SUMMARY PLAN DESCRIPTION

JOHN DEERE

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IMS #271050

John Deere Summary Plan Description for Wage Employees Represented by the UAW

Effective 1 October 2021

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THE SECTIONS OF THIS DOCUMENT TITLED, "OVERVIEW", "RETIREMENT – THE JOHN DEERE TAX DEFERRED SAVINGS PLAN" AND "ADMINISTRATIVE INFORMATION" CONSTITUTE PART OF A PLAN PROSPECTUS COVERING SECURITIES THAT HAVE BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933 AS AMENDED.

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Overview

Introduction

This benefits document provides highlights and summaries of Deere & Company's benefit plans in effect until 1 November 2027, for bargained wage employees (see Who This Document Is For). It is your summary plan description required by the Employee Retirement Income Security Act (ERISA) and is not the official Plan Document for the plans listed in this document.

Complete details of the plans are in the official Plan Documents. If any information described in this document is different from the Plan Documents, the language in the official Plan Documents governs. In addition, not all administrative procedures or policies of the various plans are explained here. If you have questions, the John Deere Benefit Center can help you through these procedures. None of the plans described in this document create a contract of employment between Deere & Company or its affiliates and subsidiaries and any employee. Deere & Company, subject to any applicable collective bargaining agreement, may amend, modify, suspend, or terminate the terms of any of the plans described in this document. Keep this document as a reference if you have questions about your benefits.

About This Document

As a full-time employee of Deere & Company (see Who This Document Is For), you are covered by a comprehensive package of benefits, which, along with your pay, make up your total compensation.

Certain benefits are designed to provide you with financial security today. These benefits include the medical and dental plans, life insurance for you and your family, and disability benefits.

Other benefits help you prepare for tomorrow's needs, such as the John Deere Pension Plan for Wage Employees. The Tax Deferred Savings Plan is designed to help you build long-term savings to supplement your retirement income from Social Security and other personal savings.

Who This Document is For

You are covered by or eligible for the benefits described in this document if you are a full-time employee on the U.S. Payroll of Deere & Company and represented by the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America were hired by the business units listed below:

- John Deere Davenport Works
- John Deere Des Moines Works
- John Deere Dubuque Works
- John Deere Harvester Works – East Moline
- John Deere Ottumwa Works
- John Deere Parts Distribution Center
- John Deere Seeding Group / Cylinder Division
- John Deere Engine Works
- John Deere Waterloo Works
- John Deere Waterloo Works – TCAO
- John Deere Waterloo Foundry
- John Deere Coffeyville Works
- John Deere Company – Atlanta
- John Deere Company – Denver

* Retired employees are also eligible for specific benefits as described in this document. The specified benefits include: Pension, Tax Deferred Savings Plan (TDSP), Group Life Insurance, Healthcare, Dental, and Legal Services.

How to Use This Document

Your benefits book is designed to be easy to use, whether you read it from beginning to end or simply use it as a reference when you have specific questions. As you read through this document, you will notice certain elements that reappear throughout. Here's what you will find:

Table of Contents

A table of contents is included at the beginning of this section (following the Overview), describing what you will find in each chapter. In addition, a detailed table of contents appears at the beginning of each chapter.

Highlights

You can get an overview of all of your Deere & Company benefits by reading the highlights sections at the beginning of each chapter.

Terms You Should Know

Because this document summarizes the technical details of how your benefits work, there are terms that have specific meanings

relative to each benefit. To help you understand how these terms are being used, a list of "Terms You Should Know" appears near the beginning of each chapter (following the highlights section).

Questions and Answers

Periodically, you will notice "Q & A" boxes throughout this document. Many commonly asked benefit questions have been recapped here for your reference.

Tips and Other Information

To help you make the most of your Deere & Company benefits, tips for using your benefits and other important plan information are included throughout this document.

John Deere Benefit Center

As you read through this document, you will notice that for certain questions, or to receive more information on a topic, you should contact a Service Representative at the John Deere Benefits Center. This service is available to you by calling 1-844-689-7833. You may also access the UPoint site at www.yourbenefitsresources.com/deere to obtain information on your benefits.

Deere Direct

There are situations when you should contact Deere Direct by calling 1-888-432-3373 or emailing DeereDirect@JohnDeere.com. This should be done in the following situations:

– Name or address changes

– Escalations not getting resolved through your interaction with the John Deere Benefit Center

– Other situations noted throughout this document

Situations That Can Affect Your Benefits

Deere & Company's wage employee benefits are intended to provide you with certain levels of financial security while you are working and after you retire from the Company. However, there are situations that could affect your benefits under these plans.

– Benefits are not payable for situations that occur before your coverage begins or after your coverage ends.

– For some benefit plans, you (or your survivor) must apply for benefits or file a claim.

– Benefits generally cannot be paid until you apply or make a claim for payment.

– You should keep your most current address on file so that the Company can locate you (or your survivors) and provide you with all of your benefit payment and any related plan information. If you are actively working or on long-term disability, you should contact Deere Direct to change your address. Retirees and surviving spouses should contact the John Deere Benefit Center to change their address.

– If you (or your surviving spouse) are unable to care for your own financial affairs, any payments due may be paid to someone who is authorized to conduct your financial affairs. This may be a relative, a court-appointed guardian, or some other person.

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A-1. Retirement Highlights

When you plan for your retirement, you need to consider three income sources — income from Company retirement plans, personal savings, and Social Security.

Two Retirement Plans	There are two Company-sponsored plans — the Pension Plan and the Tax Deferred Savings Plan.
Participation	If hired prior to 1 November 2021, you are covered under the Pension Plan automatically. If you are hired on or after 1 November 2021, you must actively elect to participate in the Pension Plan (Traditional PLUS) within 30 days from your date of hire to be covered, otherwise you will be defaulted into Choice PLUS.
Advantages	Both plans offer advantages — the Pension Plan helps you build retirement income over your career. The Tax Deferred Savings Plan allows you to defer both after-tax and pre-tax money in the Plan and, for those hired on and after 1 October 1997, receive a Company match.
Start Planning Now	Planning for retirement isn't hard, but it does take time. The first step is learning about the Company-sponsored plans by reading this chapter.

Remember...*The Retirement Plans are your plans. It's up to you to learn as much about them as you can. If you don't understand something, the John Deere Benefit Center can answer your questions.*

About Retirement Income
In most cases, the Pension Plan is not your only source of income for retirement. If you participate in the Tax Deferred Savings Plan, you will also have retirement funds available from that plan. In addition, you may have income from personal savings or investments. But the Pension Plan, along with Social Security, provides you with a base of retirement income.

The FICA taxes you and Deere pay are used to provide your Social Security benefits. The Company pays an amount equal to the FICA taxes you pay.

For more information on Social Security benefits, contact your local office of the Social Security Administration.

A-2. Retirement Terms You Should Know

- Account – The account maintained for participants in the Tax Deferred Savings Plan that includes your pre-tax and/or after-tax savings account, and any monies you have rolled over from other pre-retirement plans or from deferred profit sharing.
- Accrued benefit – Your accrued Pension Plan benefit is the benefit you have earned at a given date, based on service credit and the pension rate in effect at that time.
- Additional foundry service credit – Service credit you earned if you worked in certain foundry jobs and were hired prior to 2 June 1997.

  In general, you receive a year of additional foundry service credit for every five years of service in a foundry prior to 1 October 2003. To qualify, you must have worked in one of the following positions at least 25 weeks in the anniversary year for which the service would be credited.

  Your position must have been classified under

  - An "A" occupational code; or
  - Other occupational codes in melting, core making, molding, or cleaning-finishing occupational areas.

  You will not receive additional foundry service credit if you worked either outside the foundry or in an enclosed area within the foundry.
- Anniversary date – The annual anniversary of the date you first reported to work in your most recent period of employment with the Company.
- Anniversary year – The 12-month period starting on your anniversary date.
- Annuity – A method of paying your benefit that spreads payment out over an extended period of time, as opposed to a single-sum payment.
- Choice PLUS – A retirement program for employees hired on or after 1 November 2021, or employees hired on or after 1 October 1997 but prior to 1 November 2021 that elected Choice PLUS in the election window from 18 April 2022 - 13 May 2022. Choice PLUS participants do not accrue additional pension benefits beyond the effective date of the Choice PLUS election, but receive a higher match into the John Deere Tax Deferred Savings Plan than Traditional PLUS participants. In addition, Choice PLUS participants receive an automatic retirement contribution of 5% of FICA eligible wages.
- Earnings – Your straight-time earnings, vacation earnings, personal absence earnings, and earnings for unworked holidays. It includes any pre-tax contributions you make to any Company plan.

– Hours worked – You earn an hour of credit for each hour you work for the Company. You also receive hours for which you're paid, but not actually at work, up to certain limits. Some examples of this include hours you can earn if you receive back pay, certain disability benefits, and military pay. Contact Deere Direct for more information.

– Present value – The current lump-sum equivalent of all expected future benefit payments.

– Service credit – If you work at least 500 hours or more in any anniversary year, you receive a year of service credit. Service credit is used by the Pension Plan to determine the amount of your pension benefit and your eligibility for Plan benefits. It is also used to determine the three-year vesting criteria for TDSP company match.

  You do not receive service credit:

  - When you work less than 500 hours in any completed anniversary year;
  - After you retire;
  - When your employment ends for any reason;
  - When you fail to return from a leave of absence or military leave;
  - When you fail to return from a layoff within five days notice from the Company; or
  - After you die.

  If you become totally and permanently disabled, you continue to earn service credit that is credited to you at normal or early retirement (subject to plan restrictions). If you return to work, your service credit continues unbroken. You also receive credit for any additional foundry service credit, and partial years of service in the year of your death, termination, or retirement.

– Total and permanent disability – A physical or mental condition caused by an illness or injury that leaves you unable to work for the Company. The condition can be work-related or not, as long as you have medical evidence satisfactory to the Company to support it.

– Traditional PLUS – Employees hired on or after 1 October 1997 that continue to accrue pension benefits. These are employees that have elected to remain in Traditional PLUS during the election window from 18 April 2022 - 13 May 2022, or if hired on or after 1 November 2021, have elected Traditional PLUS within 30 days from their date of hire. Those employees who elect Choice PLUS during the election window from 18 April - 13 May 2022 will be entitled to benefits earned through 31 May 2022, subject to satisfying Plan vesting requirements.

– Vested – Means you have 100% ownership rights to your accrued retirement benefit.

