:
    - your plan
    - any care you get
    - any *covered service* or benefit ruling that your plan makes.

*See SECTION 14, Claims Review Procedure

- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care professional provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

## You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all plan rules and policies.
- Choose an in-network primary care physician (doctor), also called a PCP, if your health care plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.

- Follow the care plan that you have agreed on with your doctors or health care providers.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our customer service department know if you have any changes to your name, address or family members covered under your plan.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by this booklet and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

**15) Definitions**

***Activities of daily living***
means walking, eating, drinking, dressing, toileting, transferring (e.g. wheelchair to bed), and bathing.

***Adverse benefit determination***
is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by the health plan.

***Claim Administrator***
Anthem Blue Cross and Blue Shield, Richmond, VA 23279

***Coinsurance***
is the percentage of the maximum allowed amount you pay for some covered services.

***Copayment***
is the fixed dollar amount you pay for some covered services.

***Cost Awareness*** *Participants*
*covered persons* designated by the employer (in accordance with the guidelines set by Anthem) who do not have reasonable access to Anthem primary care physicians or to PPO Network providers and facilities due to their location. These individuals are set up under the PPO Plan without primary care referral requirements.

***Covered persons***
are you and enrolled eligible dependents.

***Covered services***
are those medically necessary hospital and medical services which are described as covered in this certificate and which are performed, prescribed or directed by a physician.

***Deductible***
is a fixed dollar amount of covered services you pay in a calendar year before your health plan will pay for any remaining covered services during that calendar year.

***Effective date***
is the date coverage begins for you and/or your dependents enrolled under the health plan.

***Emergency Medical Condition (Emergency)***
is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment of bodily functions;
- serious dysfunction of any bodily organ or part

**Emergency services (Emergency care)**
with respect to an emergency medical condition:

- a medical 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 such emergency medical condition, and
- within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "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 effect 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.

***Experimental/investigative***
means any service or supply that is judged to be experimental or investigative at *Anthem's* sole discretion. Refer to **Exhibit A** for more information.

**Facilities are**:

- dialysis centers
- home health care agencies
- hospice providers
- hospitals
- skilled nursing facilities

***Future Moms***
is a program designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery.

***Group administrator***
is the benefits administrator at your employer.

***High dose***
means a dose of chemotherapy or radiation so high that it predictably requires stem cell rescue.

***Home care services***
are services rendered in the home setting. Home care includes services such as skilled nursing visits and physical, speech, and occupational therapy for patients confined to their homes. This also means infusion services rendered in the home setting. Infusion services include such services as the intravenous and parenteral administration of medication to patients as well as enteral and parenteral nutrition. Infusion services rendered in the home setting do not require that the patient is confined to his/her home.

***In-network benefits***
are benefits for care rendered or coordinated by your PCP. In-plan benefits are the highest level of benefits available under you health plan.

***Inpatient***
means when you are a bed patient in the hospital.

***Inpatient facilities***
are settings where patients can spend the night, including hospitals, skilled nursing facilities, partial day programs.

***Maintenance medications***
are those you take routinely to treat or control a chronic illness such as heart disease, high blood pressure, or diabetes.

***Maximum allowed amount***
Means the amount on which deductible (if any), copayment, and coinsurance amounts for eligible services are calculated.

***Medical equipment (durable)***
is used for a medical purpose, can withstand repeated use, and is appropriate for use in your home for activities of daily living purposes.

***Medically necessary***
to be considered medically necessary, a service must:

- be required to identify or treat an illness, injury, or pregnancy-related condition;
- be consistent with the symptoms or diagnosis and treatment of your condition;
- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, the patient's family, or the provider.

***Mental health services***
are for the diagnosis and treatment of a psychiatric condition, including nervous, mental, and emotional disorders, including alcohol and drug abuse.

***Out-of-network***
Is care covered at a lower level of benefits. After you satisfy a calendar year deductible, you are responsible for your coinsurance.

***Outpatient***
is when you receive care in a hospital outpatient department, emergency room, professional provider's office, or your home.

***Outpatient mental health services***
are for the diagnosis and treatment of psychiatric conditions and include individual psychotherapy, group psychotherapy, and psychological testing.

***Partial day services***
are used as an alternative to inpatient treatment.

***Plan administrator***
is Volvo Group North America, LLC

***PPO Network***
is a network of providers and facilities that has agreed to accept Anthem's allowable charge as payment in full for covered services

***Post-service claims***
are all claims other than pre-service claims and urgent care claims. Post-service claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where you request authorization in advance.

***Prescription drugs***
are medicines, including insulin, that require a prescription order from your doctor.

***Pre-service claims***
are claims for a service where the terms of the health plan require the member to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If you call to receive authorization for a service when authorization in advance is not required, that claim will be considered a post-service claim.

***Primary care physician (PCP)***
is the general or family practitioner, internist, or pediatrician you choose to provide, arrange, and/or authorize any health care services you and your family members may need.

***Providers are***:
- audiologists
- certified nurse midwives
- chiropractors
- chiropodists
- clinical social workers, psychologists, clinical nurse specialists in psychiatric mental health, professional counselors, marriage and family therapists
- dentists
- doctors of medicine (MD), including osteopaths and other specialists
- independent clinical reference laboratories
- retail health clinics
- occupational therapists
- opticians
- optometrists
- podiatrists
- registered physical therapists
- speech pathologists

***Qualified beneficiary***
is a covered person who is eligible for a temporary extension of coverage under *your health plan* because of the COBRA law.

***Qualifying event***
is an event that allows you or covered persons enrolled with you to select continuation of coverage under the COBRA law.

***Referral***
is authorization from your PCP to receive services from another provider.

***Retail health clinic***
is a clinic 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 physician’s assistants and nurse practitioners.

***Setting***
is the place where you receive treatment. It could be your home, your provider's office, a hospital outpatient department, a skilled nursing home, hospital inpatient room, or a partial day program.

***Skilled nursing facility***
is a facility licensed by the state in which it operates to provide medically skilled services to inpatients.

**Specialty care providers**
are any covered providers other than those defined as primary care physicians.

***Stay***
is the period from the admission to the date of discharge from a facility. All hospital stays, for the same or related condition, less than 90 days apart are considered the same stay, and a new hospital inpatient co-payment will not apply.

***Telemedicine services***
means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment as it pertains to the delivery of covered health care services. Telemedicine services do not include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

***Urgent care claims***
are claims where care and services are actively ongoing and to which the application of time periods for making claim or appeal decisions could seriously jeopardize the patient's life, health, or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain. Notwithstanding any provision of your health plan, services for a true emergency do not require PCP referrals or any type of advance approval.

***Urgent care situations***
are medical conditions that require immediate attention, but are not as severe as an emergency. Urgent care situations are usually marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury.

***Visit***
a period during which a covered person meets with a provider to receive covered services.

***We, us, our, Anthem***
is Anthem Blue Cross and Blue Shield.

***You***
the enrolled employee.

***Your health plan***
the Anthem PPO Plan.

## 16) Exhibit A

**Experimental/investigative criteria**

*Experimental/investigative* means any service or supply that is judged to be experimental or investigative at *Anthem's* sole discretion. Services which do not meet each of the following criteria will be excluded from coverage as e*xperimental/investigative:*

**1.** Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions, which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.

a) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:

- the following three standard reference compendia defined below:
  1) the American Hospital Formulary Service - Drug Information
  2) National Comprehensive Cancer Network's Drugs & Bioligics Compendium
  3) Elsevier Gold Standard's Clinical Pharmacology
- in substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or

b) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

**2.** There must be enough information in the peer-reviewed medical and scientific literature to let us judge the safety and the efficacy.

**3.** The available scientific evidence must show a good effect on health outcomes outside a research *setting.*

**4.** The service or supply must be as safe and effective outside a research *setting* as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered *experimental/investigative.*

**Clinical trial costs**

Benefits include coverage for services 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:

1. Federally funded trials approved or funded by one of the following:
   a. The National Institutes of Health.
   b. The Centers for Disease Control and Prevention.
   c. The Agency for Health Care Research and Quality. d. The Centers for Medicare & Medicaid Services.
   e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g. 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.

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

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

Your plan may require *you* to use an in-network *provider* to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a *covered service* even though it might otherwise be investigational as defined by this plan. All other requests for clinical trials services 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. We reserve our right to exclude any of the following services:

i. The investigational item, device, or service, itself; or
ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical tnanagement of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

**17) Special Features and Programs**

We may offer health or fitness related program options to the group to purchase. If your group has selected this option, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. (Use of gift cards for purposes other than for qualified medical expenses may result in taxable income to you. For additional guidance, please consult your tax advisor.) These programs are not covered services under the plan but are in addition to plan benefits; these program features are not guaranteed under your certificate and could be discontinued at any time.

In addition to the health and wellness benefits under your health plan, or any health or fitness related program options that may be offered to your group to purchase, our 360° Health® program surrounds you and your family members with 360 degrees of preventive care resources, wellness information, savings and incentives and care management services.

Our 360° Health program focuses on helping you manage your health and make the right health care decisions for you and your family. Whether you're healthy or have medical conditions, you can turn to the programs that make up 360° Health. The program components are each designed to help you get the right care at the right time and help you lead the healthiest life possible. All the parts of 360° Health are located in one consumer-friendly source on anthem.com that you can tap into whether you're healthy and just want to stay that way or living with a chronic condition that needs regular attention.

Although these services are not part of the health and wellness benefits under your health plan, they are provided to you as a plan participant. Discount services are available through networks administered by other companies - many of which are national leaders in their fields. The discount services listed below are not covered as benefits under your health plan and can be discontinued at any time.

**Health resources and tools**

**MyHealth@Anthem**
When you visit anthem.com, you can access this personalized online resource center. It's full of interactive tools to help you assess, manage and improve your health. You can take advantage of:

- Health risk assessments – Learn your overall health status by completing a health risk assessment.
- LEAP Fitness Program – Use the Lifetime Exercise Adherence Program (LEAP) to create online fitness programs and personalized activity plans.
- Condition Centers – When you visit a Condition Center, you can access in-depth, condition-specific health assessments and personalized treatment options. Condition Centers exist for allergy, anxiety, diabetes, prostate health, breast health and more.
- Physician Pre-Visit Questionnaire – Use this to get ready for your next doctor's visit. It can help you ask the right questions and communicate effectively with your doctor.
- Child Health Manager and Pregnancy Planner – Track your children's doctor visits, immunization records and any medical concerns *you* have. Expectant mothers can track their pregnancy check-ups, tests, progress and more.
- Message Center and Health News - Receive health-related secure e-mails with current news, drug alerts and health tips based on your personal health interests and profiles.
- Depression and Anxiety Screening – Answer general questions about depression and anxiety. Based on your responses, a nurse care manager may follow up with *you* to discuss treatment options and offer support.

**AudioHealth Library**
For those who aren't comfortable discussing their health concerns with someone else or those just looking for more information on a health topic, there's the AudioHealth Library. It's accessible by phone with more than 400 recorded health topics.

**Online Preventive Guidelines**
At anthem.com, you can use the online preventive guidelines to check on when you should have certain check-ups, immunizations, screenings and tests.

**SpecialOffers@Anthem**
With SpecialOffers@Anthem, you can access discounts on a wide variety of health and wellness products and services. Find deals on natural health and wellness products; acupuncture, chiropractic and massage therapy; fitness club memberships; weight management; laser vision correction and recommended health and wellness books.

The discount programs and services available through SpecialOffers@Anthem are continually reviewed for opportunities to provide more value to your membership. For the most up-to-date information, always refer to SpecialOffers@Anthem at anthem.com. These discount programs and services are independent of your plan benefits and may change or be cancelled at any time.

## Health guidance

**MyHealth Advantage**
We know that early detection of potential health issues can lead to better health. And overall better health may reduce your annual doctor visits, which can lead to annual cost savings for you. MyHealth Advantage conducts ongoing reviews of your health status by checking your prescribed medications and alerting you and your doctor about potential drug interactions, overdue exams or recommended tests. And if MyHealth Advantage identifies issues like these for you, you may receive a **MyHealth Note** in the mail. These personalized notices include information about health recommendations and potential

pharmacy savings, and feature a summary of your recent claims data to keep for your records and share with your treatment providers.

**24/7 NurseLine**
Illness or injury can happen, no matter what time of day. As an Anthem health plan member, you have access to a team of nurses, available to assist with your questions or concerns, 24 hours a day, seven days a week. These registered nurses can discuss symptoms you're experiencing, how to get the right care in the right setting and more, and you can call as often as you like. Call 800-337-4770.

**Future Moms**
This program promotes healthy pregnancies and is designed for all expectant women – whether they're experiencing routine pregnancies or at highest risk for complications. When members enroll in the Future Moms program, they receive an up-to-date prenatal care package with valuable information for the whole family. A team of nurses – specializing in obstetrics and experienced in working with expectant mothers – is available 24/7 to help members try and have the healthiest pregnancies possible.

## Health management and coordination

**ComplexCare**
This program helps members living with multiple health care issues. Our goal is to help you access quality care, learn to effectively manage your condition and lead the healthiest life possible. When you enroll in the program, you're assigned to a nurse care manager who specializes in helping high-risk people.

The nurse care manager will work with you and your doctor to create an individualized care plan, coordinate care between different doctors and health care providers, develop personalized goals, offer health and lifestyle coaching, answer your questions and more.

**ConditionCare**
If you or a family member suffers from a chronic condition like asthma, we may be able to help you achieve better health. Our ConditionCare program gives you personalized support to take charge of your health and maybe even improve it.

We'll help you manage your symptoms related to pediatric and adult asthma, chronic obstructive pulmonary disease, pediatric and adult diabetes (Types I and II), heart failure, coronary artery disease, lower back pain, musculoskeletal pain and vascular at-risk conditions. The ConditionCare program gives you:

- 24-hour toll-free access to registered nurses who can answer your questions, provide support and educate you on how to best manage your condition.
- A health evaluation and consultation with a registered nurse over the phone, when needed, to help

you manage your condition.