  - Pension Plan: You are vested in the Pension Plan when you have earned five years (three years if you also have a cash balance benefit) of service credit. You may receive your benefit when you are eligible to retire. If you leave the Company prior to your earliest eligibility to retire, your pension benefits will be deferred until you meet the age and service requirements specified in the plan.
  - Tax Deferred Savings Plan: Your deferrals to the Tax Deferred Savings Plan are always fully vested. Employer contributions for those hired on and after 1 October 1997 are 100% vested after three years of credited service.

– Year of service – For the Pension Plan, a year of service is the same as a year of service credit.

A-3. The Pension Plan - Hired Prior to 1 October 1997*

A-3.1. The Pension Plan Highlights

The John Deere Pension Plan for Wage Employees is one way the Company recognizes your years of service with Deere & Company. It provides monthly benefits for eligible retirees and surviving spouses.

Company-Funded	The Pension Plan is 100% funded by the Company. You do not need to contribute to the Plan. The Pension Plan helps provide monthly retirement income for you after your career with the Company ends.
Coverage Under the Plan	Generally, if you're a wage employee on the U.S. payroll, and actively working at one of the U.S. operations (as outlined in "Who This Document Is For") you are covered under the Plan automatically, starting on your first day at work if you were employed prior to 1 October 1997*.
Pension Benefits	Your pension benefits are based on your years of service credit and the monthly pension amount per year of service as outlined in the agreement. (See section A-3.3 for more information.)
When You Can Receive Benefits	Your pension benefit is vested once you have at least five years of service credit. Normal retirement begins at age 65. However, the Plan also includes provisions for early retirement, deferred vested retirement, and disability retirement.
Surviving Spouse Protection	The Plan offers surviving spouse protection if you die — whether before or after benefit payments start — as long as you are vested.

** Section A-3 covers wage employees hired at most units prior to 1 October 1997. Employees hired prior to 2 June 1997 at the Waterloo Foundry and prior to 1 January 1996 at Coffeyville Works are also included in this section. Coffeyville Works has some benefit differences than the core group and are generally entitled to 75% of the benefit levels within this section. See the plan document and Coffeyville supplements for more details. A-3.2. Eligibility and Cost*

A-3.2. Eligibility and Cost

A-3.2.1. Who's Eligible

Generally, if you're a wage employee on the U.S. payroll and actively working at one of the U.S. operations (as outlined in "Who This Document Is For") you are covered under the Plan automatically, starting on your first day at work if you were employed prior to 1 October 1997*.

A-3.2.2. Plan Cost

The Company pays the full cost of your pension benefits by making contributions to a trust.

A-3.3. How Your Basic Pension Benefit is Calculated

The Pension Plan is a "defined benefit" plan. This means your monthly pension benefit is calculated using your years of service credit and the contract rate.

First, your basic pension benefit is determined. Then, it is adjusted depending on when you take retirement.

A-3.3.1. Basic Pension Benefit Components

Your basic pension benefit components include your years of service at retirement and the monthly pension amount per year of service credit in place at the time of your retirement.

A-3.3.2. Basic Pension Benefit Calculation

Generally, if you retire on or after 1 October 2015, your monthly basic pension benefit at normal retirement age is as follows depending on your retirement date.

For Retirements On or After	Monthly Pension
1 Oct. 2015	$53.00

A Basic Pension Benefit Example
You are retiring on 31 December 2021 with 30 years of service credit and you are age 62.
$ 53.00 x 30 yrs = $1,590.00 Your monthly basic pension benefit beginning 1 January 2022 would be $1,590.00.

A-3.3.3. Maximum Benefits

There are laws that limit the amount of benefits individuals can receive from this Plan in combination with other plans. You'll be notified if these limits affect you.

A-3.4. When You Retire

Depending on when you retire from the Company, the Plan pays benefits for early retirement, normal retirement, and retirement after age 65.

A-3.4.1. Normal Retirement — Retiring At or After Age 65

Under normal retirement, you are eligible for your full, unreduced pension benefit. Generally, you can receive normal pension benefits when you reach age 65 or have completed at least five years of service credit, whichever is later. If you want to continue working, you may retire at any later date.

How Your Normal Retirement Benefit is Calculated

Your normal retirement benefit even if you work past age 65 is calculated using the monthly pension amount per year of service credit in place at the time of your retirement, and your years of service credit on the date you retire. See section A-3.3.2 for an example.

If you choose to continue working beyond 1 April of the calendar year following the year in which you turn 70 1/2, your monthly benefit may be actuarially increased. See the plan document for more details.

When Normal Retirement Benefits Are Paid

Your monthly normal retirement benefit payments start on the first day of the month after your retirement date, provided your application was received by the Company at least two months prior to this date. If your application for retirement was not received at least two months prior to your retirement, your first payment will be made the first day of the month two months following notification to the Company of your retirement.

A-3.4.2. Early Retirement — Retiring Before Age 65

You may choose early retirement if:

- You are at least age 60, and you have at least 10 years of service credit;
- You are at least age 55 but not age 60, and your age plus your years of service credit equal at least 85; or
- You have 30 or more years of service credit.

How Your Early Retirement Benefit is Calculated

Your early retirement benefit is calculated as a basic pension benefit using your years of service credit on the date of your retirement and the monthly pension amount per year of service credit in place at the time of your retirement.

If you were hired prior to 1 October 1997* and retire under the early retirement pensions above, your benefit will be determined from the chart below.

For Retirements On or After	Monthly Pension
1 Oct. 2015	$53.00

A Basic Pension Benefit Example
If you retire on 31 October 2021 with 30 years of service, your basic pension benefit would be:
$ 53.00 x 30 yrs = $1,590.00 In addition to your basic pension benefit, you may also be eligible for a Supplemental Allowance.

When Early Retirement Benefits Are Paid

Early retirement benefits begin on the first day of the month after you retire, provided your application was received by the Company at least two months prior to this date. If your application for retirement was not received at least two months prior to your retirement, your first payment will be made the first day of the month following two months notification to the Company of your retirement.

Supplemental Allowance

If you were hired prior to 1 October 1997*, the Supplemental Allowance is designed to increase your retirement income temporarily, until you are eligible for an 80% benefit under Social Security. If you retire before you are eligible for an 80% benefit under Social Security or before you are eligible for and receive Social Security disability payments, you may be eligible for a Supplemental Allowance.

Supplemental Allowance Amount

The amount of the Supplemental Allowance is based on having 30 or more years of service credit:

- If you have 30 or more years of service credit, retire on 1 October 2015, and your monthly early retirement benefit is less than $3,200, your Supplemental Allowance is the difference between your monthly early retirement benefit amount and $3,200.
- If you have fewer than 30 years of service credit, you determine the total benefit by dividing $3,200 by 30 and multiplying the result times your years of service credit. A 1% reduction applies to your total benefit for each month you begin receiving benefits before age 60. The difference, if any, between your total benefit and your reduced basic pension benefit equals your Supplemental Allowance.

A Supplemental Allowance Example
Assume your early retirement benefit is $1,590 each month. You retire (and begin receiving benefits) at age 60, with 30 years of service credit. Your Supplemental Allowance would be calculated as follows:

Total Benefit Maximum	$3,200
Early Retirement Basic Pension Benefit	-$1,590
Supplemental Allowance	$1,610

So, until you reach eligibility for an 80% benefit under Social Security or actual receipt of Social Security benefits (if earlier), your total monthly benefit would be equal to $3,200 (your $1,590 early retirement benefit plus your $1,610 Supplemental Allowance).

The amount of Supplemental Allowance for an employee retiring with 30 or more years of service credit, based on your retirement date, is as follows:

For Retirements On or After	Total Monthly Benefit
1 Oct. 2015	$3,200.00

A-3.5. How You Receive Plan Payments

Your pension benefits are paid according to the payment form that applies to you when benefits start:

- If you're single, you receive a single life annuity.
- If you're married, you may elect to receive a 55% or 75% surviving spouse benefit.

A-3.5.1. Payment Methods

- Single Life Annuity. This payment method provides a monthly benefit during your lifetime, with payments stopping at your death.
- 55% Surviving Spouse Benefit. This payment method provides payments for your life and continues payments of 55% of the benefit amount to your surviving spouse after your death. If you are more than 10 years older than your spouse, your monthly benefit is reduced by ½% for each year in excess of 10 years that your spouse is younger than you.
- 75% Surviving Spouse Benefit. This payment method provides payments for your life and continues payments of 75% of the benefit amount to your surviving spouse after your death. If you elect this option, your monthly benefit will be reduced using actuarial factors based on your age and your spouse's age at the time of your retirement.

An Example of the 55% Surviving Spouse Benefit	
Assume that you retire on June 30, 2022, with 35 years of service credit and you are not more than 10 years older than your spouse. Your basic monthly pension benefit is $1,855.	
Surviving Spouse Benefits	
Your basic unreduced monthly pension benefit	$1,855.00
Surviving spouse benefit multiplier (55%)	X .55
Surviving spouse's monthly pension benefit	$1,020.25

A-3.6. To Receive Pension Benefits

For benefits to begin, you must submit a written application in accordance with the chart below. Contact the John Deere Benefits Center at 1-844-689-7833 to request an application, or if you need any additional information.

Application Received (On or Before)	Pension Benefit Commencement Date

1 November	1 January
1 December	1 February
1 January	1 March
1 February	1 April
1 March	1 May
1 April	1 June
1 May	1 July
1 June	1 August
1 July	1 September
1 August	1 October
1 September	1 November
1 October	1 December

A-3.7. If You Die After You Retire

If you die after you retire, the Plan includes protection for your surviving spouse. Surviving spouse benefits, if any, are paid only to your spouse.

A-3.7.1. Who's Eligible?

Your spouse is eligible for surviving spouse benefits if you were married to him or her at retirement. If you marry during retirement, you must have been married at least one year immediately prior to your death, and have applied for the surviving spouse protection benefit for your new spouse. If you fail to notify the Company in the event you marry following retirement, any applicable reduction in your benefit beginning on the surviving spouse benefit effective date (1 year following marriage) will be retroactively collected from your pension benefit or your spouse's benefit in the event of your death.

A-3.7.2. Benefits Payable to Your Surviving Spouse

If this coverage is in effect for you on the date of your death, your surviving spouse will receive monthly benefits equal to 55% or 75% of your pension benefit, depending upon your election at retirement or at the time you applied for the surviving spouse protection benefit for your new spouse in retirement.

A-3.7.3. When Benefits Are Paid

Benefits to your spouse will start on the first day of the month following your death.

A-3.8. If You Die Before You Retire

A-3.8.1. Who's Eligible?

If you die before you retire, your surviving spouse is eligible for surviving spouse benefits as long as you were:

- Vested under the Plan (you have at least five years of service credit); and
- Married for at least one year immediately prior to your death.