- Educational materials like care diaries, self-monitoring charts and self-care tips. To enroll in the ConditionCare program, call us toll-free at 800-638-4814.

**SECTION 7. Dental Plan**

Coverage for dental benefits will apply to all eligible employees and their eligible dependents. Coordination of benefits will apply to dental coverage and claims will be based on usual, customary, and reasonable charges for all covered expenses.

**Pre-Determination of Benefits:** Predetermination of benefits will be mandatory for estimated dental charges of $200. There is no penalty for failure to comply. However, by declining, the patient loses the

opportunity to be informed in advance of benefits payable under the Plan for the treatment proposed. You may also lose the opportunity to discuss any lower cost alternatives with the dentist and the ability to make an informed decision on the course to follow.

**Alternative Treatment Plan:** For charges in excess of $200, if there are two or more possible modes of treatment, as is so often the case in dentistry, the Plan will base its benefit on the most economical procedure. Even in situations where the Plan indicates that it will base the benefit to be paid on an alternate procedure, the treating dentist and patient are still free to elect any course of treatment which they may prefer and apply the payment for the alternate benefit to the treatment of their choice.

**a) Schedule of Benefits**

Maximum Benefits:

| | |
|---|---|
| Annual maximum | $1,800 per covered person |
| Orthodontic lifetime maximum | $1,650 per covered person |

Preventative Treatment – 100% (UCR)

- Two oral examinations and cleaning during twelve consecutive months**, excluding periodontal cleanings which are not covered under preventative treatment.**
- Two applications of fluoride, for patients under 19 years of age, during twelve consecutive months.
- Application of a sealant, for patients under 14 years of age, every 36 months.
- Initial installation of space maintainers, for patients under 19 years of age, for missing primary teeth.

Routine Treatment – 90%

- Dental X-rays:
  - Two intraoral or extraoral sets of x-rays during any 12 consecutive months.
  - One series of full mouth x-rays or panorex x-rays every 36 months for patients at least 12 years of age.
- Extractions:
  Must be for reasons other than orthodontic purposes
  - Simple extraction of teeth.
  - Surgical extractions of teeth.
  - Surgical extractions of impacted teeth.
- Fillings:
  - For restoration of diseased or accidentally injured teeth.
  - Replacement fillings at least 12 months after the date the last restoration was provided or replaced.
  - General anesthetics, as medically necessary, in connection with oral or dental surgery.
  - Single crowns as a replacement for natural teeth which were extracted after the date coverage began.
  - Periodontic Treatment.
  - Endodontic Treatment.
  - Injectable drugs when prescribed by a dentist.
  - Consultations required by the attending dentist.
  - Repair or recementing of inlays or crowns at least 90 days after final installation.

- Relining or rebasing of fixed bridgework, but no more than once every 36 months after the initial installation or last date of repair.

- **Brush biopsy**

Major Restorative Treatment – 50% (UCR)

- Initial installation of fixed bridgework, including crowns and inlays as abutments, for replacement of natural teeth which were extracted while coverage is effective.
- Replacement of fixed bridgework under the following circumstances only:
    1. When replacement is necessitated by the extraction of additional teeth while coverage is effective.
    2. Replacement of existing bridgework which is at least five years old and cannot be made serviceable.
    3. Replacement of existing temporary bridgework by permanent bridgework within 12 months of initial installation of the temporary appliance.

- **Dentures and partials**
- **Full or partial denture repairs, including broken dentures, partial denture repairs (metal), and replacing missing or broken teeth**
- **Coverage is provided for replacement of an exisiting partial or full denture only if the existing denture is 60 consecutive months old and unserviceable**
- **No coverage is provided for replacement of a lost, missing or stolen prosthetic or for extra sets of dentures or other appliances**
- **Surgical implants**

Orthodontic Treatment – 50% (UCR)

- Dependent children must be at least six years of age but not more than 19 years of age when treatment begins.
- Any charges for appliances inserted prior to becoming insured will be eligible on a prorated basis following the effective date of coverage.

**b) Exceptions and Limitations**

There are no dental benefits available for claims resulting from the following:

- Dental treatment performed by any one who is not a licensed dentist, however a dental hygienist may perform services under the direct supervision of a dentist.
- Dental treatment for which the patient is entitled to payment by Workers' Compensation.
- Intentionally self-inflicted injury.
- Any injury resulting directly or indirectly from insurrection, war, service in the armed forces, participation in a riot or engaging in a criminal act.
- Charges by dentist for travel time, transportation cost, broken appointments, telephone advice, hospital calls, home calls, or completion of insurance forms.
- Cosmetic treatment unless such treatment results from accidental injury to natural teeth and treatment began within 90 days of the accident.
- Charges for services not meeting accepted standards of dental practices or experimental in nature.
- Charges for athletic mouth guards.
- Charges for the initial installation of a prosthesis replacing any natural teeth extracted before the date of coverage was effective.
- Charges for oral hygiene, dietary instruction, or plaque control problems.
- Charges for periodontal splinting.

- Charges for any service provided by any governmental agency, facility maintained by the patient's employer, or for which no charge would be made in the absence of dental insurance.
- Services and supplies rendered for full mouth restoration, orthaognathic surgery, or a correction of temporal mandibular joint dysfunction, unless occasioned by a life threatening situation.

**c) Usual, Customary and Reasonable Charge**
The Usual, Customary and Reasonable Charge (UCR) is the most common range of fees charged by providers of services of similar training and experience within a given area for services rendered.

This information is maintained by the Fair Health, Inc. (FAIR) and **is** updated **by Cigna** in **April** and **October** of each year. The maximum of the UCR range will be the 90th percentile of the FAIR ratings.

Any service or procedure requiring additional time, skill and experience due to unusual circumstances or complications will be reviewed by the insurance carrier.

When elective procedures are performed, you may find it helpful to check in advance to see if your provider's fees are within the UCR range. This will give you the opportunity to review the treatment and the extent of coverage prior to the time of the procedure.

The following steps can be taken by an employee to resolve specifically denied claims which exceed the established UCR ranges for services rendered outside the PPO network.

Step 1) Advise your provider that your claims administrator has denied total payment because the total billing exceeded the established "Usual, Customary and Reasonable" range for your geographical area. In many cases, your provider will adjust their billing to reflect only the "covered" expenses.

Step 2) If the provider involved refuses to adjust their charges, then you need to request that detailed description of the procedures/services rendered be submitted to the claims administrator for additional consideration. In some cases, the additional information will justify the excess charges which may have been legitimate covered expenses under the Plan but not identified on the initial claim.

Step 3) If this matter is still unresolved after completing Steps 1 and 2, then you need to discuss your specific problem with the *Claim Administrator* who will investigate and attempt to resolve the issue.

Step 4) Unresolved cases will be referred by the *Claims Administrator* to the Joint Employee Benefits Representative and management benefit representative for review. Both representatives will review your claim as an "exception" and work with you and your provider to try to resolve the matter.

Note: In cases where the employee and/or eligible dependents knowingly elect to incur expenses which are not covered by the existing Plan or which are identified to be above UCR ranges in advance, then the above procedures are not applicable. The additional charges will be the employee's and/or eligible dependents' expenses.

Pre-determination procedures should be followed in all cases of elective procedures/services in an effort to reduce potential problems.

**Exceptions to this policy are as follows:**

1. Patients following the pre-determination process and who are aware in advance of excessive charges.
2. Patients signing an agreement with the provider acknowledging their responsibilities for the full fee charged.
3. Patients paying the total fee charged will not be eligible for reimbursement.

**SECTION 8: Vision Plan (through 12/31/2016)**

Coverage for vision care benefits will apply to all eligible employees and their eligible dependents. Coordination of benefits will apply.

**a) Schedule of Benefits**

Vision Examinations

- No more than one examination every 12 months for refractions, including case history, coordination measurements, tests and prescribing corrective lenses.
- Examinations are subject to the following maximum benefits: Vision Exam - $80.

Prescription Lenses:

- Corrective lenses must be prescribed by an Ophthalmologist or Optometrist.
- No more than one pair of corrective prescription lenses **or** prescription sunglass lenses every 12 months.
- Lenses are subject to the following maximum benefits:

| Prescription Lenses | Benefit Allowances |
|---|---|
| Single | $ 75 |
| Bifocal | $ 105 |
| Trifocal | $ 129 |
| Lenticular | $ 162 |

In the event the patient selects lenses with any type of tinting or photocromic lenses, that cost will be the responsibility of the patient.

The frequency limitations noted will apply whether or not the prescription lenses, contact lenses, or frames are replacement of lost, stolen, or broken items.

Contact Lenses:

- Must be prescribed by an Ophthalmologist or Optometrist.
- Contact lenses prescribed following cataract surgery or to correct extreme visual problems that cannot be corrected with spectacle lenses are subject to a maximum benefit of $275.
- Contact lenses prescribed for other reason than noted above are subject to a maximum benefit of $100.
- The frequency limitation for lenses previously noted will apply.

Frames:

- Maximum benefit payable for frames is $90. No more than one set of frames each 24 months.

**b) Exceptions and Limitations**

- Benefits are not available for any lenses not requiring a prescription, including sunglasses**.**
- 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 examinations required as a condition of employment.

**SECTION 8: Vision Plan – (Additional Benefits Effective on or after 1/1/2017)**

Coverage for vision care benefits will apply to all eligible employees and their eligible dependents. Coordination of benefits will apply. **There are many benefits to visiting Blue View Vision providers, including discounts (from 20%-50%) for many eyeglass upgrades and a second pair of glasses.**

**a) Schedule of Benefits**

**Vision Examinations:**

- No more than one examination every 12 months for refractions, including case history, coordination measurements, tests and prescribing corrective lenses.
- Examinations are subject to the following maximum benefits: Vision Exam - $80. **There is a $0 co-payment when visiting a Blue View Vision provider.**

**Prescription Lenses:**

- Corrective lenses must be prescribed by an Ophthalmologist or Optometrist.
- No more than one pair of corrective prescription lenses or prescription sunglass lenses every 12 months.
- Lenses are subject to the following maximum benefits:

| Prescription Lenses | Benefit Allowances for Blue View Vision Out-of-network providers | Member costs with Blue View Vision In-network providers |
|---|---|---|
| Single | $ 75 | **$0** |
| Bifocal | $105 | **$0** |
| Trifocal | $129 | **$0** |
| Lenticular | $162 | **$0** |

In the event the patient selects lenses with any type of tinting or photocromic lenses, that cost will be the responsibility of the patient.

The frequency limitations noted will apply whether or not the prescription lenses, contact lenses, or frames are replacement of lost, stolen, or broken items.

**Contact Lenses:**

- Must be prescribed by an Ophthalmologist or Optometrist.
- Contact lenses prescribed following cataract surgery or to correct extreme visual problems that cannot be corrected with spectacle lenses are subject to a maximum benefit of $275.
- Contact lenses prescribed for other reason**s** than noted above are subject to a maximum benefit of $100 **out-of-network and $180 in-network.**
- The frequency limitation for lenses previously noted will apply.

**Frames:**

- Maximum benefit payable for frames is $90 **out-of network and $165 in-network**. No more than one set of frames each 24 months.

**b) Exceptions and Limitations**

- Benefits are not available for any lenses not requiring a prescription, including sunglasses.
- 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 examinations required as a condition of employment.

## SECTION 9. Employee Assistance Program (EAP)

From time to time, everyone has a personal concern that is difficult to handle. In fact, health care experts estimate that tens of millions of American workers suffer from problems such as marital and family stress, legal and financial difficulties, and alcoholism and drug abuse. Experts also agree, however, that most of these problems can be resolved successfully if they are identified and treated in the early stages before they get out of hand.

The EAP is completely free to you and your family members; the Company pays the full cost. The program provides up to five visits of confidential assistance for a variety of personal concerns including:

- Emotional distress
- Marital problems
- Family matters
- Alcohol and substance abuse
- Job worries
- Stress
- Financial concerns, and
- Other personal problems that affect your ability to enjoy life and perform your job well.

### a) How the EAP Works

The EAP is a private counseling service designed to help you and your family find the right help at the right time. Whenever you or your dependents have difficulty solving a personal problem, you can call the EAP and receive professional, confidential help. The EAP's goal is to help you resolve your concern so you can return to your normal, productive life as soon as possible.

When you or your dependents need help with a personal concern, all you have to do is call the EAP's toll free number: 800-395-1616. will assist you in getting the appropriate help. The first step is to pick up the phone and call the EAP. You can call 24 hours a day, 365 days a year.

When you call, an EAP counselor will help you by:

- Identifying your concerns,
- Arriving at realistic alternatives, and
- Working with you to outline a plan of action.

You will be offered an appointment with an EAP counselor; the appointment will scheduled within three working days, or immediately in a crisis situation.

Because every individual has unique needs, your EAP counselor will work with you to develop a plan tailored to your situation. Most problems can be clarified in one to five sessions. You will come away from these sessions with a plan of action to resolve your problem. This strategy may include further counseling sessions with an EAP approved mental health professional and/or community resource.

If you do need additional help (after the five free sessions) you will be referred to the POS network of providers. At that time you would utilize your Health Care Benefits.

Keep in mind that because the EAP is an independent counseling firm, program contacts are confidential. In fact, even a simple call to find out more about the Program is private.

**SECTION 10. General Claim Information**

If you use in-network providers, claims will automatically be filled for you and paid to your provider.

When you seek services out-of network, you may need to file a claim if the provider declines. When you file an out-of-network claim you should complete the required employee portions of the claim form and attach itemized bill indicating the patient's name, diagnosis, and date of service, charge, and nature of treatment. A separate claim form is needed for each patient incurring expenses. Out-of-network claims are paid directly to you and you are responsible to pay the provider.