A-3.8.2. Benefits Payable to Your Surviving Spouse

Your surviving spouse will receive monthly benefits equal to 55% of the benefit you would have received if you had lived to your earliest retirement age and retired. The Company pays the full cost of this coverage; however, the surviving spouse benefit will be reduced if your spouse is more than 10 years younger than you (see section A-3.5.1).

A-3.8.3. When Benefits Are Paid

If you die after you are eligible to retire, benefits to your spouse may start on the first day of the month following your death.

If you die before you are eligible to retire, benefits to your spouse may start on the first day of the month following what would have been your earliest retirement date (based on your service credit at the time of your death).

A-3.9. Disability Retirement – If You Become Disabled

The Pension Plan pays benefits if you are totally and permanently disabled.

Q: What is total and permanent disability?

A: You are considered totally and permanently disabled if you have a physical or mental condition caused by an illness or injury that leaves you unable to work for the Company. The condition can be work-related or not, as long as you have medical evidence satisfactory to the Company to support it.

You can receive disability pension benefits if you are younger than age 68 and if you have at least 10 years of service credit when you become totally and permanently disabled.

A-3.9.1. How Your Disability Retirement Benefit Is Calculated

Permanent and Total Disability

For employees hired prior to 1 October 1997*, the chart below will be used to calculate your disability pension benefit. This benefit will continue until the earlier of: (1) attaining 30 years of pension service (if disability commenced on or after 1 October 2003), (2) age 65 if disability commenced prior to age 60, (3) age 68 or 60 months if disability commenced on or after age 60, (4) upon reaching a plan limitation, or (5) upon request of the employee eligible for early or normal retirement. Your disability retirement benefit is calculated using your years of service credit on the date of your disability, as follows:

For Retirements On or After	Amount Per Year of
1 Oct. 2015	$53.00

Additional Temporary Benefit

For employees hired prior to 1 October 1997* and ineligible for unreduced Social Security Disability; if you become totally and permanently disabled before you are eligible for an 80% benefit under Social Security, you also may be eligible for an Additional Temporary Benefit, up to your eligibility for an 80% benefit under Social Security. You can receive a monthly benefit equal to:

	Additional Temporary Benefits	
For Retirements On or After	Per Month Per Year of Service Credit	Subject to a Maximum of
1 Oct. 2015	$47.15	$1,414.50

A-3.9.2. When Disability Retirement Benefits Begin and End

If you're eligible, disability retirement benefits usually start on the first day of the month after the Company accepts proof of your total and permanent disability, but not before your Weekly Indemnity benefits end. Disability retirement benefits can start as early as the sixth month after you become totally and permanently disabled, if you are not receiving Weekly Indemnity benefits.

Disability benefits generally continue until you recover or you reach age 65. In the case of disabilities (LTD or Disability Retirement) commencing on or after 1 October 2003, disability retirement benefits will cease upon attaining 30 years of service credit. No further service credit will be earned. Your retirement benefit includes service credit for the time you were on long-term disability and disability retirement (for disabilities commencing on or after 1 October 2003, time credited while on LTD or Disability retirement will be limited to a total of 30 years). Disability retirement benefits will continue until the earlier of: (1) attaining 30 years of pension service (if disability commenced on or after 1 October 2003), (2) age 65 if disability commenced prior to age 60, (3) age 68 or 60 months if disability commenced on or after age 60, (4) upon reaching a plan limitation, or (5) upon request of the employee eligible for early or normal retirement.

Additional Temporary Benefits are payable until you reach eligibility for an 80% benefit under Social Security, or until you become eligible for an unreduced Social Security benefit, whichever is earlier.

A-3.9.3. If You Recover

If you recover and return to work with the Company, the time you were receiving Disability Retirement Benefits counts as service credit towards your future normal or early retirement benefit. It will be added to the service credit you had earned up to your disability retirement.

A-3.10. Deferred Vested Pension – If You Leave Before Retirement

When you have at least five years of service credit, you're considered to be vested under the Plan. This means that you have 100% ownership rights to your accrued pension benefit, which is payable in the future.

If you leave the Company for any reason once you are vested, but before you reach early or normal retirement age, you are eligible for a deferred vested pension benefit.

Q: Why is it called a deferred vested pension?

A: Because you're vested (you have 100% ownership rights to your accrued pension benefit). You also left the Company earlier than the Plan allows for you to receive monthly distributions, and therefore the payment of the benefit is deferred, or delayed, until you meet eligibility for a distribution.

If the present value of your accrued benefits is less than $5,000, you will be notified and receive a lump sum distribution of your vested benefit. See "Tax Tip" to avoid withholding on your lump sum.

A-3.10.1. How Your Deferred Vested Pension Is Calculated

Your deferred vested pension benefit is calculated using the service credit, pension bracket, and Plan provisions in effect on the date you left the Company. The benefit is calculated as a basic pension benefit. The chart below shows monthly pension amounts per year of service credit.

For employees hired prior to 1 October 1997* who are terminated, quit, etc., between the dates specified below, the vested benefits are as follows and are reduced ½% for each month benefits begin prior to age 65.

For Separations On or After	Amount Per Year of
1 Oct. 2015	$53.00

Deferred Vested Pension Calculation

The deferred vested pension is calculated by multiplying years of service times the contract rate in effect at the time of the separation. Age reduction and/or pre-retirement surviving spouse coverage reduction factors may also apply.

A-3.10.2. When Deferred Vested Benefits Are Paid

The Company will notify you when you are eligible to begin deferred vested pension benefits. For benefits to begin, you must apply in writing. Your written request can be made by completing an application request form or by submitting a letter with the date you'd like payments to begin. Your request must be received at least 60 days prior to the date you want payments to begin. To request an application request form or if you need any additional information, contact the John Deere Benefits Center at 1-844-689-7833.

You may choose to start payments at any time after age 60 (if you have 10 years of service credit), age 65 (if you have between 5 and 10 years of service credit), or any time after your age and service credit equal 85.

Choosing your benefit start date is important, because reductions apply for early payments:

- If you choose to start payments on or after the date you reach age 65, no reductions apply.
- If you choose to start payments before age 65, benefits are reduced by ½% (one-half of one percent) for each month they start before age 65.

A Deferred Vested Benefit Example	
Assume you left the Company at age 40, with 15 years of service credit. Your basic accrued pension benefit, based on your service credit and pension bracket when you left, is $750.00 a month. You decide to begin receiving benefits at age 63. Therefore, your deferred vested benefit would be:	
Unreduced Accrued age-65 benefit	$750.00
Reduction (½% x 24 months before age 65 x $750.00)	-$90.00
Monthly Deferred Vested Benefit	$660.00

A-3.10.3. How Deferred Vested Benefits Are Paid

If you are eligible for a deferred vested benefit and the present value of your benefit is $5,000 or less, you may receive the present value of your benefit in a single lump sum. If this option is available to you, you will be notified. Otherwise, benefits are paid as previously described.

If your present value is less than $1,000, the default distribution option will be a lump sum payment directly to you. If your present value is between $1,000 and $5,000, the default distribution option will be a rollover to an Individual Retirement Account with a third party administrator. The default distribution option can be overridden by providing your alternate election prior to the distribution date.

Tax Tip
If your deferred vested benefit is distributed to you as a single, lump sum payment, a mandatory 20% federal withholding tax applies. To avoid withholding, you may request a direct rollover to another employer's plan or to an IRA. Contact the John Deere Benefits Center at 1-844-689-7833 for more information before payment is made.

A-3.10.4. Deferred Vested Surviving Spouse Benefit

If you die before your deferred vested benefits start, your spouse is eligible for surviving spouse benefits, as long as you did not waive this coverage before your death. You can waive this coverage with your spouse's consent, if he or she signs the consent form in the presence of a Plan representative or notary public. You and your spouse must have been married for at least one year immediately prior to your death for these surviving spouse benefits to be payable.

Cost of Coverage
There is a charge for deferred vested surviving spouse coverage prior to the date you begin drawing your benefit. You pay the cost through a reduction in your pension benefit. The amount of the reduction depends on your age when you choose this coverage and how long the coverage is in effect. The chart below shows the monthly cost as a percentage reduction in your benefits.

Deferred Vested Benefit – Surviving Spouse Coverage	
If you are this age:	**Your pension will be reduced by this percentage for each year of coverage:**
Under 35	0%
35-44	0.1%
45-54	0.3%
55 and older	0.8%

So, if this protection starts at age 50 and stays in effect until you reach age 65, your monthly pension will be reduced .3% each year for five years (ages 50 to 54) and .8% for 10 years (ages 55 to 64), for a total reduction of 9.5% ([.3% x 5] + [.8% x 10]).

Making Your Election
You may elect to waive preretirement surviving spouse coverage at any time. If you make your election before age 35, you must re-elect to waive this coverage between the year you reach age 35 and the date Plan payments start. If you're married and you reject this coverage, your spouse must consent in writing in the presence of a Plan representative or notary public.

Benefits Payable
If the preretirement survivors' coverage is in effect for you on the date of your death, your surviving spouse will receive a monthly benefit equal to 55% of the benefit you would have received if you had reached your earliest eligibility to start your deferred vested pension.

Your surviving spouse may begin receiving benefits as of the date you would have first been eligible to receive a deferred vested pension. To receive deferred vested surviving spouse benefits, your spouse must apply in writing as described in the preceding section A-3.10.2, When Deferred Vested Benefits Are Paid.

A-3.11. Assignment of Benefits

Your benefits from the Pension Plan belong to you and may not be sold, assigned, transferred, pledged, or garnished, under most circumstances.

However, if you become divorced or separated, certain court orders could require that part of your benefits be paid to someone else — your spouse or children, for example. This is known as a qualified domestic relations order (QDRO). As soon as you are aware of any court proceedings which may affect your Pension Plan benefits, contact the John Deere Benefits Center.

You may receive a copy of the qualified domestic relations order, free of charge, from the Plan Administrator. See Chapter H, Administrative Information for the Plan Administrator's address.

A-3.12. A Few Words About Taxes

Your pension payments from this Plan are subject to federal and certain state income taxes. For the most up-to-date tax information for your personal financial situation, it's important that you consult a qualified tax expert.

A-4. The Pension Plan (Traditional PLUS) - Hired On Or After 1 October 1997*

A-4.1. The Pension Plan Highlights

The John Deere Pension Plan for Wage Employees is one way the Company recognizes your years of service with Deere & Company. It provides monthly benefits for eligible retirees and surviving spouses.