In the event of your death prior to all benefits being paid, remaining benefits may be paid to a relative or your estate.

*Health and dental claims must be filed within two years from date of treatment, or no benefit is payable*.

Weekly disability claims must be filed within **30** days of the **incident or injury in order to be accepted and processed for payment**.

Should an insurance claim be paid in error or overpaid, you will receive written notice that a refund is due the carrier. Should you fail to make full repayment of this refund, the carrier may deduct this overpayment from future claims or may request the Company to make a payroll deduction in order to repay the overpayment.

If in its judgment, the Company considers it advisable and in the interest of the employee, alternative arrangements may be made to provide all or part of the benefit coverages through carriers designated by the Company.

**SECTION 11. Coordination of Benefits**

When both you and your spouse are working, members of your family could be covered under more than one group medical (or dental and vision) Plan. For this reason, most group Plans include a coordination of benefits (COB) provision to eliminate duplicate payments. This means the total amount paid under all Plans will not exceed 100% of your actual expenses.

In addition to a spouse's group medical (or dental and vision) plan, coordination of benefits also applies to any type of group health coverage (whether insured or not) and motor vehicle no-fault coverage. Coordination of benefits does not apply to any individual policy you may have.

These guidelines determine which group medical (or dental and vision) plan pays benefits first.

- The plan covering a person as an employee pays first. This means the Volvo Medical Plan is your primary plan, and your spouse's plan is his or her primary plan.
- For a dependent child of married parents, the plan of the parent whose birthday falls earlier in the year pays first. If you and your spouse have the same birthday, the plan covering either you or your spouse for the longer period pays first.
- For a dependent child of a separated or divorced parent, the rules are determined in this order:
- The plan of the parent who is responsible for the child's health expenses pays first, or
- The plan of the parent with custody pays first, or
- The plan of the stepparent with custody pays first, or
- The plan of the parent without custody pays first, or
- Your no-fault auto insurance plan pays first.

When your Volvo coverage is secondary, it is recommended that you send the payment worksheet showing any other insurance payment to the Claims administrator for more prompt processing.

***SECTION 12. Continuation of Benefits after Retirement, Death, Termination of Employment, Disability, Leave of Absence or Layoff***

***a) Benefit Entitlements Resulting from Retirement***

1) Core Employees

**Eligibility:**
Future retirees (not including deferred vested future retirees): employees whose seniority dates precede February 1, 2005, and who retire after March 17, 2008, as well as their spouses and eligible dependents.

Future surviving spouses: surviving spouses of pension eligible employees whose seniority dates precede February 1, 2005, and who die(d) on or after March 17, 2008, as well as their eligible dependents.

Hereinafter, future retirees and future surviving spouses collectively shall be referred to as "Retiree Participants".

**Coverage:**
Volvo Group North America, LLC will continue coverage under the Volvo-UAW health, dental, and prescription drug programs ("the Volvo Plan") for Retiree Participants, for the duration of this Agreement.

1. **Coverage: There are only three (3) retiree medical plans available to eligible New River Valley-UAW retirees and participation in each plan is determined by the employee's date of retirement (or date of death for active employees who are retiree eligible). The three (3) retiree medical plans available to the eligible retirees referenced in #1 above are as follows:**

    a. **Pre 02/01/2005 Plan of Benefits**

        i. **Covers employees (to include surviving spouses and eligible dependents) who retired prior to February 1, 2005.**

    b. **Post 02/01/2005 Plan of Benefits**

        i. **Covers employees (to include surviving spouses and eligible dependents) who retired on or after February 1, 2005 but prior to March 17, 2008.**

    c. **Post 03/17/2008 Plan of Benefits**

        i. **Covers all eligible employees (to include surviving spouses and eligible dependents) who retire on or after March 17, 2008.**

2. **All eligible future retirees (to include surviving spouses and eligible dependents) will be subject to the post 03/17/2008 Plan of Benefits for health, dental and prescription drugs.**

**Cost:**
The Company will pay the cost of continued coverage under the Volvo Plan for Retiree Participants in an amount not to exceed an average cost per Retiree Participant of $13,606 per calendar year for non-Medicare eligible Retiree Participants. For Retiree Participants who become eligible for Medicare under the Social Security Act, the Volvo Plan shall supplement Medicare. The Company will pay the cost of Medicare supplemental coverage for each Medicare-eligible Retiree Participant in an amount not to exceed an average cost per Retiree Participant of $3,292 per calendar year. In calculating the average cost per participant for Medicare-eligible Retiree Participants, the Company shall subtract from gross claims a pro rata share of the estimated amount of the Medicare Part D subsidy. In accordance with the February 1, 2005, Collective Bargaining Agreement, the Company established a Trust Fund in compliance with IRC section 501(c)(9) ("the VEBA Trust") and contributed the sum of $3,943,000.00 to the Trust. The assets of the VEBA Trust, including the above-described contributions and all earnings net of expenses

and distributions, shall continue to be held and used for the purpose of paying all costs incurred by Retiree Participants under the Volvo Plan that exceed the limits set forth above. If the cost of non-Medicare coverage and/or Medicare supplemental coverage for a calendar year is projected to exceed the limits set forth above and exhaust the VEBA Trust, the Company and the Union will meet to develop changes to the Volvo Plan as it applies to each group which will reduce the average cost per participant projected for the following year below the applicable limitation. If the Union is unwilling to meet or if the parties are unable to reach agreement on plan changes that will reduce the projected cost below the applicable limitation, the Company will charge each Retiree Participant a monthly contribution for each covered participant (including the retiree, spouse, surviving spouse, and eligible dependents) equal to one-twelfth (1/12) of the average cost per participant in excess of the applicable limitation (net of costs in excess of the limitation paid out of the VEBA Trust to/for the benefit of Retiree Participants) incurred in the preceding calendar year; provided that no Retiree Participant shall be required to pay monthly contributions for more than two participants (including himself/herself) to continue coverage for his/her spouse and all eligible dependents.

Life insurance (basic & optional), survivor income benefits, and accidental death and dismemberment insurance coverage will cease on the last day of the month in which you last work. You have 31 days following the termination of your group life insurance coverages to convert/port your coverages to non-group coverages, if eligible. Human Resources will provide the appropriate information and forms for you to exercise any conversion and/or portability rights. AD&D coverage and survivor income benefits are not convertible.

Weekly indemnity benefits and extended disability benefits will cease as of the last day worked.

2) **Competitive Employees**

**Health, dental, vision, life insurance (basic & optional), survivor income benefits, and accidental death and dismemberment insurance coverage will cease on the last day of the month in which you last work. You will have a right to elect COBRA coverage for plans subject to COBRA. You have 31 days following the termination of your group life insurance coverages to convert/port your coverages to non-group coverages, if eligible. You will be provided the appropriate information and forms for you to exercise any COBRA, and conversion and/or portability rights. AD&D coverage and survivor income benefits are not convertible.**

**Weekly indemnity benefits and extended disability benefits will cease as of the last day worked.**

**b) Benefit Entitlements for a Surviving Spouse of an Active Employee**

If you die after becoming eligible for health care coverage, your surviving spouse and eligible dependents will continue to be covered under the health care and prescription drug programs for the duration of this agreement. For the first twelve (12) months following the death of the employee, the Company will pay the full cost of health and prescription drug coverages. Thereafter, this coverage will be extended provided the spouse **of a Competitive employee is receiving transition benefits or the spouse of a Core employee** is receiving transition, bridge or survivor pension benefits, and contributes at the group premium rate. At age 65, the Volvo health care plan becomes a supplement to Medicare.

Dental and vision coverages (if applicable) will cease as of the last day of the month in which your death occurs.

Once your surviving spouse no longer qualifies as stated above, your spouse may exercise his/her Federal COBRA rights, which allow continuance of your health, dental, vision, and prescription drug coverages for an additional period by paying the group premium rates in effect at the time of death. Additional information concerning COBRA is outlined in SECTION 13 and your spouse may also contact Human Resources for information regarding the appropriate forms.

Human Resources will also provide the appropriate forms for your spouse to exercise the portability rights of his/her Optional Life insurance, if any. Optional AD&D coverage i**s** not convertible**.**

**c) Benefit Entitlement Resulting from Termination of Employment**

Weekly indemnity benefits and extended disability benefits will cease as of the last day worked.

Health, dental, vision, prescription drug, life, survivor income benefits, and accidental death and dismemberment insurance coverage will cease on the last day of the month in which you last work.

You have 31 days following the termination of your coverage to convert your basic life insurance to a non-group, individual life policy and apply for portability for any optional life insurance you may carry on you or your dependents, if eligible. Human Resources will supply you with the necessary information and forms if you wish to exercise this privilege.

You have the right to exercise your Federal COBRA rights, which allow you to continue your group health, dental, vision, and prescription drug coverage for an additional period of time by paying the group premium rates. Additional information concerning COBRA, see SECTION 13. Please contact Human Resources for more information about the appropriate forms.

There are no conversion privileges for any AD&D insurance coverages, survivor income benefits, weekly indemnity, or extended disability benefits.

**d) Benefit Entitlements for Disabled Employees**

All Company-paid insurance coverages will continue with Volvo making the full contributions for any period in which the employee continues to be eligible to receive either weekly indemnity benefits or extended disability benefits. Volvo may periodically require documentation of continued disability.

Optional life insurance coverage remains effective for you during your weekly indemnity or extended disability period as long as you continue to pay the required premiums. Optional life coverage for your dependents ends after one year of disability. If you discontinue your optional life coverage, you have the right to port the coverage if you do so within 31 days of your coverage ending. Human Resources will supply you with the appropriate forms. AD&D coverage ends after one year of disability with no conversion.

If you remain disabled at the expiration of the weekly and extended disability benefits, you have the right to exercise your Federal COBRA rights which allow you to continue your health, dental, vision, and prescription drug coverages for an additional period **of time by** paying the group premium rates. Additional information concerning COBRA is included in SECTION 13. You can contact Human Resources for more information on the appropriate forms.

You have 31 days following the termination of your group life insurance coverage (basic and/or optional) to convert/port your coverage to a non-group policy. Weekly indemnity benefits and extended disability benefits will cease as of the last day worked.

**e) Benefit Entitlement as the result of Leave of Absence**

Weekly indemnity and extended disability benefits will cease as of the last day of month following the month in which the employee last worked.

The employee may elect to continue optional life and AD&D insurance coverage at the rate then in effect, provided seniority is not broken (See Human Resources for rate information). When the employee is no longer eligible to continue group life coverage, the employee may exercise the conversion/portability rights if he/she does so within 31 days of termination of coverage.

Your health, dental, vision, and prescription drug coverages will cease as of the last day of the month following the month in which you last worked. You have the right to exercise your Federal COBRA rights, which allow you to continue your health, dental, vision, prescription drug coverages for an additional period with your paying the group premium rate. Additional information concerning COBRA is included in SECTION 13. You can contact Human Resources for more information on the appropriate forms.

**f) Benefit Entitlements as the Result of Permanent Layoff –Core Employees**

Weekly indemnity benefits and extended disability benefits will cease as of the last day worked.

Dental and vision benefits will cease as of the last day of the month following the month in which layoff occurs. You may then exercise your Federal COBRA continuation rights.

Company-paid Life, survivor income benefits, and AD&D insurance coverages will continue based on the Schedule contained within this section, at no cost to the employee. After this period, you may exercise your conversion rights within 31 days of termination of life insurance coverage. Human Resources will supply you with the necessary information and forms if you wish to exercise this privilege.

Survivor income benefits and AD&D coverage are not convertible.

Optional Life and AD&D coverages end at the end of the month in which layoff occurs. You have the right to exercise your portability rights on your optional life insurance coverage within 31 days of coverage termination. Optional AD&D coverage is not convertible. Human Resources will provide you with the necessary information and forms to exercise your portability rights.

Health and prescription drug coverages will continue during permanent layoff based on the schedule below at no cost to the employee.

| Years of Seniority at Layoff | Maximum number of Months |
|---|---|
| Less than 1 | 0 |
| 1 but less than 2 | 6 |
| 2 or more | 12 |

After this period, you have the right to exercise your Federal COBRA rights, which allow you to continue your health and prescription drug coverages for an additional period with your paying the group premium rate. Additional information concerning COBRA is included in SECTION 13. You can contact Human Resources for more information on the appropriate forms

When the employee returns to active work following a layoff, all insurance coverages will become effective immediately.

For an employee on temporary layoff, as defined by the collective bargaining agreement, all benefits will continue at no cost to the employee.

**g) Benefit Entitlements as the Result of Temporary or Permanent Layoff – Competitive Employees**

**Weekly indemnity benefits and extended disability benefits will cease as of the last day worked.**

**Medical, prescription drug, dental and vision benefits will continue to the end of the month following the month in which the layoff occurs. During this period, employees are not required to pay weekly contributions, nor will they be required to make them up if they return to work. If coverage terminates, normal COBRA rules will apply.**

**Company-paid Life, survivor income benefits, and AD&D insurance coverages will continue to the end of the month following the month in which the layoff ocurrs, at no cost to the employee. After this period, you may exercise your conversion rights within 31 days of termination of life insurance coverage. Human Resources will supply you with the necessary information and forms if you wish to exercise this privilege.**

**Survivor income benefits and AD&D coverage are not convertible.**

**Optional Life and AD&D coverages end at the end of the month in which layoff occurs. You have the right to exercise your portability rights on your optional life insurance coverage within 31 days**

**of coverage termination. Optional AD&D coverage is not convertible. Human Resources will provide you with the necessary information and forms to exercise your portability rights.**

**When the employee returns to active work following a layoff, all insurance coverages will become effective immediately.**

**h) Benefit Entitlements as the Result of Military Leave**

**Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), an employee who is out on a military leave of absence will retain their health insurance coverage (including medical, prescription drug, dental and vision coverage) for the first 31 days of uniformed service. Employees on military leave of absence which extend beyond 31 days will be eligible for COBRA benefits for up to 24 months. The company will subsidize the cost of COBRA benefits for two months, reducing the cost to the same level active employees pay.**

**The maximum period of coverage for the employee and the employee's dependents under such an election shall be the lesser of:**

**(1) the 24-month period beginning on the date on which the employee's absence begins; or**

**(2) the day after the date on which the employee was required to apply for or return to a position of employment in accordance with USERRA.**

**An employee who elects to continue Medical, Prescription Drug, Dental and Vision coverage in accordance herewith will be required to pay the cost of coverage under the Plan.**

**All life insurance for the employee and enrolled dependents as well as short term disability and long-term disability for the employee will be continued for 12 weeks after the employee begins leave to enter active service with the armed services, subject to the provisions of USSERA set forth in U.S.C.S. 4301 et seq. Payment for supplemental coverage must be made to the Company.**

**SECTION 13. COBRA Continuation Rights** (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 **Conexis**. **Conexis** can be reached at 1-**888-678-4881**.

**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 your local Human Resources Department. You may be required to provide proof of your qualifying event to Human Resources when you provide notice of that event. Human Resources will notify **Conexis**, who is under contract with the Company to administer COBRA. **Conexis** can be reached at 1-**888-678-4881.** 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 coverage 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 Human Resources or **Conexis** 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 (i.e., Part 5.A.) 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 Requirements**

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 your Human Resources Department.

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 your Human Resources Department 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 your Human Resources Department 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 your Human Resources Department.

**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.

**g) Termination of COBRA Continuation Coverage**

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.

**h) 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.

**i) If You Have Questions**

If you have questions about your COBRA continuation coverage, you should contact your Human Resources Department at:

540-674-7464
4881 Cougar Trail Road
P.O. Box 1126
Dublin, VA 24084

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 14. Claims Review Procedure**

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. Claim forms are available from your Human Resources Department.

Your claim and appeal rights as described herein may be asserted on your behalf by your authorized representative.

The law allows a reasonable amount of time for the Plan Administrator to evaluate a claim and to decide whether to pay benefits based on the information contained in the written claim.

In the event you or your authorized representative fail to follow the plan's procedures for filing a claim, the Plan shall notify you or your representative of the failure and the proper procedures to be followed in filing the claim as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by you or your authorized representative.

**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 Medical Claim Denial**

**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 You 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; and**
- **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.**

- **the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist You**

**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 on 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."**

**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, 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 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.**

**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.**

**You may request assistance from your Local UAW representative to help you with the appeal process. Members may designate a representative to speak for them by completing a "Designation of Representation Form" (available from Anthem). This form is required due to HIPAA privacy laws.**

**d) Appeal of Disability or Life Insurance 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. **You may request assistance with your appeal from your Local UAW representative.**

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. **A full review of the information will be conducted utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to 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 may 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. If a consultation is requested, 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.

**e) Timing of Notification on Appeals**

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 **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 ~~60~~ **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. **However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.**

**f) 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 **any** voluntary appeal procedures 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.

The Plan shall not assert that you have failed to exhaust administrative remedies if you do not elect to submit a benefit dispute to any additional voluntary appeal provided herein.

The Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such additional voluntary appeal is pending.

**g) Additional Benefits Assistance**

**If you have a benefits claim issue that is not addressed by the appeals processes defined in the previous paragraphs of this Section, you may request assistance from your Local UAW representative who will discuss your claim with representatives from Volvo. If these discussions do not result in settlement of your claim, your Local UAW representative may request assistance from the Heavy Trucks Department of the UAW. Volvo will furnish any requested information about your claim.**

**The Heavy Trucks Department may request a meeting with Volvo representaives to discuss the claim. All issues discussed will be based on the legal documents that govern the plan under which the claim was made.**

**If this meeting does not resolve the claim and , in the opinion of the Union, the denial of the claim violates any provision of the plans, the Union may request that an impartial arbitrator determine the claim appeal. The arbitrator will base his or her decision on the provisions of the legal documents of the plan. The arbitrator's decision will be the controlling and final authority.**

## SECTION 15. Administrative Information

**Plan Name**
The official name of the Plan is the Volvo Welfare Benefits Plan. Article III of this Benefits Agreement highlights the welfare benefits for the New River Valley Union Employees.

**Plan Type**
This plan is a welfare benefits plan.

**Plan Sponsor and Plan Administrator**
Volvo Group North America, LLC
PO Box 26115
Greensboro, NC 27409-26
(226) 393-2000

**Employer Identification Number**
58-2431188

**Plan Number**
506

**Plan Year**
The plan year is January 1 to December 31

**Agent for Service of Legal Process**
For disputes arising under the plan, services of legal process can made upon the Plan Administrator.

## SECTION 16: Your Rights Under ERISA

As a participant in the Volvo Welfare Benefits Plan for the New River Valley Union Employees, 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 Volvo, 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.

# APPENDIX C

## SUPPLEMENTAL UNEMPLOYMENT BENEFIT PLAN

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# APPENDIX C

## SUPPLEMENTAL UNEMPLOYMENT BENEFIT PLAN

## ARTICLE I – PLAN SUMMARY

### SECTION 1. Effective Date of Plan

This amended Agreement shall become effective on March *17, 20**16**.*

### SECTION 2. Obligation During Term of Agreement

During the term of this Agreement, neither the Company nor the Union shall request any change in, deletion from, or addition to the Plan, or this Agreement; or be required to bargain with respect to any provision or interpretation of the Plan or this Agreement, and during such period no change in, deletion from, or addition to any provisions, or interpretation, of the Plan or this Agreement, shall be an objective of, or a reason or cause for, any action or failure to act, including, without limitation, any strike, slowdown, work stoppage, lockout, picketing, or other exercise of economic force, or threat thereof, by the Union or the Company.

### SECTION 3. Term of Agreement: Notice to Modify or Terminate

This Agreement shall remain in full force and effect without change until *March 16, 20**21***. As of that date, this Agreement may be terminated, modified, changed, or continued, subject to and in accordance with the provisions of the Collective Bargaining Agreement of which this Agreement is a part.

Anything herein which might be construed to the contrary notwithstanding, however, it is understood that termination of this Agreement shall not have the effect of automatically terminating the Plan. Any notice under this Section shall be in writing and shall be sufficient, if to the Union, if sent by mail addressed to International Union, UAW, Heavy Truck Department, 8000 East Jefferson Avenue, Detroit, Michigan 48214, or to such other address as the Union shall furnish to the Company in writing; and if to the Company to the Attention: Human Resources Director, New River Valley Plant, Volvo Trucks North America, 4881 Cougar Trail Road, Dublin, Virginia 24084 or to such other address as the Company shall furnish to the Union in writing.

### SECTION 4. Governmental Rulings

a) The Plan provided for in this amended Agreement and incorporated in Appendix C hereof shall be subject to subsequent receipt by the Company of rulings from the United States Internal Revenue Service and the United States Department of Labor, satisfactory to the Company that:

   1. Benefits paid are not treated as “wages” for purposes of the Federal Unemployment Tax, the Federal Insurance Contributions Act Tax, or Collection of Income Tax at Source on Wages, under Subtitle C of the Internal Revenue Code; and

   2. no part of any payments made by the Company under the Plan are included for purposes of the Fair Labor Standards Act in the regular rate of any Employee.

b) Notwithstanding any other provisions of this Agreement or the Plan, the Company, with the consent of the Assistant Director of the UAW Heavy Trucks Department of the Union, may, during the term of the Agreement, make revisions in the Plan not inconsistent with the purposes, structure, and basic provisions thereof which shall be necessary to obtain or maintain any of the rulings referred to in subsection (a) of this Section 5. Any such revisions shall adhere as closely as possible to the language and intent of provisions outlined in Appendix C.

# ARTICLE II - ELIGIBILITY FOR BENEFITS

**SECTION 1. Eligibility for a Regular Benefit**

An employee shall be eligible for a Regular Benefit for any Week beginning on or after March *17, 20**16***, if with respect to such week he:

a) was on a qualifying layoff, as described in Section 3 of this Article, for all or part of the Week;

*b)* had at least one Year of Seniority as of his last day worked prior to qualifying layoff;

c) did not receive an unemployment benefit under any contract or program of another employer (and was not eligible for such benefit under a contract or program of another employer with whom he has greater seniority than with the Company);

d) was not eligible for an Automatic Short Week Benefit;

e) qualifies for a Benefit of at least $2;

f) has made a Benefit application in accordance with procedures established by the Company hereunder.

**SECTION 2. Eligibility for an Automatic Short Week Benefit**

a) An employee shall be eligible for an Automatic Short Week Benefit for any Week if:

1. during such Week he had less than 40 compensated or Available Hours and
   i. he performed some work for the Company, or
   ii. for such Week he received some jury duty pay, bereavement pay or military pay from the Company, or
   iii. for such Week, he received only holiday pay from the Company and, for the immediately preceding Week, he either received an Automatic Short Week Benefit or had 40 or more Compensated or Available Hours. **When the Company determines that a temporary shutdown week is required for such week in which a holiday falls, the Parties will move the holiday to another mutually agreed upon date. In this case, employees will be eligible for benefits under the Supplemental Unemployment Benefits Plan, Appendix C, Article III, Section 1.**

2. he had a least 1 Year of Seniority as of the last day of the Week (or during some part of such Week he had at least 1 Year of Seniority and broke Seniority by reason of death or of retirement under the provisions of the New River Valley Plant Hourly-Rate Employees Pension Plan);

3. he was on a qualifying layoff, as described in Section 3 of this Article, for some part of the Week, or he was ineligible as defined under the Collective Bargaining Agreement for pay from the Company for all or part of a period of jury duty, bereavement or short-term active duty of 30 days or less because he was called to active service in the National Guard by state or federal authorities in case of public emergency during the Week and during all or part of such period he would otherwise have been on qualifying layoff under this Plan.

b) No application for an Automatic Short Week Benefit will be required of an Employee. However, if an Employee believes himself entitled to an Automatic Short Week Benefit for a Week which he does not receive on the date when such Benefits for such Week are paid, he may file written application therefore within 30 calendar days after such date.

c) An Automatic Short Week Benefit payable for a Week shall be in lieu of any other Benefit under the Plan for that Week.

**SECTION 3. Conditions with Respect to Layoff**

a) A layoff for the purposes of the Plan includes any layoff resulting from a reduction in force or temporary layoff, or from the discontinuance of a Plant or operation, or a 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 Plan purposes only if:

1. such layoff was from the Bargaining Unit;

2. such layoff was not for disciplinary reasons, and was not a consequence of:

   i. any strike, slowdown, work stoppage, picketing (whether or not by Employees), or concerted action, at a Company Plant 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 Plant or Plants or elsewhere,

   ii. any fault attributable to the Employee,

   iii. any war or hostile act of a foreign power (but not government regulation or controls connected therewith),

   iv. sabotage or insurrection, or

   v. any act of God; provided, however, this subsection (v) shall not apply to the first 2 Weeks of layoff resulting from such cause;

3. with respect to such Week the Employee did not refuse to accept work when recalled pursuant to the Collective Bargaining Agreement and did not refuse an offer by the Company of other available work which he had no option to refuse under the Collective Bargaining Agreement;

4. with respect to such Week the Employee was not eligible for and was not claiming:

   i. any statutory or Company accident or sickness or any other disability benefit (except a benefit which he received or could have received while working full time, and except a lost time benefit which he received under a Workers' Compensation Law or other law providing benefits for occupational injury or disease, while not totally disabled and while ineligible for a sickness and accident benefit under the Insurance Program); or

   ii. any Company pension or retirement benefit; and

5. with respect to such Week the Employee was not in military service (other than short-term active duty of 30 days or less, including required military training, in a National Guard, Reserve or similar unit) or on a military leave.

c) If an employee is on short-term active duty of 30 days or less, for required military training, in a National Guard, reserve or similar unit and is ineligible under the Collective Bargaining Agreement for pay from the Company for all or part of such period solely because he would be on a qualifying layoff but for such active duty, he will be deemed to be on a qualifying layoff, for the determination of eligibility for not more than two Regular Benefits in a calendar year, provided, however, that this two Regular benefit limitation shall not apply to short-term active duty of 30 days or less because he was called to active service in the National Guard by state or federal authorities in case of public emergency.

d) If an Employee enters the Armed Services of the United States directly from the employ of the Company, the Employee shall while in such service be deemed, for purposes of the Plan, to be on leave of absence and shall not be entitled to any Benefit. This Section shall not affect the payment of Benefits to any Employee referred to in Section 3(c) of Article II.

e) An Employee who attempts to return to work from sick leave of absence or military leave on or after the effective date of this Plan and for whom there is no work available in line with the Employee's Seniority and who is placed on layoff status, shall be deemed to have been "at work" on or after the effective date of this Plan.

f) If, with respect to a Week, or with respect to any prior Week during the Employee's same continuous period of layoff from the Company, the Employee willfully misrepresents any material fact in connection with the Employee's application for Benefits under the Plan, the Employee shall be disqualified for Benefits for all Weeks of layoff thereafter during the same continuous period layoff from the Company.

## ARTICLE III –
## AMOUNT AND DURATION OF BENEFITS

**SECTION 1. Weekly Benefits**

**Regular Benefits**

| | **Weekly Benefit Amount** | **Duration** |
|---|---|---|
| Actively at Work<br>... as of March 17, 2011: | | |
| 10 or more years of service | $ 250 | 52 weeks |
| 1 to 9 years of service | $ 250 | 26 weeks |
| | | |
| Not Actively at Work<br>... as of March 17, 2011: | | |
| Recalled Thereafter | $ 250 | 26 weeks maximum |
| Newly Hired | $ 180 | 13 weeks maximum |

Employees who were actively at work **in a bargaining unit position at the NRV Truck Plant** on March 17, 2011 will be eligible for 26 Weeks of Regular Benefits if they have less than 10 Years of Seniority at the time of layoff or 52 Weeks of Regular Benefits if they have 10 or more Years of Seniority at the time of layoff.