Company-Funded	The Pension Plan is 100% funded by the Company. You do not need to contribute to the Plan. The Pension Plan helps provide monthly retirement income for you after your career with the Company ends.
Coverage Under the Plan	Generally, if you're a wage employee on the U.S. payroll, and actively working at one of the U.S. operations (as outlined in "Who This Document Is For") you are covered under the Plan automatically, starting on your first day at work if you were employed on or after 1 October 1997*. Additionally, those hired on or after 1 November 2021 are only covered if they elected Traditional PLUS within 30 days of hire.
Pension Benefits	Your pension benefits are based on your years of service credit and the monthly pension amount per year of service as outlined in the agreement. (See section A-4.3 for more information) In addition to this benefit, a cash balance benefit, and retirement bonus (under certain circumstances), are also available for those active under Traditional PLUS after 1 November 2021.
When You Can Receive Benefits	Your pension benefit is vested once you have at least five years of service credit (three, if active after 1 November 2021). Normal retirement begins at age 65. However, the Plan also includes provisions for early retirement, deferred vested retirement, and disability retirement.
Surviving Spouse Protection	The Plan offers surviving spouse protection if you die — whether before or after benefit payments start — as long as you are vested.

A-4.2. Eligibility and Cost

A-4.2.1. Who's Eligible

Generally, if you're a wage employee on the U.S. payroll and actively working at one of the U.S. operations (as outlined in "Who This Document Is For") you are covered under the Plan automatically, starting on your first day at work if you were employed on or after 1 October 1997*. Employees hired after on or after 1 November 2021 will have 30 days to make an election to participate in Traditional PLUS. If they do not make an election and default to Choice PLUS, or actively elect Choice PLUS, they are not covered under the Plan.

A-4.2.2. Plan Cost

The Company pays the full cost of your pension benefits by making contributions to a trust.

** Section A-4 covers wage employees hired at most units on or after 1 October 1997. Employees hired on or after 2 June 1997 at the Waterloo Foundry and on or after 1 January 1996 at Coffeyville Works are also included in this section.*

A-4.3. How Your Basic Pension Benefit is Calculated

The Pension Plan is a "defined benefit" plan. This means your monthly pension benefit is calculated using your years of service credit and the contract rate.

First, your basic pension benefit is determined. Then, it is adjusted depending on when you take retirement.

A-4.3.1. Basic Pension Benefit Components

Your basic pension benefit is calculated using your earnings bracket amounts and your service credit.

A pension additive also applies for each year of service completed between 1 October 2009 and 30 September 2015.

A-4.3.2. The Basic Pension Benefit Calculation

Generally, if you retire on or after 1 October 2015 and before 1 November 2021, your monthly basic pension benefit at normal retirement age is determined by multiplying your service credit times the dollar amount for your earnings bracket, as shown below. For covered employees who retire after 1 November 2021, the table below is replaced by one $48 flat rate.

For employees hired on or after 1 October 1997* and who were not active after 1 November 2021 -
Bracketed amounts per year of service credit:

Earnings Bracket at Retirement		Monthly Pension Amount Per Year of Service Credit
At Least	But Less Than	

	$13.926	$25.75
$13.926	$16.924	$27.85
$16.924	$19.924	$29.95
$19.924	$22.924	$32.05
$22.924	$25.924	$34.15
$25.924	$28.924	$38.60
$28.924	$31.924	$38.60
$31.924	and up	$38.60

In combination with the monthly pension benefits provided based on the table above, a pension additive for each year of service credit completed between 1 October 2009 and 30 September 2015:

Year of Service Credit Completed Between 1 October 2009 and 30 September 2015	Amount of Monthly Pension Additive Per Year of Service Credit Completed
Anniversary Year 1	$3.00
Anniversary Year 2	$3.00
Anniversary Year 3	$4.00
Anniversary Year 4	$4.00
Anniversary Year 5	$5.00
Anniversary Year 6	$5.00

A Basic Pension Benefit Example	
You are retiring on 31 December 2021 with 10 years of service credit and you are age 60. You completed six anniversary years between 1 October 2009 and 30 September 2015.	
$48.00 x 10 yrs.	$480.00
Pension Additive	+24.00
	$504.00
Your monthly basic pension benefit beginning 1 January 2022 would be $504.00.	

A-4.3.3. Maximum Benefits

There are laws that limit the amount of benefits individuals can receive from this Plan in combination with other plans. You'll be notified if these limits affect you.

A-4.4. When You Retire

Depending on when you retire from the Company, the Plan pays benefits for early retirement, normal retirement, and retirement after age 65.

A-4.4.1. Normal Retirement — Retiring At or After Age 65

Under normal retirement, you are eligible for your full, unreduced pension benefit. Generally, you can receive normal pension benefits when you reach age 65 or have completed at least five years of service credit, whichever is later. If you want to continue working, you may retire at any later date.

How Your Normal Retirement Benefit is Calculated

Your normal retirement benefit even if you work past age 65 is calculated using your earnings bracket and your years of service credit on the date you retire. A pension additive may be added for each year of service completed between 1 October 2009 and 30 September 2015. See section A-4.3.2 for an example.

If you choose to continue working beyond 1 April of the calendar year following the year in which you turn 70 1/2, your monthly benefit may be actuarially increased. See the plan document for more details.

When Normal Retirement Benefits Are Paid

Your monthly normal retirement benefit payments start on the first day of the month after your retirement date, provided your application was received by the Company at least two months prior to this date. If your application for retirement was not received at least two months prior to your retirement, your first payment will be made the first day of the month two months following notification to the Company of your retirement.

A-4.4.2. Early Retirement — Retiring Before Age 65

You may choose early retirement if:

- You are at least age 60, and you have at least 10 years of service credit;
- You are at least age 55 but not age 60, and your age plus your years of service credit equal at least 85; or
- You have 30 or more years of service credit.

How Your Early Retirement Benefit is Calculated

Your early retirement benefit is calculated as a basic pension benefit using your earnings bracket and your years of service credit on the date you retire. A pension additive may be added for each year of service completed between 1 October 2009 and 30 September 2015. See Section A-4.3 for the basic pension benefit calculation.

Early Retirement Reduction.

If benefits start before age 62 (60 for retirements on or after 1 November 2021), they are reduced 1/3% (one- third of one percent) for each month payments start earlier than age 62 (60 for retirements on or after 1 November 2021). This is no age reduction for payments starting on or after age 62 (60 for retirements on or after 1 November 2021).

When Early Retirement Benefits Are Paid

Early retirement benefits begin on the first day of the month after you retire, provided your application was received by the Company at least two months prior to this date. If your application for retirement was not received at least two months prior to your retirement, your first payment will be made the first day of the month following two months notification to the Company of your retirement. If you retire before age 62 (60 for retirements on or after 1 November 2021), you can defer benefit payments to any time up to age 62 (60 for retirements on or after 1 November 2021). The age reduction associated with your pension benefit will be calculated based on when payments begin.

An Early Retirement Benefit Example	
Assume you retire at age 58, with 27 years of service credit. You are eligible for $1,296.00 and a $24.00 pension additive, for an unreduced basic pension total of $1,320.00 each month. You would like to begin receiving early retirement benefits immediately.	
Basic Pension (reduced before age 60)	
Basic Monthly Pension Benefit	$1,320.00
Reduction Before Age 60 (1/3% x 24 months x $1,296.00)	- 103.68
Early Retirement Monthly Formula Benefit	$1,216.32

A-4.5. How You Receive Plan Payments

Your pension benefits are paid according to the payment form that applies to you when benefits start:

- If you're single, you receive a single life annuity.
- If you're married, you may elect to receive a 55% or 75% surviving spouse benefit.

A-4.5.1. Payment Methods

- Single Life Annuity. This payment method provides a monthly benefit during your lifetime, with payments stopping at your death.
- 55% Surviving Spouse Benefit. This payment method provides payments for your life and continues payments of 55% of the benefit amount to your surviving spouse after your death. If you are more than 10 years older than your spouse, your monthly benefit is reduced by ½% for each year in excess of 10 years that your spouse is younger than you.
- 75% Surviving Spouse Benefit. This payment method provides payments for your life and continues payments of 75% of the benefit amount to your surviving spouse after your death. If you elect this option, your monthly benefit will be reduced using actuarial factors based on your age and your spouse's age at the time of your retirement.

An Example of the 55% Surviving Spouse Benefit	
Assume that you retire with 15 years of service credit and you are not more than 10 years older than your spouse. Your basic monthly pension benefit is $744.00 ($720.00 basic pension plus $24 pension additive).	
Surviving Spouse Benefits	
Your basic unreduced monthly pension benefit	$744.00
Surviving spouse benefit multiplier (55%)	X .55
Surviving spouse's monthly pension benefit	$409.20

A-4.5.2. When Your Benefits Are Paid

The date you begin receiving benefits depends on the type of retirement you choose. See sections A-4.3 and A-4.4 for more information.

A-4.6. To Receive Pension Benefits

For benefits to begin, you must submit a written application in accordance with the chart below. Contact the John Deere Benefits Center at 1-844-689-7833 to request an application, or if you need any additional information.

Application Received (On or Before)	Pension Benefit Commencement Date
1 November	1 January
1 December	1 February
1 January	1 March
1 February	1 April
1 March	1 May
1 April	1 June
1 May	1 July
1 June	1 August
1 July	1 September
1 August	1 October
1 September	1 November
1 October	1 December

A-4.7. If You Die After You Retire

If you die after you retire, the Plan includes protection for your surviving spouse. Surviving spouse benefits, if any, are paid only to your spouse.

A-4.7.1. Who's Eligible?

Your spouse is eligible for surviving spouse benefits if you were married to him or her at retirement. If you marry during retirement, you must have been married at least one year immediately prior to your death, and have applied for the surviving spouse protection benefit for your new spouse. If you fail to notify the Company in the event you marry following retirement, any applicable reduction in your benefit beginning on the surviving spouse benefit effective date (1 year following marriage) will be retroactively collected from your pension benefit or your spouse's benefit in the event of your death.

A-4.7.2. Benefits Payable to Your Surviving Spouse

If this coverage is in effect for you on the date of your death, your surviving spouse will receive monthly benefits equal to 55% or 75% of your pension benefit, depending upon your election at retirement or at the time you applied for the surviving spouse protection benefit for your new spouse in retirement.

A-4.7.3. When Benefits Are Paid

Benefits to your spouse will start on the first day of the month following your death.

A-4.8. If You Die Before You Retire

A-4.8.1. Who's Eligible?

If you die before you retire, your surviving spouse is eligible for surviving spouse benefits as long as you were:

– Vested under the Plan (you have at least five years of service credit); and

– Married for at least one year immediately prior to your death.