Employees who were on layoff on March 17, 2011 and who are subsequently recalled to work will be eligible to earn up to 26 Weeks of Regular Benefits during the life of the Agreement at $250 per week.

Employees who are newly hired during the life of this Agreement will be eligible **for** 13 Weeks of Regular Benefits during the life of this Agreement at $180 per week.

**Employees hired on or after January 1, 2004 and on or before December 31, 2006 will be eligible for Supplemental Unemployment Benefits upon transition into Core status at the same level as those employees who were actively at work as of March 17, 2011 as indicated in the chart above.**

**SECTION 2. Automatic Short Work Week Benefits**

The automatic Short Week Benefit, payable to any eligible employee, shall be an amount equal to the product of the number by which 40 exceeds his Compensated or Available Hours, counted to the nearest tenth of an hour, multiplied by 80% of his Basic Hourly Rate.

An employee who breaks Seniority during a Week by reason of death or of retirement under the provisions of the New River Valley Plan hourly-Rate Pension Plan, and is eligible of an Automatic Short Week Benefit with respect to certain hours of layoff during the Week prior to the date his Seniority is broken, will receive an amount computed as provided in subsection 2(a) above based on the number by which the hours for which the Employee would regularly have been compensated exceeds his

Compensated or Available Hours with respect to that part of the Week prior to the date his Seniority is broken.

**SECTION 3. Benefit Overpayments**

a) If the Company or the Board determines that any Benefit(s) paid under the Plan should not have been paid or should have been paid in a lesser amount, written notice thereof shall be mailed to the Employee receiving the Benefit(s) and he shall return the amount of overpayment to the Company; provided, however, that no repayment shall be required if the cumulative overpayment is $3 or less or if notice has not been given within 120 days from the date the overpayment was established or created, except that no such time limitation shall be applicable in cases of fraud or willful misrepresentation.

b) If the Employee shall fail to return such amount of overpayment promptly:

    1. with respect to Benefits paid by the Company, the Company shall deduct from any future Benefits (not to exceed $20 from any one Benefit except in cases of fraud or willful misrepresentation) otherwise payable to Employee by the Company, or shall deduct from compensation payable by the Company to the Employee (not to exceed $30 from any one paycheck except in cases of fraud or willful misrepresentation), or both.

The Company is authorized to make the deductions from the Employee's compensation as provided under subparagraph (1).

**SECTION 4. Withholding Tax**

The Company shall deduct from the amount of any Benefit any amount required to be withheld by the Company by reasons of any law or regulation, for payment of taxes or otherwise to any federal, state, or municipal government. In determining the amount of any applicable tax entailing personal exemptions, the Company shall be entitled to rely on the official form filed by the Employee with the Company for purposes of income tax withholding on regular wages.

## ARTICLE IV –

## APPLICATION, DETERMINATION OF ELIGIBILITY, AND APPEAL PROCEDURES FOR BENEFITS

**SECTION 1. Applications**

a) Filing of Applications

An application for a Benefit may be filed either in person or by mail in accordance with procedures established by the Company. No application for a Benefit shall be accepted unless it is submitted to the Company within 30 calendar days after the end of the Week with respect to which it is made.

b) Application Information

Applications filed for a Benefit under the Plan will include:

    1. in writing any information deemed relevant by the Company with respect to other benefits received, earnings and the source thereof, dependents, and such other information as the Company may require in order to determine whether the Employee is eligible to be paid a Benefit and the amount thereof.

**SECTION 2. Determination of Eligibility**

a) Application Processing by Company

When an application is filed for a Benefit under the Plan and the Company is furnished with the evidence and information required, the Company shall determine the Employee's entitlement to a Benefit.

b) Notice of Denial of Benefits

If the Company determines that an Employee is not entitled to a Benefit, it shall notify him promptly, in writing, of the reason(s) for the determination.

c) Union Copies of Certain Applications, Determinations and Letters

The Company shall furnish promptly to a Union member of the Board of Administration a copy of all Company determinations of Benefit ineligibility or overpayment.

**SECTION 3. Appeals**

a) Applicability of Appeals Procedure

1. The appeals procedure set forth in this Section may be employed only for the purposes specified in this Section.

2. No question involving the interpretation or application of the Plan shall be subject to the grievance procedure provided for in the Collective Bargaining Agreement.

b) Procedure for Appeals

1. An Employee may appeal from the Company's written determination. Appeals shall be in writing and shall specify the respects in which the Plan is claimed to have been violated. In situations where a number of Employees had filed applications for Benefits under substantially identical conditions, an appeal may be filed with respect to one of such Employees, in accordance with procedures established by the Board, and the decision thereon shall apply to all such Employees.

2. The appeal shall be filed with the designated Company representative within 30 days following the date of mailing of the determination appealed. If the appeal is mailed, the date of filing shall be the postmark date of the appeal. No appeal will be valid after the 30-day period.

3. The handling and disposition of each appeal to the Board shall be in accordance with regulations and procedures established by the Board.

4. The Employee or the Union Members of the Board may withdraw any appeal to the Board at any time before it is decided by the Board, on a form provided for that purpose.

5. There shall be no appeal from the Board's decision. It shall be final and binding upon the Union, its members, the Employee, and the Company. The Union will discourage any attempt of its members to appeal and will not encourage or cooperate with any of its members in any appeal, to any Court or Labor Board from a decision of the Board, nor will the Union or its members by any other means attempt to bring about the settlement of any claim or issue on which the Board is empowered to rule hereunder.

c) Benefits Payable After Appeal

In the event that an appeal with respect to entitlement to a Benefit is decided in favor of the Employee, the Benefit shall be paid to him.

d) Special Definition of Employee

With respect to the appeal provisions set forth under this Section only, the term Employee shall include any person who received or was denied the Benefit in dispute.

# ARTICLE V - ADMINISTRATION OF THE PLAN

**SECTION 1. Powers and Authority of the Company**

a) Company Powers

The Company shall have such powers and authority as are necessary and appropriate in order to carry out its duties under this Article, including, without limitation, the following:

1. to obtain such information as the Company shall deem necessary in order to carry out its duties under the Plan;

2. to investigate the correctness and validity of information furnished with respect to an application for a Benefit;

3. to make initial determinations with respect to Benefits;

4. to establish reasonable rules, regulations and procedures concerning:

   i. the manner in which and the times and places at which applications shall be filed for Benefits, and

   ii. the form, content and substantiation of applications for Benefits.

   In establishing such rules, regulations and procedures, the Company shall give due consideration to any recommendations from the Board;

5. to designate an office or department, where Employees laid off from the Plant may appear for the purpose of complying with the Plan requirements;

6. to establish appropriate procedures for giving notices required to be given under the Plan;

7. to establish and maintain necessary records; and

8. to prepare and distribute, on behalf of the Company, information explaining the Plan.

b) Company Authority

Nothing contained in the Plan shall be deemed to qualify, limit or alter in any manner the Company's sole and complete authority and discretion to establish, regulate, determine, or modify at any time levels of employment, hours of work, the extent of hiring and layoff, production schedules, manufacturing methods, the products and parts thereof to be manufactured, where and when work shall be done, marketing of its products, or any other matter related to the conduct of its business or the manner in which its business is to be managed or carried on, in the same manner and to the same extent as if this Plan were not in existence; nor shall it be deemed to confer either upon the Union or the Board any voice in such matters.

c) Named Fiduciary

The Company's Board of Directors shall be the named fiduciary with respect to the Plan. They may delegate to various officers, employees and committees of the Company authority to carry out such of its responsibilities as it deems proper to the extent permitted by the Employee Retirement Income Security Act of 1974.

**SECTION 2. Board of Administration of the Plan**

a) Composition and Procedure

1. There shall be established a Board of Administration of the Plan consisting of 6 members, 3 of whom shall be appointed by the Company (hereinafter referred to as the Company members) and 3 of whom shall be appointed by the Union (hereinafter referred to as the Union members). Each member of the Board shall have an alternate. In the event a member is absent from a

meeting of the Board, his alternate may attend, and, when in attendance, shall exercise the power and perform the duties of such member. Either the Company or the Union at any time may remove a member appointed by it and may appoint a member to fill any vacancy among the members appointed by it. The Company and the Union each shall notify the other in writing of the members respectively appointed by it before any such appointment shall be effective.

2. The members of the Board shall appoint an Impartial Chairman, who shall serve as needed. If the members of the Board are unable to agree upon a Chairman, an arbitrator shall be selected by mutual agreement with the assistance and under the rules of the American Arbitration Association. The Impartial Chairman shall be considered a member of the Board and shall vote only in matters within the Board's authority to determine which the other members of the Board shall have been unable to dispose of by majority vote, except that the Impartial Chairman shall have no vote concerning determinations made in connection with Section 1(c)(8) of Article II (contrary to intent of Plan).

3. At least 2 Union members and 2 Company members shall be required to be present at any meeting of the Board in order to constitute a quorum for the transaction of business. At all meetings of the Board, the Company members shall have a total of 3 votes and the Union members shall have a total of 3 votes, the vote of any absent member being divided equally between the members present appointed by the same party. Decisions of the Board shall be by a majority of the votes cast.

4. The Board shall not maintain any separate office or staff, but the Company and the Union shall be responsible for furnishing such clerical and other assistance as its respective members of the Board shall require. Copies of all appeals, reports and other documents to be filed with the Board pursuant to the Plan shall be filed in duplicate, with 1 copy to be sent to the Company members at the address designated by them and the other to be sent to the Union members at the address designated by them.

b) Powers and Authority of the Board

1. It shall be the function of the Board to exercise ultimate responsibility for determining whether an Employee is eligible for a Benefit under the terms of the Plan, and, if so, the amount of the Benefit.

   The Board shall be presumed conclusively to have approved any initial determination by the Company unless the determination is appealed as set forth in Section 3(b) of Article V.

2. The Board shall be empowered and authorized and shall have jurisdiction to:

   i. hear and determine appeals by Employees;

   ii. obtain such information as the Board shall deem necessary in order to determine such appeals;

   iii. prescribe the form and content of appeals to the Board and such detailed procedures as may be necessary with respect to filing of such appeals;

   iv. direct the Company to pay Automatic Short Week Benefits or to pay other Benefits provided by this Plan pursuant to determinations made by the Board;

   v. prepare and distribute, on behalf of the Board, information explaining the Plan;

   vi. rule upon disputes as to whether any Short Work Week resulted from an act of God, as defined in Article VII*,* Section 2*;* and

   vii. perform such other duties as are expressly conferred upon it by the Plan.

3. In ruling upon appeals, the Board shall have no authority to waive, vary, qualify, or alter in any manner the eligibility requirements set forth in the Plan, the procedure for applying for Benefits

as provided for therein, or any other provision of the Plan; and shall have no jurisdiction other than to determine, on the basis of the facts presented and in accordance with the provisions of the Plan:

i. whether the appeal to the Board was made within the time and in the manner specified in Section 3(b) of Article *V;*

ii. whether the Employee is eligible for the Benefit claimed and, if so;

iii. the amount of any Benefit payable.

4. The Board shall have no jurisdiction to act upon any appeal filed after the applicable time limit or upon any appeal that does not comply with the Board-established procedures.

5. The Board shall have no power to determine questions arising under the Collective Bargaining Agreement, even though relevant to the issues before the Board. All such questions shall be determined through the regular procedures provided therefor by the Collective Bargaining Agreement, and all determinations made pursuant to the Agreement shall be accepted by the Board.

6. Nothing in this Article shall be deemed to give the Board the power to prescribe in any manner internal procedures or operations of either the Company or the Union.

**SECTION 3. Determination of Dependents**

In determining an Employee's Dependents for purposes of Regular Benefit determinations, the Company (and the Board) shall be entitled to rely upon the official form filed by the Employee with the Company for income tax withholding purposes, and the Employee shall have the burden of establishing that he is entitled to a greater number of withholding exemptions than he shall have claimed on such form.

**SECTION 4. To Whom Benefits are Payable in Certain Conditions**

Benefits shall be payable only to the eligible Employee except that if the Board shall find that the Employee is deceased or is unable to manage his affairs for any reason, any Benefit payable to him shall be paid to his duly appointed legal representative, if there be one, and, if not, to the spouse, parents, children, or other relatives or dependents of the Employee as the Board in its discretion may determine. Any Benefit so paid shall be a complete discharge of any liability with respect to such Benefit. In the case of death, no Benefit shall be payable with respect to any period following the last day of layoff immediately preceding the Employee's death.

**SECTION 5. Non-alienation of Benefits**

No Regular Benefit, Leveling Week Benefit or Alternate Benefit shall be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution or encumbrance of any kind other than an authorization for check-off of dues and any attempt to accomplish the same shall be void. In the event that the Board shall find that such an attempt has been made with respect to any such Benefit due or to become due to any Employee, the Board in its sole discretion may terminate the interest of the Employee in such Benefit and apply the amount of such Benefit to or for the benefit of the Employee, his spouse, parents, children, or other relatives or dependents as the Board may determine, and any such application shall be a complete discharge of all liability with respect to such Benefit.

**SECTION 6. Applicable Law**

The Plan and all rights and duties there under shall be governed, construed and administered in accordance with the laws of the State of Virginia.

## ARTICLE VI - FINANCIAL PROVISIONS AND REPORTS

**SECTION 1. Liability**

a) The provisions of these Articles I through VIII, together with the provisions of any Alternate Benefit plans established and maintained pursuant to this Plan, constitute the entire Plan.

b) Except as otherwise may be required by the Employee Retirement Income Security Act of 1974, the Board, the Company, and the Union, and each of them, shall not be liable because of any act or failure to act on the part of any of the others, and each is authorized to rely upon the correctness of any information furnished to it by an authorized representative of any of the others.

c) Notwithstanding the above provisions, nothing in this Section shall be deemed to relieve any person from liability for willful misconduct or fraud.