A-4.8.2. Benefits Payable to Your Surviving Spouse

Your surviving spouse will receive monthly benefits equal to 55% of the benefit you would have received if you had lived to your earliest retirement age and retired. The Company pays the full cost of this coverage; however, the surviving spouse benefit will be reduced if your spouse is more than 10 years younger than you (see section A-4.5.1).

A-4.8.3. When Benefits Are Paid

If you die after you are eligible to retire, benefits to your spouse may start on the first day of the month following your death.

If you die before you are eligible to retire, benefits to your spouse may start on the first day of the month following what would have been your earliest retirement date (based on your service credit at the time of your death).

A-4.9. Disability Retirement – If You Become Disabled

The Pension Plan pays benefits if you are totally and permanently disabled.

Q: What is total and permanent disability?

A: You are considered totally and permanently disabled if you have a physical or mental condition caused by an illness or injury that leaves you unable to work for the Company. The condition can be work-related or not, as long as you have medical evidence satisfactory to the Company to support it.

You can receive disability pension benefits if you are younger than age 68 and if you have at least 10 years of service credit when you become totally and permanently disabled.

A-4.9.1. How Your Disability Retirement Benefit Is Calculated

Your disability retirement benefit is calculated using your years of service credit on the date of your disability, as follows:

– If you commence disability retirement prior to 1 November 2021, dollar amount in Earnings Bracket at date of disability (See Earnings Brackets displayed in section A-4.3.2) x Years of Service Credit at disability. If you commence disability retirement on or after 1 November 2021, $48 x Years of Service Credit at disability. In addition, if you commence disability retirement on or after 1 November 2021, you may also be due a cash balance benefit based on what you have accrued as of the date of your disability retirement.

Additional Temporary Benefit

If you become totally and permanently disabled before you are eligible for an 80% benefit from Social Security or receipt of Social Security Disability, you also may be eligible for an Additional Temporary Benefit, up to your eligibility for an 80% benefit from Social Security.

You can receive a monthly Additional Temporary Benefit equal to:
$21.85 x Your Years of Service Credit at Disability (up to 30 years) to a Maximum of $655.50

A-4.9.2. When Disability Retirement Benefits Begin and End

If you're eligible, disability retirement benefits usually start on the first day of the month after the Company accepts proof of your total and permanent disability, but not before your Weekly Indemnity benefits end. Disability retirement benefits can start as early as the sixth month after you become totally and permanently disabled, if you are not receiving Weekly Indemnity benefits.

Disability benefits generally continue until you recover or you reach age 65. In the case of disabilities (LTD or Disability Retirement) commencing on or after 1 October 2003, disability retirement benefits will cease upon attaining 30 years of service credit. No further service credit will be earned. Your retirement benefit includes service credit for the time you were on long-term disability and disability retirement (for disabilities commencing on or after 1 October 2003, time credited while on LTD or Disability retirement will be limited to a total of 30 years). Disability retirement benefits will continue until the earlier of: (1) attaining 30 years of pension service (if disability commenced on or after 1 October 2003), (2) age 65 if disability commenced prior to age 60, (3) age 68 or 60 months if disability commenced on or after age 60, (4) upon reaching a plan limitation, or (5) upon request of the employee eligible for early or normal retirement.

Additional Temporary Benefits are payable until you reach eligibility for an 80% benefit under Social Security, or until you become eligible for an unreduced Social Security benefit, whichever is earlier.

A-4.9.3. If You Recover

If you recover and return to work with the Company, the time you were receiving Disability Retirement Benefits counts as service credit towards your future normal or early retirement benefit. It will be added to the service credit you had earned up to your

disability retirement.

A-4.10. Deferred Vested Pension – If You Leave Before Retirement

When you have at least five years of service credit, you're considered to be vested under the Plan. This means that you have 100% ownership rights to your accrued pension benefit, which is payable in the future. Those employees who also have a cash balance component to their pension benefits vest in all of their pension benefits with three years of service credit.

If you leave the Company for any reason once you are vested, but before you reach early or normal retirement age, you are eligible for a deferred vested pension benefit.

Q: Why is it called a deferred vested pension?

A: Because you're vested (you have 100% ownership rights to your accrued pension benefit). You also left the Company earlier than the Plan allows for you to receive monthly distributions, and therefore the payment of the benefit is deferred, or delayed, until you meet eligibility for a distribution.

If the present value of your accrued benefits is less than $5,000, you will be notified and receive a lump sum distribution of your vested benefit. See "Tax Tip" to avoid withholding on your lump sum.

A-4.10.1. How Your Deferred Vested Pension Is Calculated

Your deferred vested pension benefit is calculated using the service credit, earnings bracket amounts (or a flat $48 rate if active after 1 November 2021), pension additive rates for each year completed between 1 October 2009 and 30 September 2015, and Plan provisions in effect on the date you left the Company. The benefit is calculated as a basic pension benefit (see section A-4.3 for the basic pension benefit calculation). The chart shows monthly pension amounts per year of service credit.

For employees hired on or after 1 October 1997* who are terminated, quit, etc. between the dates specified below, the vested benefits are as follows and are reduced ½% for each month benefits begin prior to age 65.

Deferred Vested Pension Calculation

The deferred vested pension is calculated by multiplying years of service times the contract rate in effect based on the earnings bracketed rates at the time of the separation. Any pension additive amounts earned for years completed between 1 October 2009 and 30 September 2015 are also applicable. Age reduction and/or pre-retirement surviving spouse coverage reduction factors may apply.

A-4.10.2. When Deferred Vested Benefits Are Paid

The Company will notify you when you are eligible to begin deferred vested pension benefits. For benefits to begin, you must apply in writing. Your written request can be made by completing an application request form or by submitting a letter with the date you'd like payments to begin. Your request must be received at least 60 days prior to the date you want payments to begin. To request an application request form or if you need any additional information, contact the John Deere Benefits Center at 1-844-689-7833.

You may choose to start payments at any time after age 60 (if you have 10 years of service credit), age 65 (if you have between 5 and 10 years of service credit), or any time after your age and service credit equal 85.

Choosing your benefit start date is important, because reductions apply for early payments:

- If you choose to start payments on or after the date you reach age 65, no reductions apply.
- If you choose to start payments before age 65, benefits are reduced by ½% (one-half of one percent) for each month they start before age 65.

A Deferred Vested Benefit Example	
Assume you left the Company at age 40, with 15 years of service credit. Your basic accrued pension benefit, based on your service credit and pension bracket when you left, is $730.00 a month (a $720.00 basic calculation plus $10 pension additive). You decide to begin receiving benefits at age 63. Therefore, your deferred vested benefit would be:	
Unreduced Accrued benefit (Age 65)	$730.00
Reduction (½% x 24 months before age 65 x $720.00)	- 86.40
Monthly Deferred Vested Benefit	$643.60

A-4.10.3. How Deferred Vested Benefits Are Paid

If you are eligible for a deferred vested benefit and the present value of your benefit is $5,000 or less, you may receive the present value of your benefit in a single lump sum. If this option is available to you, you will be notified. Otherwise, benefits are paid as

previously described.

If your present value is less than $1,000, the default distribution option will be a lump sum payment directly to you. If your present value is between $1,000 and $5,000, the default distribution option will be a rollover to an Individual Retirement Account with a third party administrator. The default distribution option can be overridden by providing your alternate election prior to the distribution date.

Tax Tip

If your deferred vested benefit is distributed to you as a single, lump sum payment, a mandatory 20% federal withholding tax applies. To avoid withholding, you may request a direct rollover to another employer's plan or to an IRA. Contact the John Deere Benefits Center at 1-844-689-7833 for more information before payment is made.

A-4.10.4. Deferred Vested Surviving Spouse Benefit

If you die before your deferred vested benefits start, your spouse is eligible for surviving spouse benefits, as long as you did not waive this coverage before your death. You can waive this coverage with your spouse's consent, if he or she signs the consent form in the presence of a Plan representative or notary public. You and your spouse must have been married for at least one year immediately prior to your death for these surviving spouse benefits to be payable.

Cost of Coverage

There is a charge for deferred vested surviving spouse coverage prior to the date you begin drawing your benefit. You pay the cost through a reduction in your pension benefit. The amount of the reduction depends on your age when you choose this coverage and how long the coverage is in effect. The chart below shows the monthly cost as a percentage reduction in your benefits.

Deferred Vested Benefit – Surviving Spouse Coverage	
If you are this age:	**Your pension will be reduced by this percentage for each year of coverage:**
Under 35	0%
35-44	0.1%
45-54	0.3%
55 and older	0.8%

So, if this protection starts at age 50 and stays in effect until you reach age 65, your monthly pension will be reduced .3% each year for five years (ages 50 to 54) and .8% for 10 years (ages 55 to 64), for a total reduction of 9.5% ([.3% x 5] + [.8% x 10]).

Making Your Election

You may elect to waive preretirement surviving spouse coverage at any time. If you make your election before age 35, you must re-elect to waive this coverage between the year you reach age 35 and the date Plan payments start. If you're married and you reject this coverage, your spouse must consent in writing in the presence of a Plan representative or notary public.

Benefits Payable

If the preretirement survivors' coverage is in effect for you on the date of your death, your surviving spouse will receive a monthly benefit equal to 55% of the benefit you would have received if you had reached your earliest eligibility to start your deferred vested pension.

Your surviving spouse may begin receiving benefits as of the date you would have first been eligible to receive a deferred vested pension. To receive deferred vested surviving spouse benefits, your spouse must apply in writing as described in the preceding section A-4.10.2, When Deferred Vested Benefits Are Paid.

A – 4.11 Cash Balance

When You Can Receive Benefits

Your pension benefit, including the cash balance portion, is vested once you have at least three years of service credit or if you are employed by the company or any affiliate when you reach normal retirement age. Your cash balance benefit is payable upon separation from Deere & Company and affiliates or subsidiaries regardless of age.

Although you can take a distribution of your cash balance plan benefit when you terminate employment at any age, the Plan does provide for Normal Retirement at age 65 as well as Early Retirement. These terms are not relevant to the commencement of cash balance benefits because you may request payment when you terminate employment, but these terms may still apply to other benefits from the company to which you may be entitled such as the flat rate benefit. For example, you must still wait until your Early or Normal Retirement Date to commence payment of benefits under the fixed rate component once you have terminated employment, even though you may take an immediate distribution of your cash balance plan benefit when you leave.

Normal retirement age is defined as the later of you reaching the age of 65 or having completed at least five years of service credit. If you want to continue working, you may retire at any later date. Early retirement age is defined as shown in A – 4.4.2.

How You Receive Benefits
The Plan offers several payment methods.

Surviving Spouse Protection
The Plan offers surviving spouse protection if you die before or after benefit payments start, as long as you are vested and married prior to your death.