**SECTION 2. Cost of Administering the Plan**

a) Expense of the Board

The compensation of the Impartial Chairman, which shall be in such amount and on such basis as may be determined by the other members of the Board, shall be shared equally by the Company and the Union. Reasonable and necessary expenses of the board for forms and stationery required in connection with the handling of appeals shall be borne by the Company. The Company members and the Unions members of the Board shall serve without compensation.

## ARTICLE VII - MISCELLANEOUS

**SECTION 1. General**

a) Purpose of Plan

It is the purpose of this Plan in respect to payment of Regular Benefits to supplement State System Benefits and not to replace or duplicate them.

b) Receipt of Benefits

Except as required by applicable federal, state, and local laws, regular Benefits paid under the Plan shall be not considered a part of any Employee's wages for any purpose. No person who receives any Regular Benefit shall for that reason be deemed an employee of the Company during such period.

**SECTION 2. Effect of Revocation of Federal Rulings**

If any rulings which have been or may be obtained by the Company holding

a) that no part of benefits paid hereunder shall be included for purposes of the Fair Labor Standards Act in the regular rate of any Employee, shall be revoked or modified in such manner as no longer to be satisfactory to the Company, all obligations of the Company under the Plan shall cease and the Plan shall thereupon terminate and be of no further effect (without in any way affecting the validity or operation of the Collective Bargaining Agreement).

**SECTION 3. Amendment and Termination of the Plan**

a) So long as the Collective Bargaining Agreement, of which this Supplemental Unemployment Benefit Plan as amended is a part shall remain in effect, the Plan shall not be amended, modified, suspended, or terminated, except as may be proper or permissible under the terms of the Plan or the Collective Bargaining Agreement. Upon termination of the Plan, the Plan shall terminate in all respects.

## ARTICLE VIII - DEFINITIONS

As used herein:

1. "Active Employment Roll" - An Employee shall be deemed to be on the Active Employment Roll:
   a) while he is in Active Service,
   b) while he is on an authorized vacation,
   c) while he is on an authorized leave of absence (other than a sick leave) which is limited, when issued, to 90 days or less,
   d) during the first 90 days he is on a sick leave of absence,
   e) while he is on a temporary layoff,
   f) while he is on a disciplinary layoff, or
   g) while he is absent without leave up to 10 calendar days from his last day worked;
2. "Active Service" - An Employee is in Active Service in any Pay Period for which he draws pay;
3. "Bargaining Unit" means a unit of Employees covered by the Collective Bargaining Agreement;
4. "Base Hourly Rate" (excluding cost-of-living allowance and all other premiums and bonuses of any kind) means:
   a) with respect to a Regular Benefit, the Employee's straight-time hourly rate on his last day of work in the Bargaining Unit;
   b) with respect to an Automatic Short Week Benefit, the highest straight time hourly rate paid the Employee in the Bargaining Unit during the Pay Period in which the Short Work Week occurs;
   c) the Base Hourly Rate determined under (a) or (b) above, shall be adjusted to include:
      i. the amount of any applicable cost-of-living allowance in effect with respect to the Week for which the Benefit is paid; and
      ii. with respect to Benefits, the amount of any wage increase, if any, provided for in the Collective Bargaining Agreement which became effective (pursuant to the Collective Bargaining Agreement) after the day or period used to establish his Base Hourly Rate. In such event the amount of increase shall be the amount applicable to the job classification in which the Employee worked either on the day, or the last day of the period, for which his Base Hourly Rate was determined under (a) or (b) above. The Base Hourly Rate adjustment due to the increase shall be effective with respect to Benefits which may be payable for and subsequent to the Week in which such increase became or becomes effective;
5. "Benefit" means a regular Benefit, an Automatic Short Week Benefit, or any or both, as indicated by the context:
   a) "Automatic Short Week Benefit" means the benefit payable to an eligible Employee for a Short Work Week;
   b) "Regular Benefit" means the benefit payable to an eligible Employee for a Week of layoff in which he performed no work for the Company and for which he received no jury duty pay, bereavement pay, or military pay from the Company, or for which he received holiday pay from the Company if he was not eligible for an Automatic Short Week Benefit for such Week;
6. "Board" means the Board of Administration under the Plan;

7. “Collective Bargaining Agreement” means the currently effective collective bargaining agreement between the Company and Union which incorporates this Plan by reference;

8. “Company” means Volvo Trucks North America, New River Valley Plant;

9. “Compensated or Available Hours” for a Week shall be the sum of:

   a) all hours for which an Employee receives pay from the Company (excluding pay in lieu of vacation and any holiday pay paid for a Sunday) with each hour paid at premium rates to be counted as 1 hour; plus

   b) all hours scheduled for or made available to the Employee by the Company but not worked by him after having been given reasonable notice (including any period on leave of absence).

   c) all hours not worked by the Employee because of any of the reasons disqualifying the Employee from receiving a Benefit under subsections 3(b)(2) and 3(b)(4) of Article II; plus

   d) all hours not worked by the Employee which are in accordance with a written agreement between the Company and the Union or which are attributable to absenteeism of other Employees; plus

   e) with respect to an Employee on a three-shift operation on which less than 8 hour shifts of work are scheduled, or an Employee on any shift of work on which less than 40 hours of work per Week are regularly scheduled, a number of hours equal to the difference between such Employee’s regularly compensated hours during a Work Week and 40.

   Compensated or Available Hours will exclude any hours of overtime in excess of two hours that are either worked or made available subsequent to a layoff of Employees during the Week unless notice of intent to work overtime has been given to Employees by the Company prior to the layoff. Notice of intent to work overtime shall include without limitation either notice of the overtime schedule which would be applicable to the Employee or an offer of work to the Employee.

10. “Dependent” means a spouse or person recognized as a dependent under the Internal Revenue Code;

11. “Employee” means an hourly-rate employee;

12. “Plan” means the amended Supplemental Unemployment Benefit Plan as set forth in this Appendix C;

13. “Plant” means the location or locations in, or out of, which an Employee works;

14. “Seniority” means seniority status under the Collective Bargaining Agreement;

   a) “Break in Seniority” means any break in or loss of Seniority pursuant to the Collective Bargaining Agreement;

   b) “Years (or Year) of Seniority” means for all purposes of this Plan and for those purposes only, the longest Seniority an Employee has as an hourly employee at the New River Valley Plant.

15. “Short Work Week” means a Work Week during which an Employee has less than 40 Compensated or Available Hours and (a) during which he performs some work for the Company or (b) for which he receives some jury duty pay, bereavement pay or military pay from the Company, or (c) for which he receives only holiday pay from the Company (excluding any holiday pay period for a Sunday) and for the immediately preceding Week, he either received an Automatic Short Week Benefit or had 40 or more Compensated or Available Hours;

16. “Supplementation” means recognition of the right of a person to receive both a State System Benefit and a Regular Benefit under the Plan for the same Week of layoff at approximately the

same time and without reduction of the State System Benefit because of the payment of the Regular Benefit under the Plan;

17. "Union" means International Union, UAW, and its Local No. 2069;

18. "Week" when used in connection with eligibility for and computation of Benefits with respect to an Employee means:

    a) a period of layoff equivalent to a Work Week;
    b) a Short Work Week.

    "Week of Layoff" shall include any such Week; provided, however, that if there is a difference between the starting time of a Work Week and of a week under an applicable State System, the Work Week shall be paired with the State System week which corresponds most closely thereto in time; except that if an Employee is ineligible for a State System Benefit because of any of the reasons set forth in Section 1(c) of Article II (excluding the reasons under item (3) thereof) for the entire continuous period of layoff, the week under the State System shall be assumed to be the same as the Work Week. If an Employee becomes ineligible for a State System Benefit because of the reasons set forth in Section 1(c) of Article II, excluding item (3) thereof, during a continuous period of layoff, the week under the State System shall be assumed to continue to be, for the duration of the layoff period during which he remains so ineligible, the 7-day period for which a State System Benefit was last paid to the Employee during such continuous period of layoff. Each Week within a continuous period of layoff will not be considered a new or separate layoff. Notwithstanding the foregoing provisions of this definition, if an Employee is ineligible for a State System Benefit because of the reasons set forth in item (3) of Section 1(c) of Article II, the week under the State System shall be assumed to be the 7-day period which would have been used by the State System if the Employee had applied for a State System Benefit on the first day of partial or full layoff in the Work Week and had been eligible otherwise for such State System Benefits;

19. "Work Week" or "Pay Period" means 7 consecutive days beginning on Monday at the regular starting time of the shift to which the employee is assigned, or was last assigned immediately prior to being laid off.

Letter of Understanding
**March 17, 2016**
Updated and Revised

**Kenny Shepherd**
UAW Benefits Representative
Volvo Trucks – New River Valley

Re: SUB Benefit Payment Information

Dear **Kenny**,

This will confirm our agreement to provide the following information to you in your capacity as Benefits Representative for the UAW Bargaining Unit employees at the New River Valley Plan of Volvo Trucks North America.

Accordingly, we will provide you with the following reports on or before the fifteenth of the month following the month to which the report relates:

- A monthly report of the number and amount of Regular Benefits and Automatic Short Work Week Benefits paid during each week of the preceding month to employees who were on layoff.
- A monthly report of the number of employees on active status, the number of employees on temporary layoff status, and the number of employees on permanent layoff status as of the beginning of the preceding month.

In addition, we will provide you with written annual confirmation that the W-2s received by bargaining unit employees who received benefits during the preceding calendar year state the amount of SUB benefits paid and the taxes withheld from those benefit payments.

Sincerely,

**Gerald Shiffner**
Director, Human Resources
New River Valley Plant
Volvo Trucks North America

# APPENDIX D

**VOLVO GROUP NORTH AMERICA, LLC**
**VOLUNTARY INVESTMENT PRETAX (401K) PLAN**
**FOR VOLVO GROUP NORTH AMERICA UNION EMPLOYEES**
**AS REVISED FOR MARCH 17, 2016 THROUGH March 16, 2021**

**UAW AGREEMENT**

**SUMMARY PLAN DESCRIPTION**
**TABLE OF CONTENTS**

# ARTICLE I – INTRODUCING YOUR 401(K) PLAN BENEFITS

Volvo Group North America, LLC (the "Sponsor") maintains the Voluntary Investment Pretax Plan for Volvo Group North America Union Employees (the "Plan" or the "401(k) Plan") for the benefit of eligible employees and their beneficiaries.

*The 401(k) Plan makes saving for retirement easy. It is designed to help supplement your income from other sources, such as Social Security.*

Each year, the Company (as defined in the next paragraph) allows you to contribute part of your annual pay into a personal account. **For Competitive employees**, the Company matches a portion of your savings. 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 (including the vested portion of your Company Contributions) when you leave the Company and all affiliates for any reason.

Except as otherwise specified in this SPD, the term "Company" refers to Volvo Group North America, LLC

This booklet is the summary plan description ("SPD") for the Plan. It summarizes the provisions of the Plan as in effect on March 17, **2016** (as updated for certain Internal Revenue Code requirements). You may be subject to different rules if you terminated your employment before this 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 the 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 |
|---|---|
| *Pretax Contributions* | You can save from 1% to 75% of your Pay in the Plan. The **2016** limit on pre-tax contributions **is** $**18,000**. |
| *Catch-up Contributions* | If you are age 50 or older by the end of the year, you can contribute an additional amount on a pre-tax basis, up to $**6,000** in **2016** (subject to the 75% maximum contribution percentage). |
| ***Automatic Company Contributions*** | **For Competitive employees, the Company makes automatic contributions equal to 2% of your Pay, regardless of how much you contribute.** |
| ***Company Matching Contributions*** | **For Competitve employees, the Company matches 60% of the first 6% of Pay that you contribute each pay period. Together with Automatic Company Contributions, the Company contributes up to 5.6% of your Pay (2% Automatic + 3.6% Matching), as long as you contribute at least 6% of Pay.**<br><br>**Catch-up contributions are not eligible for Company Matching Contributions.** |
| *Choice of Investment Funds* | You determine how your Plan account is invested. You may change your investments by calling Mercer HR Services' toll-free number or by accessing their Internet site. |
| *Automatic Payroll Deductions* | It's easy to make 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. **If you are a Competitive employee hired on or after June 1, 2011, you are automatically enrolled after 30 days with a pre-tax election equal to 3% of your Pay, unless you elect otherwise.** |
| *Loans and Withdrawals* | Under certain circumstances, you may have access to your savings while you're still working for the Company. |
| *Quarterly Statements* | You will receive a statement each quarter 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), by contacting Mercer at 1-800-356-9240 or online at www.ibenefitcenter.com. |

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**

Participating in the 401(k) Plan is entirely up to you. You are eligible if you are employed by the Company and your benefits are subject to a collective bargaining agreement with the Company and the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW) and its Local 2069.

**SECTION 2. When Participation Begins**

You may begin participating in the Plan on the first day of the payroll period which begins in the month following the date you meet the eligibility requirements. 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 as of the first day of the payroll period which begins in the month following your return to work.

**SECTION 3. Enrolling in the Plan**

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 Mercer HR Services.

**If you were hired as a Competitive employee on or after June 1, 2011, unless you elect otherwise ("opt out") prior to automatic enrollment date, you will be automatically enrolled. Your automatic enrollment date is the first day of the first pay period that occurs on or after the 30th day following the later of:**

- **The date you became an eligible employee; and**
- **The date on which the Plan Administrator provided you with a notice of the Plan's automatic enrollment procedures.**

*You are eligible to join the 401(k) Plan beginning with the first payroll period after meeting the eligibility requirements.*

To enroll, **or opt of automatic enrollment**, you may call the Plan's toll free number at 1-800-356-9240 or go to the Plan's website at www.ibenefitcenter.com. 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 pretax dollars*
- *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.