Nonspousal Beneficiaries
The Plan offers protection if you die before or after benefit payments start, as long as

you are vested and have named an individual or individuals as a nonspousal beneficiary(ies). If you are married prior to your death, a spousal waiver is required.

A - 4.11.1 Basic Cash Balance Benefit Components

Your cash balance benefit is derived from a hypothetical account balance that the company established on your behalf in the Plan. Your account may be paid in several different forms. When you first join the Plan, your beginning account value is zero (for those employees who were actively employed after 1 November 2021, the company has seeded your account with $2,000 per completed years of service as of 1 October 2021) and at the end of each calendar year a pay credit and an interest credit are added to your account. The pay credit is calculated by multiplying your annual earnings by a pay crediting rate. The pay crediting rate varies based on years of service. If you have under 5 years of service, the pay credit is 2.5%. For 5-14 years of service, the pay credit is 3%. For 15 or more years of service, the pay credit is 4%. The interest credit is calculated by multiplying your beginning of the year account balance by the interest crediting rate for the calendar year. The interest crediting rate is the lesser of 9% or the four-month average of the annual yield on non-inflation adjusted 30-year Treasury constant maturities for the months of June, July, August and September of the calendar year preceding the calendar year to which the interest credit applies. The interest crediting rate will not be less than 1.67%. If you are a new hire, the interest credit is zero for the first year of your Plan participation because the interest credit is applied to your beginning of the year account balance, which would be zero for the year in which you first commence to participate. You will receive a prorated interest credit in the year in which your benefit commences to be paid to you.

Eligible earnings for the cash balance portion of the pension benefit closely follow eligible earnings for the TDSP. Eligible earnings include straight time, overtime, grievance pay, profit sharing, and others (for a comprehensive list, please consult your unit payroll department). Compensation is capped by law based on an amount set each year by the Internal Revenue Service. Amounts in excess of the limit are not counted under the Plan. The cumulative pay credits and interest credits comprise your account.

When You Terminate Employment
Depending on when you terminate employment with the company, the Plan pays benefits which are adjusted depending on the survivor benefit option you choose. See Payment Methods—Survivor Options for more details. You may commence payment of benefits from your hypothetical cash balance account at any time after you terminate employment as of the first day of any month.

A - 4.11.2 How You Receive Plan Payments

Your pension benefits are paid according to the payment form you elect at the time of your retirement or upon separation from Deere & Company and affiliates or subsidiaries regardless of age:

– If you're single, you receive a single life annuity or you may elect a lump sum.

– If you're single and designate a nonspousal beneficiary, you may elect to provide a 55% or 75% survivor benefit.

– If you're married, you may elect to provide a 55% or 75% surviving spouse benefit. If you choose to waive the surviving spouse coverage or name a nonspousal beneficiary for the survivor benefit, your spouse must consent to your choice by signing the consent form in the presence of a notary public. Contact the John Deere Benefits Center to add or change your beneficiary at www.yourbenefitsresources.com/deere or 1-844-689-7833.

Payment Methods:
Lump Sum. This method provides a one-time payment equal to your account.

Single Life Annuity Option. This method provides a monthly benefit during your lifetime, with payments stopping at your death.

55% Survivor Benefit Option. This payment method provides payments for your life and continues payments to your survivor after your death. The survivor payment will be 55% of what you receive in retirement.

75% Survivor Benefit Option. This payment method provides payments for your life and continues payments to your survivor after

your death. The survivor payment will be 75% of what you receive in retirement. With this payment form, you agree to a reduction in your benefit.

See the Surviving Spouse Benefit reduction examples for further explanation.

When Your Benefits Are Paid
You may commence payment as of the first day of any month following your termination of employment with the Company. However, payments must begin no later than the April 1 following the calendar year in which you reach age 72, unless you are still actively working for the Company.

To Receive Pension Benefits
You may not apply earlier than 180 days and no later than 60 days prior to the date of your intended retirement. Call the John Deere Benefits Center at 1-844-689-7833. You can call between 8:00 a.m. and 6:00 p.m. Central Time, Monday through Friday. Choose the "initiate retirement" option to direct your call to a retirement specialist. Or, you may visit UPoint® at www.yourbenefitsresources.com/deere. This site provides modeling tools and you can even start your pension payment online, without the help of a retirement specialist.

A – 4.11.3 Death After Retirement–Cash Balance Benefit

If you die after your benefits commence to be paid, the Plan includes protection for your survivor, if any, if you elect an annuity payment with a survivor annuity to be paid either to your spouse or nonspousal beneficiary.

Who's Eligible?
Your spouse is eligible for surviving spouse benefits if you were married to him or her on the date your benefits are due to commence. You can waive the spousal coverage with your spouse's consent, if he or she signs the consent form in the presence of a notary public. If you are not married or your spouse consents, a non-spousal beneficiary may be named at the time of retirement.

Benefits Payable to Your Survivor
If this coverage is in effect for you on the date of your death, your survivor will receive monthly benefits based upon your election, or under the 55% Survivor Benefit Option (described under Payment Methods), if a spouse waiver is not on file and you are married at the time of your death.

When Benefits Are Paid
Benefits to your spouse will start on the first day of the month following your death and are payable the first work day of each month.

A – 4.11.4 Death Before Retirement–Cash Balance Benefit

Who's Eligible?
If you die before your benefits commence to be paid to you, your surviving spouse is eligible for surviving spouse benefits as long as you were vested under the Plan (you have at least three years of service credit or are employed with the Company or an affiliate at normal retirement age), and married at the time of your death. You may name someone other than your spouse with their consent. If you are not married, you may designate a nonspousal beneficiary or beneficiaries.

Benefits Payable to Your Surviving Spouse
Your surviving spouse will receive a single life annuity which is the actuarial equivalent of your total cash balance account. Your spouse may elect to receive a single lump sum instead. If you were unmarried or your spouse waived his or her right to the benefit, your designated beneficiary(ies) will receive a lump sum payment based upon their proportionate share. Consistent with federal regulations, if you are married and waive the pre-retirement death benefit for your spouse before you reach age 35, in conjunction with designation of a non-spouse beneficiary or otherwise, then your designation will automatically become void on January 1 of the year you reach age 35. However, with your current spouse's consent, you may make a new election to waive the pre-retirement death benefits, whether or not you name a beneficiary other than your spouse. Your spouse's consent must acknowledge the effect of your election, and must be witnessed by a notary public.

When Benefits Are Paid
If you die before your benefits commence to be paid to you, benefits to your survivor will start on the first day of the month following your death and are payable the first work day of each month. However, if your survivor is your surviving spouse, your spouse may elect to defer payment until the date you would have reached normal retirement age had you lived.

A – 4.11.5 Deferred Vested Pension–Cash Balance Benefit: If You Leave Before Retirement and do not Elect to Receive Your Payment(s)

When you have at least three years of service credit you are considered to be "vested" under the Plan. This means that you have 100% ownership rights to your accrued pension benefit, which is payable in

the future. You are also 100% vested if you are employed by the company or any of its affiliates when you reach normal retirement age. If you leave the company for any reason before you are retirement eligible and do not elect to receive your payment even though you are vested, you are eligible for a deferred vested pension benefit.

How Your Deferred Vested Pension is Calculated
Pay Credits will cease upon your separation. However, Interest Credits will continue to be added to your existing account balance until you elect to commence your payment(s).

When Deferred Vested Benefits Are Paid
You may not apply earlier than 180 days and no later than 60 days prior to the date of your intended retirement. Call the John Deere Benefits Center at 1-844-689-7833. You can call between 8:00 a.m. and 6:00 p.m. Central Time, Monday through Friday. Choose the "initiate retirement" option to direct your call to a retirement specialist. Or, you may visit UPoint® at www.yourbenefitsresources.com/deere. This site provides modeling tools and you can even start your pension payment online, without the help of a retirement specialist. You may choose to start payments at any time after your separation date, but no later than April 1 following the calendar year in which you reach age 72. Benefits are payable starting on the first day of the month.

How Deferred Vested Benefits Are Paid
If you are eligible for a deferred vested benefit and your benefit under the Pension

Plan (including your cash balance account and the present value of your fixed rate benefit), is less than $5,000 but more than $1,000, you will be notified and asked to make an election to have your benefit

paid in cash or rolled over to an IRA or eligible employer retirement plan of your choice. If you do not make an election, the Plan will establish an Individual Retirement Account (IRA) in your name, to which will be transferred your account balance. If your account balance is less than $1,000, it will be paid to you automatically in a lump sum (with 20% federal income tax withholding applied) if you do not make an election to roll it over to an IRA or eligible employer retirement plan. You will be notified if this payment affects you. Otherwise, benefits are paid under one of the options previously described.

A – 4.11.6 Deferred Vested Surviving Spouse Benefit

If you die before your deferred vested benefits start, your spouse is eligible for surviving spouse benefits, unless you designated another beneficiary(ies) with your spouse's consent by signing the consent form in the presence of a notary public.

Benefits Payable
Your surviving spouse will receive a monthly benefit which is the actuarial equivalent of 55% of your account, or he/she shall have the option to elect a single lump sum payment. If you designate someone other than your spouse or you are not married, your designated beneficiary(ies) will receive 55% of your account in a single lump sum based upon their proportionate share. Your spouse may not apply earlier than 180 days and no later than 60 days prior to the date of payment. Your spouse should call the John Deere Benefits Center at 1-844-689-7833. Your spouse may call between 8:00 a.m. and 6:00 p.m. Central Time, Monday through Friday.
They should choose the "initiate retirement" option to direct her/his call to a retirement specialist. Or, he/she may visit UPoint® at www.yourbenefitsresources.com/deere.

Making Your Election
You may change your beneficiary(ies) at any time before you commence your payment. If you're married and designate someone other than your spouse, your spouse must consent in writing, in the presence of a notary public.

A – 4.11.7 Pension Benefit Examples—Cash Balance Benefit

Accumulation Phase—Cash Balance Benefit

Hired Nov. 1, 2018	Calendar Year 2022	Calendar Year 2023	Calendar Year 2024
Annual Compensation	$60,000	$60,000	$63,000
Interest Credit Rate	1.99%	2.50%	1.76%
	12/31/2022	12/31/2023	12/31/2024
Beginning of Year Balance	N/A	$1,500	$3,037.50
Pay Credit	$1,500	$1,500	$1,575
Interest Credit	N/A	$37.50	$50.73
Total Cash Balance Account	$1,500	$3,037.50	$4,663.23

Example One —Cash Balance Benefit

Assume retire at age 64 and your survivor is the same age, you have 32 years of service credit, and a total cash balance account value of $181,000.

Lump Sum. The lump sum amount is $181,000.

Single Life Annuity Option.

Total Cash Balance Account Value	$181,000
Annuity Conversion Factor	/ 175.5478
Monthly Formula Benefit at age 64	**$1,031.06**

In this case you would be eligible to receive a monthly annuity of $1,031.06 for life.

55% Survivor Benefit Option.

Total Cash Balance Account Value	$181,000
Annuity Conversion Factor	/ 175.5478
Monthly Formula Benefit at age 64	**$1,031.06**

In this case you would be eligible to receive a monthly annuity of $1,031.06 and upon your death, if your beneficiary survived you, your beneficiary would receive $567.08 per month for his/her lifetime.

75% Survivor Benefit Option.

Total Cash Balance Account Value	$181,000
Annuity Conversion Factor	/ 199.5658
Monthly Formula Benefit at age 64	**$906.97**

In this case you would be eligible to receive a monthly annuity of $906.97 and upon your death, if your beneficiary survived you, your beneficiary would receive $680.23 per month for his/her lifetime.

Example Two —Cash Balance Benefit

Assume you were hired after October 31, 2014; you retire at age 65 and your survivor is the same age, you have 33 years of service credit, and a total cash balance account value of $190,000.

Lump Sum. The lump sum amount is $190,000.

Single Life Annuity Option.

Total Cash Balance Account Value	$190,000
Annuity Conversion Factor	/ 170.4681
Monthly Formula Benefit at age 65	**$1,114.58**

In this case you would be eligible to receive a monthly annuity of $1,114.58 for life.

55% Survivor Benefit Option.

Total Cash Balance Account Value	$190,000
Annuity Conversion Factor	/ 170.4681
Monthly Formula Benefit at age 65	**$1,114.58**

In this case you would be eligible to receive a monthly annuity of $1,114.58 and upon your death, if your beneficiary survived you, your beneficiary would receive $613.02 per month for his/her lifetime.

75% Survivor Benefit Option.

Total Cash Balance Account Value	$190,000
Annuity Conversion Factor	/ 197.7765
Monthly Formula Benefit at age 65	**$960.68**

In this case you would be eligible to receive a monthly annuity of $960.68 and upon your death, if your beneficiary survived you, your beneficiary would receive $720.51 per month for his/her lifetime.

Permanent Separation Benefit Example—Cash Balance Benefit

Assume you were hired after October 31, 2014, you separate from Deere & Company or an affiliate or subsidiary with 15 years of service credit. You are age 38 and your survivor is the same age, and you have a total cash balance account value of $59,000.

Lump Sum. The lump sum amount is $59,000.

Single Life Annuity Option.

Total Cash Balance Account Value	$59,000
Annuity Conversion Factor	/ 281.3656
Monthly Formula Benefit at age 38	**$209.69**

In this case you would be eligible to receive a monthly annuity of $209.69 for life.

55% Survivor Benefit Option.

Total Cash Balance Account Value	$59,000
Annuity Conversion Factor	/ 281.3656
Monthly Formula Benefit at age 38	**$209.69**

In this case you would be eligible to receive a monthly annuity of 209.69 and upon your death, if your beneficiary survived you, your beneficiary would receive $115.33 per month for his/her lifetime.

75% Survivor Benefit Option.

Total Cash Balance Account Value	$59,000
Annuity Conversion Factor	/ 295.5684
Monthly Formula Benefit at age 38	**$199.62**

In this case you would be eligible to receive a monthly annuity of $199.62 and upon your death, if your beneficiary survived you, your beneficiary would receive $149.72 per month for his/her lifetime.

**Actual factors are calcualted based upon the mortality and interest rates in effect at the time the benefit is commenced. Factors shown here are illustrative only.*

A – 4.12 Retirement Bonus

Who's Eligible

Employees who have earned a benefit under the pension plan may be eligible for a retirement bonus at the time of their retirement. The retirement bonus is available to employees who meet the conditions of early, normal, or postponed retirement and have earned at least 10 years of service.

Amount of Bonus

Retirement eligible employees who have earned at least 10 but less than 25 years of service credit are eligible for a retirement bonus of $37,500. Retirement eligible employees who have 25 or more years of service credit are eligible for a retirement bonus of $50,000.

A - 4.12.1 How You Receive Plan Payments

Your pension benefits are paid according to the payment form you elect at the time of your retirement or when you decide to commence your pension benefits

– If you're single, you receive a single life annuity or you may elect a lump sum.

– If you're married, you may elect a lump sum, or to provide a 55% or 75% surviving spouse benefit. If you choose a lump sum, your

spouse must consent to your choice by signing the consent form in the presence of a notary public. Contact the John Deere Benefits Center to add or change your beneficiary at www.yourbenefitsresources.com/deere or 1-844-689-7833.

It is important to note that while you may elect to receive your retirement bonus in a different form than your fixed rate pension payment, you must commence these two benefits together. For example, you may not choose to receive your retirement bonus and then commence your fixed rate pension at a later time, and vice versa.

A – 4.12.2 Death Before Retirement–Retirement Bonus

If you are retirement eligible but pass way prior to retiring, and you are married, the retirement bonus will be paid to your spouse as a single life annuity unless your spouse elects to receive the payment as a lump sum. If you die prior to reaching Normal Retirement age, your spouse may delay commencement of the payment of the retirement bonus to coincide with the commencement of the fixed rate benefit. If you are not married, the retirement bonus will be paid to your estate as a lump sum as soon as administratively practicable.

A-4.13. Assignment of Benefits

Your benefits from the Pension Plan belong to you and may not be sold, assigned, transferred, pledged, or garnished, under most circumstances.

However, if you become divorced or separated, certain court orders could require that part of your benefits be paid to someone else — your spouse or children, for example. This is known as a qualified domestic relations order (QDRO). As soon as you are aware of any court proceedings which may affect your Pension Plan benefits, contact the John Deere Benefits Center.

You may receive a copy of the qualified domestic relations order, free of charge, from the Plan Administrator. See Chapter H, Administrative Information for the Plan Administrator's address.

A-4.14. A Few Words About Taxes

Your pension payments from this Plan are subject to federal and certain state income taxes. For the most up-to-date tax information for your personal financial situation, it's important that you consult a qualified tax expert.

A-5. The Tax Deferred Savings Plan

A-5.1. The Tax Deferred Savings Plan Highlights

The Tax Deferred Savings Plan is an easy way to supplement the retirement income you'll receive from the Pension Plan and Social Security. The Plan encourages you to save by providing you with both a pre-tax and after-tax savings opportunity.

Tax Advantages	The money you contribute to the Plan is deposited in your account on a pre-tax and/or after-tax basis. If you elect pre-tax savings, taxes are delayed on your full account until the money is distributed from the Plan.
Participating in the Plan	Generally, if you're a regular wage employee, you may participate in the Plan. If you are hired on or after 1 January 2022, you will be automatically enrolled at a 6% contribution rate. You have 30 days from your date of hire to opt out or make a change.
Your Plan Account	You can save from 1% to 75 of eligible earnings each pay period. If you are age 50 or older, you may save an additional catch-up amount.
You Choose the Funds	You choose how to invest your account among the funds offered by the Plan.
When You Retire	When you retire or leave the Company for any other reason, you may elect to have your Tax Deferred Savings Plan account paid to you through several distribution options.

A-5.2. Eligibility and Enrollment

A-5.2.1. Who's Eligible?

You're eligible to participate if you're a wage employee who:

– Is a citizen or resident of the U.S.;

– Is a member of a group of employees to whom the Plan has been extended by Deere & Company or is a member of a collective bargaining group whose collective bargaining agreement provides for participation in the Plan.

For more information on eligibility, contact the John Deere Benefits Center 1-844-689-7833..

Uniformed Services Employment and Reemployment Rights Act of 1994

An Employee who left employment with the Company and immediately entered the service of the "Uniformed Services of the United States" will be considered as continuing to have been employed by the Company; will be given an opportunity for "make-up contributions" in order to receive any matching contributions; and service in the Uniformed Services of the United States will be credited towards vesting; all in accordance with Section 414(u) of the Code, provided the employee has reemployment rights under applicable law and does become reemployed by the Company under the provisions of that law. Contact Deere Direct for additional information.

A-5.2.2. Enrolling in the Plan

The Tax Deferred Savings Plan is completely voluntary. You need to enroll before you can make deferrals. To enroll, call the John Deere Savings Plan Service Center (Service Center) at Fidelity Investment at (800) 354-3427; or, log on to Fidelity Net-Benefits, www.401k.com. Your participation begins the next pay period after you make your election.

Employee's hired on and after 1 January 2022 will be automatically enrolled in the plan with a 6% deferral contribution that will begin on or about 30 days following the entry of employee enrollment information to Fidelity's system. Also, employees not enrolled in the Plan at this time or enrolled with a deferral contribution less than 6%, will be enrolled at 6%. Within 30 days, you may elect a different percentage or opt out of the Plan.

If you decide not to enroll when first eligible, you can enroll at any later time. Your participation will be effective the next occurring payroll period.

A-5.2.3. Naming a Beneficiary

Your beneficiary is the person you name to receive your Plan benefits if you die. Under current laws, if you're married, your spouse is automatically your beneficiary. If you want to name someone other than or in addition to your spouse, your spouse must consent to your choice and have it notarized. If you ever want to change your beneficiary, your spouse must again approve the change. Call the Service Center or log on to Fidelity NetBenefits, www.401k.com for more information.

Q: Can I change my beneficiary?

A: You may change your beneficiary(ies) at any time. To make changes to your beneficiary designation, call the Service Center or log on to Fidelity NetBenefits, www.401k.com.

A-5.2.4. Recordkeeping Fees

Participant accounts are charged an $8 annual recordkeeping fee. The fee is deducted from participant accounts on a quarterly basis in $2 increments.

A-5.3. Contributions Under the Plan

The Tax Deferred Savings Plan is designed around different types of contributions being made to each participant's account.

A-5.4. Your Contributions

The maximum deferral percentage is 75%.

If you participate in the Tax Deferred Savings Plan, each pay period you can contribute from 1% to 75% of your pay or such maximum percentage as provided by the Plan, or other such plan limits. You must elect a whole percentage; for example, 15% not 14.5%.

Your contributions can be made on a pre-tax basis and/or a Roth after-tax basis. The contributions are deducted from your paycheck and are deposited in your account as soon as practicable, but not later than 15 business days following the month contributions are made. The contributions you can make:

Your regular and/or Roth 401(k) contributions

These contributions are credited to your account.