**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 pretax contributions
- Company Matching Contributions **(for Competitive employees)**
- Automatic Company Contributions **(for Competitve employees)**
- Your rollover contributions (if any) and
- Investment growth.

*You may save from 1% to 75% of your annual pay in whole percentages on a pretax basis.*

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 www.ibenefitcenter.com 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's Smart Goal™ feature 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 pay, overtime pay, bonuses, shift differentials, and any other amounts paid to you through the Company's payroll system, excluding the amount of the subsequent award of back pay applicable to that period, or any amount that is payable on account of your termination of employment that would not be payable if you had continued employment (for example, severance or cashed out vacation pay). If the Company continues your salary for a period of qualified military service that lasts more than 30 days, that amount shall be included in your pay.

The amount of your Pay that can be taken into account each year is subject to a limit imposed by the IRS ($**265,000 in 2016**).

**SECTION 2. Your Pretax Contributions**

You may save from 1% to 75% – in whole percentages – of your Pay in the form of *pretax* contributions. If you are age 50, or will reach age 50 by the end of the year, you can contribute an additional amount on a pre-tax basis, up to $**6,000** in **2016**. 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 contributions can't exceed 75% of your Pay.

*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 pre-tax contributions cannot exceed an annual dollar limit ($**18,000** in **2016**).
- The maximum amount that can be contributed to your account each year – in the form of regular pre-tax contributions, **Automatic Company Contributions and Company Matching Contributions** – cannot exceed a dollar amount ($**53,000** in **2016**) or 100% of your compensation, whichever is less.
- 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.
- Your Pay that can be taken into account each year is subject to a limit ($**265,000** in **2016**).
- If you are age 50, or will reach age 50 by the end of the year, you can contribute an additional pre-tax amount each year in excess of the foregoing limits ($**6,000** in **2016**) 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 Plan's limits on contributions for the year. Your catch-up contributions plus your other before-tax contributions can't exceed 75% of your Pay. Your total pre-tax contributions (including catch-up contributions) can't exceed $**24,000** in **2016**.

These limits are adjusted from time to time by the government for changes in the cost of living.

***How Pretax Contributions Work.*** Pretax 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 pretax 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 pretax contributions do *not* reduce Social Security taxes or Social Security benefits.

**SECTION 3. Automatic Company Contributions**

**The Company makes automatic contributions for Competitve employees each pay period, in an amount equal to 2% of your Pay. Automatic Contributions are made commencing June 1, 2011, regardless of how much you choose to contribute to the Plan.**

**SECTION 4. Company Matching Contributions**

**To help your Plan account grow, the Company makes matching contributions on your behalf for Competitive employees commencing June 1, 2011. Generally, each pay period, the Company matches 60% (that is, 60 cents on the dollar) of your pre-tax contributions (excluding catch-up contributions) which do not exceed 6 percent of your Pay for such pay period. If you contribute at least 6% of your Pay to the Plan, the Company matching contribution is 3.6% of your Pay.**

***The Company may match up to the first 6% of Pay you contribute to the Plan each pay period.***

**Catch-up contributions 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 on a pre-tax basis to your account, you will want to 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.**

**SECTION 5. An Example of Your Plan Savings**

**Competitive Employees**

**Assume you're married with one child and decide to save 6% of your $36,400 pay, or $2,184, through the Plan. The following chart shows how your pre-tax contributions increase your spendable income.**

*Here's an example of the advantage of saving on a pre-tax basis as opposed to saving through an ordinary bank account:*

| | Pre-Tax Savings Through the Plan | Saving Outside the Plan |
|---|---|---|
| Pay | $36,400 | $36,400 |
| Pre-Tax Savings | - 2,184 | - 0 |
| Taxable Income | $34,216 | $36,400 |
| Federal Income Tax* | - $947 | - $1165 |
| Post-Tax Savings (6%) | - 0 | - 2,184 |
| Spendable Income | $33,269 | $33,051 |
| Immediate Gain Through Tax Savings | $ 218 | $ 0 |
| Company Contributions (2% Automatic + 3.6% Match) | + 2,038 | + 728 |
| Total Immediate Plan Advantage | $ 2,256 | $ 728 |

* Based on estimated federal income tax rates for **2016** assuming you are married, file jointly, take the standard deduction, claim three exemptions and have no other income.

**As you can see, in this example you would have $218 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 saving, Company Matching Contributions and any investment earnings when you receive a payout of your Plan account.**

**You come out even further ahead when you consider the Company Matching Contribution. In this example, you would receive an additional $1,310 from the Company. In either case, you would receive the Automatic Company Contribution of $728.**

**Core Employees**

**Assume you're married with one child and decide to save 6% of your $50,000 pay, or $3,000, through the Plan. The following chart shows how your pre-tax contributions increase your spendable income.**

*Here's an example of the advantage of saving on a pre-tax basis as opposed to saving through an ordinary bank account:*

| | Pre-Tax Savings Through the Plan | Saving Outside the Plan |
|---|---|---|
| Pay | $52,000 | $52,000 |
| Pre-Tax Savings | – 3,120 | – 0 |
| Taxable Income | $48,880 | $52,000 |
| Federal Income Tax* | – 3,077 | – 3,545 |
| Post-Tax Savings (6%) | – 0 | – 3,120 |
| Spendable Income | $45,803 | $45,335 |
| Immediate Gain Through Tax Savings | $ 468 | $ 0 |

* Based on estimated federal income tax rates for **2016** assuming you are married, file jointly, take the standard deduction, claim three exemptions, and have no other income.

As you can see, in this example you would have $468 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.

**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 savings 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(a) 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 as long as you do so *within 60 days* of receiving the money, as required by the IRS.

You also may be able to have your plan account from your prior employer-sponsored plan transferred as a direct rollover to the 401(k) Plan. 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, profit sharing, 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**

*Like your pre-tax contributions, the investment earnings in your account accumulate on a tax-deferred basis until you withdraw the money.*

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. More information about taxes and the Plan is included under "How Taxes Affect Your Benefits".

## 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 D15). 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 page D32 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 Mercer HR Services. 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 Target Retirement 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***

| 1. If your expected or actual year of retirement is | 2. Consider |
|---|---|
| **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 |
| 2023–2027 | Target Retirement 2025 Fund |
| 2018–2022 | Target Retirement 2020 Fund |
| 2013–2017 | Target Retirement 2015 Fund |
| 2008–2012 | Target Retirement 2010 Fund |
| Before 2007 | 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 the Mercer website 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.

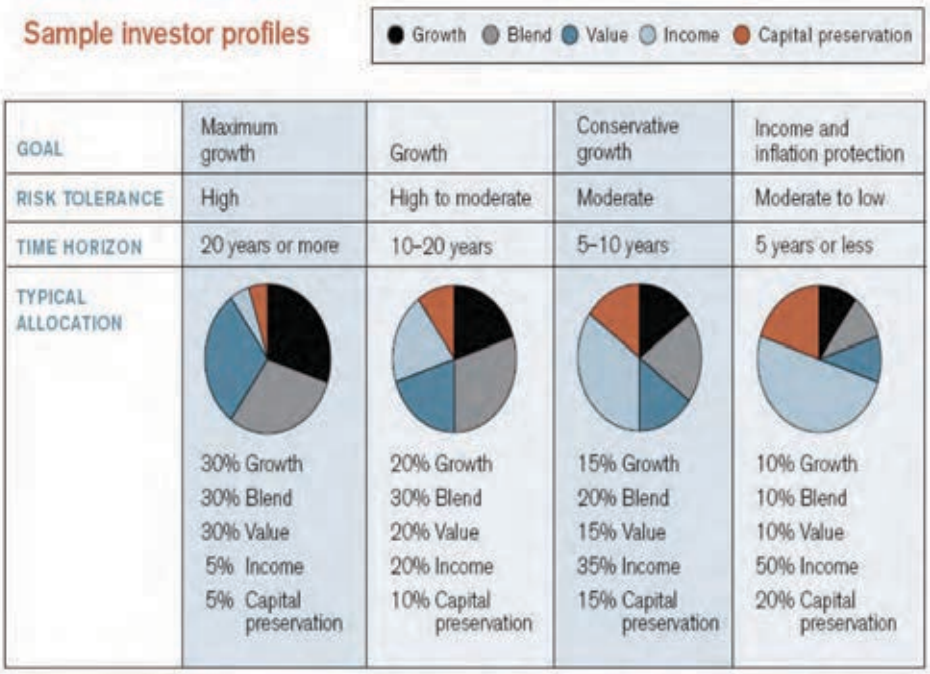
Domestic funds invest in stocks issued by companies or bonds issued by government entities or companies located in the United States and tend to track the ups and downs of the U.S. economy.

***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.




The sample profiles take into consideration the time remaining to anticipated 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.

*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.*

**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 Mercer HR Services by phone at 1-800-356-9240 or online at www.ibenefitcenter.com.

## 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. You're always 100% vested in your pretax contributions and rollover account.*

You are always 100% vested in *your* pretax contributions, rollover contributions, if any, and the investment gains or losses on that money. **You become fully vested in Automatic Company Contributions and any Company Matching Contributions, Company Matching that money as follows:**

- **You become vested in your Automatic Company Contributions and your Company Matching Contributions at the rate of 20% for each year of service (see chart below).**

| Years of Service… | Vested Percentage… |
|---|---|
| 1 | 20% |
| 2 | 40% |
| 3 | 60% |
| 4 | 80% |
| 5 | 100% |

**You will also become 100% vested if you reach age 65 or die while employed by the Company or while performing Qualified Military Service or if you become disabled as defined in the Company's long-term disability plan.**

**If you are less than 100% vested in the Automatic Company Contribution account and the Company Matching Contribution account and you receive a distribution from that account, the vested interest in those accounts will be equal to P(AB + (R x D)) – (R x D) where:**

**P is the vested percentage at the time at which your vested interest cannot increase;**

**AB is the account balance determined at the time at which your vested interest cannot increase;**

**D is the amount of the distribution; and**

**R is the ratio of the account balance determined at the time at which your vested interest cannot increase to the account determined after the distribution. For purposes of determining your vesting, you earn a year of service for each 365-day period of service beginning on your date of hire and ending on your severance from service date.**

**Your *severance from service date* is the earliest of:**

- **The date you quit, retire, are discharged from the Company and all of its affiliates, or the date you die**
- **The first anniversary of an absence for any other reason (other than parental leave or a protected military leave), or**
- **The second anniversary of a *parental leave*, which is a leave of absence because of pregnancy, childbirth, or adoption, or to take care of a child immediately following birth or adoption – as long as you provide documentation regarding your leave for such purposes.**

**If you return to the Company or an affiliate within 12 months of your severance from service date, the period of absence will count as a period of service for vesting purposes.**

**If you transfer employment to an entity that is an affiliate or subsidiary of the Company that has not adopted the Plan, your service for that entity will be treated as service under the Plan for vesting purposes.**

**If you are not fully vested when you leave the Company and all of its affiliates and are subsequently rehired, the length of your absence, called a "period of severance," can affect your non-vested benefit. A *period of severance* is the time from your *severance from service date* to the day you again perform an hour of service for the Company. A one-year period of severance is a 12-month period beginning on your severance from service date (or anniversary of that date) during which you do *not* perform an hour of service. Generally, an hour of service is an hour for which you are paid for the performance of duties.**

**A period of severance will *not* result from a military leave – as long as you return to active employment with the Company within the period in which your reemployment rights are protected by law.**

**If you are not fully vested when you leave the Company and all of its affiliates, the non-vested portion of your account will be forfeited when you receive a distribution of your Plan account or you have five consecutive one-year periods of severance, whichever occurs first. Forfeitures will be used by the Company first to reinstate forfeitures and next to reduce future Company contributions or to pay Plan expenses.**

**If you are rehired before you have five consecutive one-year periods of severance, the amount forfeited will be restored when you return, as long as you repay the full amount of any distribution made to you when you left. You must repay that amount within five years of your reemployment date to have your forfeited amounts restored.**

**Any vesting service earned before you left will be restored, regardless of the length of your absence.**

**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 pre-tax 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 Automatic Contributions and Matching Contributions with respect to your restorative contributions and any discretionary contributions to your account, as if you had remained actively employed. 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 Mercer HR Services at 1-800-356-9240 or online at www.ibenefitcenter.com:

*You can change your elections as your circumstances change. You can change your investments simply by calling Mercer HR Services or accessing their web site.*

- ***Change your contribution percentage.*** You may increase or decrease the amount you contribute to the Plan at any time. To change your contribution percentage, contact Mercer HR Services 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 Mercer HR Services. 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 Mercer HR Services 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 Mercer HR Services' 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.

*You can receive your account in a single lump sum, or in periodic installments if your account is greater than $1,000. In most cases, you will have to request distribution.*

### 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.

You can elect to have your account distributed:

- In a lump sum, or
- Quarterly, semi-annual, or annual installments over your life expectancy, or the joint life expectancies of you and your beneficiary. 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 distribution of your account balance will begin the April 1 following the year in which you reach age 70½.

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, he or she can elect to defer payment until the date you would have reached age 70½.

**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 Mercer HR Services at 1-800-356-9240 or by visiting their website at www.ibenefitcenter.com.

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. You cannot withdraw profit-sharing contributions, Automatic Company Contributions, Company Matching Contributions or pre-tax contributions prior to age 59½, except that pre-tax contributions may be available for hardship withdrawal (explained below under the heading "Hardship Withdrawals") and may be withdrawn if you are receiving continued payments of some or all of your salary while on protected military leave, or if you are on a protected military leave because you are called to active duty for at least 180 days or an indefinite period.

**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 are younger than age 59½, you may withdraw your pre-tax contributions and earnings on pre-tax contributions made before 1989 *only if* you experience financial hardship as defined by the IRS. 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:

*If you experience certain financial hardships, you can withdraw money from your account. If you do, you may have to stop contributing to the Plan for six months.*

- 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, and/or your dependents;
- Post-secondary tuition expenses and related educational fees for you, your spouse, or your dependents for the next twelve months only, and
- Unreimbursed medical expenses (incurred or to be incurred) for yourself, spouse, or 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.
- Your pre-tax contributions (and any other elective contributions under a plan sponsored by the Company or an affiliate) will automatically be suspended for the six-month period following the date of your withdrawal. You must make a new election after the end of the six-month period to resume making contributions to the Plan.

For *all* withdrawals, including Hardship withdrawals, you must contact Mercer HR Services at 1-800-356-9240.

You are responsible for paying ordinary income taxes on the 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.)

## ARTICLE IX - ACCOUNT INFORMATION

**SECTION 1. Quarterly Statements**

- **Plan account statements are available on the Plan's website, www.ibenefitcenter.com. If you have an email address on file you will receive notification when your quarterly statement is available online. The quarterly statement shows**:
- The amount of pretax contributions you made
- **The amount of Company Matching Contributions credited to your account**
- **The amount of Automatic 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.

**If you would like to receive a paper copy please call 1-800-356-9240 between 8:30 am and 6:30 pm Eastern Time, any business day, to speak with a service representative.**

**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 www.ibenefitcenter.com. 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 Mercer HR Services at 1-800-356-9240 or by logging onto www.ibenefitcenter.com.*

## ARTICLE X - How Taxes Affect Your Benefits

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.

*Although you are not taxed on your savings while the money remains in the 401(k) Plan, you'll have to pay income taxes when you receive a distribution.*

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 Volvo 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, or
- You direct the Plan Administrator to transfer your entire account to an IRA or another *qualified* employer-sponsored plan.

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 case, you will avoid paying the 10% penalty. You will also avoid paying ordinary income taxes currently if you rollover the taxable portion to another eligible retirement plan or a traditional IRA. You will be subject to ordinary income taxes if you elect a rollover to a Roth IRA. You must elect a direct rollover before you receive your benefits.
- You may choose to receive some or all of your distribution. In this case, the Plan is required to withhold 20% of the taxable amount you receive to be applied toward your taxes. You can still roll over the

remaining amount into another qualified plan or IRA within 60 days, and you will defer taxes on that amount. You also may roll over 100% of your distribution. However, you will have to find other money to replace the 20% that is withheld.

## 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 Mercer HR Services 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***

If your claim for benefits is denied, you have certain rights under the law. For more information, see the description of your rights under Benefit Denial and Appeal.

## 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. 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 or your beneficiary 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.

**SECTION 3. 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 XIII - ADMINISTRATIVE INFORMATION

***Plan Name***

The official name of the plan is the *Voluntary Investment Pretax Plan for Volvo Group North America Union Employees.*

***Plan Type***

The Plan is a defined contribution profit-sharing plan with a 401(k) feature.

***Plan Sponsor and Plan Administrator***

The Plan Sponsor and Plan Administrator is:
Volvo Group North America, LLC
7900 National Service Road (27409)
P.O. Box 26115
Greensboro NC 27402-6115

***Plan Trustee***

The Trustee is:
Mercer Trust Company
1 Investors Way
Norwood, MA 02062.
*Employer Identification Number (EIN)*
58-2431188

***Plan Number***

014

***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.

# ARTICLE XIV - YOUR RIGHTS UNDER ERISA

As a participant in the *Voluntary Investment Pretax Plan for Volvo Group North America Union Employees*, 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 Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, by calling the toll-free hotline at 866-444-EBSA (3272). You will be automatically transferred to the nearest EBSA office (based on the area code of the telephone used to place the call). Alternatively, you may write to 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 contacting the EBSA by telephone or mail (at the number and address stated above) or through the internet at www.dol.gov/ebsa.

## ARTICLE XV - A FINAL NOTE

The Sponsor 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 Sponsor 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 Voluntary Investment Pretax Plan for Volvo Group North America Union Employees. 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.

## ARTICLE XVI – LOAN PROGRAM

**Voluntary Investment Pretax Plan for**
**Volvo Group North America Union Employees**
**Loan Program**

This Loan Program is effective for loans made on or after **July 1, 2016**. Loans issued prior to that date are subject to their original terms. Terms not defined herein have the same meaning as in the Plan's summary plan description.

1. **Administration.** The Plan Administrator is authorized to administer the Loan Program, and to prescribe such forms and regulations as it considers necessary or appropriate to administer the Loan Program. The Plan Administrator has directed Mercer to act as its agent to administer the Loan Program in accordance with the Plan Administrators's prescribed forms and procedures. The Plan Sponsor may amend or terminate the Loan Program at any time.

2. **Conditions and Limitations Applicable to All Loans**

   A. **Eligibility.** You may apply for a loan if you are an active participant who has a vested account balance in the Plan. By applying for a loan, you are certifying that the proposed borrowing is for your own purposes and not for the benefit of any other party-in-interest to the Plan (such as an Employer or any Plan fiduciary). No more than one loan may be outstanding from the Plan at any time.

   B. **Maximum Principal Amount.** The maximum principal amount of any loan is the lessor of (i) 50% of the vested balance of your account, determined on the day of the loan, minus the balance of all other loans from the Plan, and from all other qualified plans of your employer, outstanding on that date, or (ii) $50,000, minus the highest outstanding principal balance of loans from the Plan, and from all other qualified plans of your employer, to you during the period of one year ending on the day preceding the origination of the loan being requested.

   C. **Minimum Principal Amount.** The minimum principal amount of any loan is $500. Loans will only be issued in $1.00 increments.

**D. Duration.** The repayment period of any general purpose loan will be no more than 5 years. The repayment period of an primary residence loan will be no more than 10 years. The repayment period you choose must be in 1 month increments.

**E. Repayment Method.** A loan will generally be repaid in substantially equal installments by payroll deduction from each paycheck. Loan repayments are made in after-tax dollars. Partial pre-payment of your outstanding balance is not permitted. All repayments of principal and interest will be invested in accordance with your investment elections then in effect under the Plan.

**F. Timing of Repayment.** Repayment will begin as soon as administratively practicable following the loan issuance.

**G. Leave of Absence. If you are on an approved leave of absence, either without pay or at a rate of net pay that is less than the amount of the installment payments required under the terms of your loan, you may continue repaying your loan on a monthly basis through a direct debit from a bank checking or savings account. You may request an ACH Deduction Form by contacting the Plan's toll-free number below.**

If you go on an authorized unpaid leave of absence of up to one year, you may contact Mercer HR Services at 1-800-356-9240 to request a repayment suspension for this period. You will be required to make up the missed payments by either of the following options (as you elect): (1) making a catch-up loan payment when your leave of absence ends, or (2) having the Plan reamortize your outstanding loan over the remaining portion of the original loan term.

**H. Plan Accounting.** The distribution of the proceeds of a loan will be charged solely against your account, and all repayments of principal and interest will be credited solely to your account in accordance with the requirements of the Plan. The unpaid principal balance of a loan will be reflected as a receivable for your account.

**I. Interest Rate.** As determined by the Company, 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 rate so determined will remain fixed throughout the duration of the loan. Loans granted at different times may bear different interest rates.

**J. Security.** Each loan will be secured by the assignment of up to 50% of your vested account balance, not to exceed the amount of your loan. No other security will be required or accepted.

**K. Loan Default.** If you fail to make an installment payment on your loan when due, the Company will arrange for Mercer to provide you written notice of your right to cure this failure by making up missed payments or repaying the loan in full. If your failure to make an installment repayment continues after such written notice has been provided, the Company shall inform Mercer of a default in your repayment of the loan. Such default will occur no later than the last business day of the calendar quarter following the calendar quarter in which your last payment was received. This will result in a deemed distribution for federal income tax purposes (i.e., a distribution subject to applicable taxes and penalties), and the Internal Revenue Service will be notified of such distribution. The amount of the distribution equals the entire outstanding balance of the loan (including accumulated interest) at the time of the default. The Plan is authorized to offset this amount against your account at the time you are eligible for a distribution from the Plan.

**L. Termination of Employment**. If you terminate employment with an outstanding loan, **you will have 90 days from your termination of employment to repay your loan in full. Laid off employees may continue to make loan repayments through ACH debit directly from your checking or savings account. Laid off employees may obtain the ACH Deduction Form by contacting the Plan's toll-free number below.**

If you do not repay your loan in full or make arrangements to continue paying your loan by that time, the unpaid loan balance will be treated as a deemed distribution paid directly to you and will therefore be subject to applicable taxes and penalties. Additionally, the Internal Revenue Service will be notified that you received a distribution from your account.

**M. Repayment in Full.** As noted above, partial prepayments are not permitted. However, you may pay off the entire balance of the loan at any time without penalty or service fee by sending a certified check made payable to **Mercer Trust Company, FBO [your name]** and mail it to the following address:

| **US Postal (including USPS Express Mail)** | **Other Courier Mail** |
|---|---|
| **Mercer** | **Mercer** |
| **Attn: *VIP Plan for VGNA Union Employees*** | **Attn: *VIP Plan for VGNA Union Employees*** |
| **P.O. Box 9747** | **Investors Way** |
| **Providence, RI 02940-9747** | **Norwood, MA 02062** |

**3. Application Procedure.** You may request a loan by phone at 1-800-356-9240 or through the internet at www.ibenefitcenter.com any day. You will be told the maximum amount you may borrow, the interest rate that will apply, and the amount and number of payroll deductions required to repay your loan based on its term. If you direct a loan be made to you from the Plan on the terms described, a Truth in Lending Disclosure Statement explaining the financial terms of your loan will be mailed to you, along with a check for the amount of your loan.

If you would like to request a loan with a loan term of longer than five (5) years to purchase a principal residence, you must obtain a Primary Residence Verification form by calling the toll-free number aboveor accssing the Mercer website *www.ibenefitcenter.com*.

**4. Approval or Denial.** Your loan application will be reviewed by a representative and may be approved only to the extent that the loan requested complies with the requirements of this Loan Program. To the extent that a loan application is denied, the representative will inform you of the reason(s) for the denial, with specific reference to the requirements of the Loan Program upon which the denial is based. If you are denied **a** loan, you may discuss this with the Plan Sponsor.

***5.*** **Promissory Note and Security Agreement.** *By cashing or depositing the check for your loan, you are agreeing to repay the loan in accordance with the terms of the Truth In Lending Disclosure Statement and this Loan Program. Together your endorsed or negotiated loan check, Truth In Lending Disclosure Statement, and this Loan Program will constitute your Promissory Note and Security Agreement with respect to your loan. Without limiting the foregoing, this means that:*

- *You agree that your loan payments (including interest and other finance charges) will be made by payroll deduction as provided in the payment schedule of the Truth In Lending Disclosure Statement.*
- *You assign and grant to the Plan a security interest of up to 50% of your vested account balance, not to exceed the balance of your loan immediately after it is made, as security for prompt and full repayment of the loan.*

If for any reason you do not wish to accept the loan on the terms of this Loan Program and the Truth In Lending Disclosure statement, do not cash or deposit the check. Mark the front of the check "VOID" and return it immediately to Mercer. Returned checks will be reinvested in your account on a current market basis, not retroactively to the date the loan was issued.

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.

# APPENDIX E

## BENEFIT PLAN
## LETTERS OF UNDERSTANDING

### TABLE OF CONTENTS

**Section 1** **LETTER OF UNDERSTANDING – HEALTHCARE REOPENER**

Mr. Willard Beck
Administrative Assistant
UAW Heavy Truck Department
8000 East Jefferson Avenue
Detroit, MI 48214

Re: Health Care Re-Opener

The parties recognize that the passage of the Patient Protection and Affordable Care Act imposed more changes on employer health care plans than in any prior year. Some of those changes have taken effect prior to the execution of this Agreement. However, Congress is now considering amendments to the legislation to change various provisions, and regulations have not yet been finalized.

A) In the event there are amendments or other new provisions of the Patient Protection and Affordable Care Act, other legislation, or new regulations that significantly impact the cost of, or the employee benefits available under, the current negotiated health care plan, either the Company or the Union may give notice to meet and confer in an effort to address the changes, if any, required, provided that the required changes were unknown to either party during the initial negotiations. The parties agree to meet within forty-five (45) days following such notice for this purpose.

B) In the event mandated provisions of the Patient Protection and Affordable Care Act directly affecting a health care plan are negated by the Courts, legislation or interpretative regulations or if the effective date of any mandated changes is delayed, the Company will have the right to amend and/or administer the plan as in existence immediately prior to inclusion of the negated provision in the plan after giving forty-five (45) days written notice to the Union. The Company agrees to meet with the Union during the forty-five (45) day period to review the changes.

Very truly yours,

**Eanne Gillon**
Director, Benefits

# 2016 CALENDAR

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# 2019 CALENDAR

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| S | M | T | W | T | F | S |
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| | | | 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 | |

## JUNE

| 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 | | | | | | |

## JULY

| 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 | | | |

## 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 | | | | |

# 2020 CALENDAR

## JANUARY

| 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 | |

## FEBRUARY

| 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 |

## MARCH

| 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 | | | | |

## APRIL

| 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 | | |

## MAY

| 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 | | | | | | |

## JUNE

| 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 | | | | |

## JULY

| 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 | |

## 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 | | |

# 2021 CALENDAR

## JANUARY

| 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 | | | | | | |

## FEBRUARY

| 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 | | | | | | |

## MARCH

| 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 | | | |

## APRIL

| 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 | |

## MAY

| 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 | | | | | |

## JUNE

| 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 | | | |

## JULY

| 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 |

## 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 | |