Catch-up contributions

The Tax Deferred Savings Plan allows catch-up deferrals as provided through the Economic Growth & Tax Relief Reconciliation Act. If you are age 50 or older by any 31 December, you may defer an additional amount of eligible earnings. For 2022, this amount is $6,500. There is no company match applied to a catch-up contribution. Contact the Service Center at Fidelity (800) 354-3427 for more information and the current year's limit.

A-5.4.1. The Advantage of Before-Tax and Roth After-Tax Contributions

The Tax Deferred Savings Plan lets you defer taxes by making pre-tax and/or Roth after-tax contributions. Here's how:

Pre-tax contributions mean:
– Your Tax Deferred Savings Plan contributions and earnings are not taxed immediately;

– Your earnings grow tax-deferred; and

– You pay less taxes on your wages.

Roth after-tax contributions mean:
– Your Tax Deferred Savings Plan contributions are taxed immediately;

– Your earnings grow tax-deferred;

– At the time of distribution, no taxes are owed.

Company Match
If you were hired on and after 1 October 1997, by participating in the Tax Deferred Savings Plan, you have the opportunity to receive Company matching contributions. If you are a Traditional PLUS participant, the Company match is 60% of your wage deferral, up to 6% of earnings. Your Company matching contributions will be fully vested after you have three years of credited service with the Company. Restored service will be used in the vesting calculation.

If you are a Choice PLUS participant, the Company match in calendar 2022 is 100% of your wage deferral, up to 6% of earnings. Beginning in calendar 2023, the Company match is based on the prior fiscal year's Profit Sharing results shown in the table below. Additionally, Choice PLUS participants will receive a 5% automatic retirement contribution based on FICA eligible earnings.
The retirement contribution is fully vested at all times.

If Profit Sharing Payout % is...		
At least	Less Than	TDSP Match is
0	8.5	$0.70
8.5	8.75	$0.71
8.75	9	$0.73
9	9.25	$0.75
9.25	9.5	$0.78
9.5	9.75	$0.80
9.75	10	$0.82
10	10.25	$0.84
10.25	10.5	$0.86
10.5	10.75	$0.88
10.75	11	$0.90
11	11.25	$0.92
11.25	11.5	$0.94
11.5	11.75	$0.96
11.75	12	$0.98
12	Unlimited	$1.00

Effective for each pay period processed after July 20, 2014, a calculation will be performed to determine if a matching contribution is due. The calculation will take into account your year-to-date deferrals divided by the year-to-date eligible compensation to determine a year-to-date deferral rate. The year-to-date deferral rate shall be applied against the matching level provided by your employer to determine the required year-to-date matching contribution amount by the conclusion of the pay period, subject to IRS limits. If you were employed by more than one employer that has adopted the plan in any calendar year, the matching contribution provided shall be based upon the matching level of the highest matching employer.

A-5.4.2. Changing Your Contributions

You may increase, decrease, or stop your contribution any pay period by calling the Service Center at (800) 354-3427 or logging on to Fidelity NetBenefits at www.401k.com.

A-5.5. Rollover Contributions

If, before joining the Company, you participated in a qualified savings, 457 or 403(b) plan, you may be able to roll over pre-tax and/or after-tax contributions and earnings from your former plan into the Tax Deferred Savings Plan.

Contact the Service Center (800) 354-3427 to find out whether a rollover is possible in your situation. When you roll over money to the Plan, a separate source is set up for your rollover contribution. You are not considered a Plan participant until you start saving through wage deferrals.

You may want to take a distribution from a previous employer because:

- TDSP offers different investment funds;
- You want to be able to access previous funds through a loan; or
- Your previous employer requires distribution and you wish to continue to defer taxes on earnings previously deferred.

Special Note: If you save through another tax qualified plan in any calendar year, it is very important to report these other deferrals to Deere Direct. The IRS maximum is applied to the total amount you defer through all employers. Deere Payroll will subtract any amount you already deferred toward the maximum limit, helping you avoid a plan excess. Company contributions do not count toward the IRS maximum.

Q: Do I need to let the Company know if I've saved through another tax qualified plan?

A: **Yes**, The IRS limits 401(k) deferrals to $20,500 for tax year 2022. It is very important to report other deferrals to Deere Direct. The IRS maximum is applied to the total amount you defer through all employers. Deere will subtract the amount you already deferred from the maximum, helping you avoid a plan excess. Be sure to call Deere Direct to report deferrals made through other plans for the current calendar year.

A-5.6. Limits on Contributions

TDSP is highly regulated and subject to Internal Revenue Code (IRC) provisions and regulations. Specific regulatory limits apply to TDSP.

- Annual IRS limit – This limit (on your pre-tax and/or Roth after-tax contributions) is adjusted each calendar year to reflect changes in the cost of living. For 2022, this limit is $20,500.

A-5.7. Your Investment Choices

You decide how your contributions are invested. There are a number of investment options provided by the plan. For a complete list of current fund options, contact Fidelity, (800) 354-3427 or log on to www.401k.com.

Funds offered as of 1 October 2021:

CHOICE 1

LifePath® Target Date Funds: the LifePath® Index Target Date funds are the default investment option for the Plan. These funds offer a simple, single-fund approach to investing and are designed to become more conservative as the target date gets closer.

A list of funds follows:

- BTC LIFEPATH RET G
- BTC LIFEPATH 2025 G
- BTC LIFEPATH 2030 G
- BTC LIFEPATH 2035 G
- BTC LIFEPATH 2040 G
- BTC LIFEPATH 2045 G
- BTC LIFEPATH 2050 G
- BTC LIFEPATH 2055 G
- BTC LIFEPATH 2060 G
- BTC LIFEPATH 2065 G

CHOICE 2

A selection of Indexed Funds that are generally lower-cost funds in which the portfolio manager tries to achieve a rate of return that is comparable to the return of the benchmark the fund tracks, less fees and expenses. The benchmark for the index fund is usually a single market index or a combination of several market indices. A list of funds follows:

- S & P 500 STOCK INDEX, CLASS F
- SMALL/MID STOCK INDEX, CLASS F
- INTERNATIONAL STOCK INDEX, CLASS F
- U.S. TIPS BOND INDEX, CLASS F
- U.S. BOND INDEX, CLASS F
- COMMODITY INDEX, CLASS F
- REAL ESTATE INDEX, CLASS F

The Real Estate Index, Class F and the Commodity Index, Class F carry investment restrictions. Participants will not be allowed to direct more than 10% of their contributions to either of these funds.

CHOICE 3

Includes actively managed funds that have portfolio managers that try to outperform the market, or the segment of the market, in which the fund was designed to invest, based on the objectives outlined in the fund's prospectus. A list of funds follows:

- FIDELITY GROWTH COMPANY COMMINGLED POOL CLASS #3
- BOSTON PARTNERS LARGE CAP VALUE FUND SHARE CLASS E
- QMA US SMALL CAP CORE EQUITY FUND CL 4
- INTERNATIONAL EQUITY FUND
- WELLS FARGO ADVANTAGE EMERGING MARKETS EQUITY FUND CIT CLASS E2
- WELLS FARGO CORE PLUS BOND FUND

In addition, CHOICE 3 includes the Deere & Company Common Stock Fund, Blended Interest Fund, Short-Term Investment Fund W and Fidelity BrokerageLink® that offers both passively managed and actively managed mutual funds not available directly through the Plan.

You have the right to direct the Plan trustee concerning shareholder rights, such as the right to vote or tender, for shares attributable to the units of Deere & Company Common Stock Fund credited to your account. The trustee will hold your decision with respect to the exercise of shareholder rights in confidence, except to the extent required by law. In addition, the Company will not review information concerning any individual participant's purchase, holding or sale of Deere & Company Common Stock Fund, unless required to fulfill its fiduciary obligations, or by applicable law. The Company does not have access to your decisions with respect to exercise of your rights as a shareholder.

You are allowed to contribute up to 20% of your contributions to the Deere & Company Stock Fund. Additionally, you are not able to exchange more than 20% of your account into the Deere & Company Stock Fund. Through market performance your balance in the Deere Company Stock Fund can exceed 20%.

A-5.8 Making Your Investment Choices

All eligible earnings are invested in the Funds you elect. You invest a percentage of pay. Any income earned by each fund is reinvested in that fund.

A-5.8.1 Investment Fund Changes

You can change how your savings are invested at any time. When changing investments, you have two options:

- Change future contributions – The default investment for future employee contributions is the LifePath fund closest to the participant's 65th birthdate. This fund default can be changed at any time by the participant.
- Transfer current investments – You may move your existing savings between funds, except you cannot move directly from the Blended Interest Fund to Fidelity Institutional Money Market Fund or directly from the Blended Interest Fund to BrokerageLink. These two options compete with the Blended Interest Fund and are subject to a 3-month equity wash.

To change your current investments, or to change future contributions, call the Service Center at Fidelity (1-800-354-3427) or log on to Fidelity NetBenefits at www.401k.com. The changes you request will be effective at the end of the business day if you call before 3:00 p.m. Central Time (or the next business day, if your call is received after 3:00 p.m. Central Time).

USE THE WEBSITE OR PHONE!

Log on or call the John Deere Savings Plan Service Center to check your account balance, make transactions, or obtain prices and yields.

Access is available as follows:	
Type of Business	Hours of Operation
Automated Inquiries	24 hours a day, 7 days a week
Fidelity Representative	7:30 a.m. to 11:00 p.m. Central Time, Monday through Friday ((800) 354-3427)
Web Access	Log on to Fidelity Net Benefits at www.401k. com. Available 24 hours a day, 7 days a week.

A-5.8.2 Account Valuations and Statements

Each participant has an individual account with different types of contributions. Your account is valued at the end of each business day. A personalized statement is available at any time by logging on to www.401k.com or calling the Service Center (800) 354-3427.

A-5.8.3 A Few Words About Investing

Certain types of investments carry more risk than others. It's up to you to decide how much risk you are willing to take in order to earn your desired level of investment return. If you want to earn a higher return, you'll want to consider investments that have a higher level of risk associated with them. The lower the level of investment risk, the lower the expected return.

Past performance is no guarantee of future investment return. Since investment information changes so often, it's important that you protect yourself by ensuring that you get fund information directly from Fidelity or a qualified investment expert.

As you're making investment choices, keep in mind that all investments involve some degree of risk as well as potential return. The Tax Deferred Savings Plan is intended to qualify as a 404(c) plan under Federal law. This means you will be given information about the investment options and about setting and achieving investment objectives, so that you can make sound investment decisions. Because you exercise control over the assets in your account and make investment decisions from a broad range of investment alternatives, plan fiduciaries will not be liable for any losses resulting from your control and investment decisions.

A-5.9. Loans

To meet the objective of providing you with a substantial personal investment, the Company encourages you to leave your account untouched for retirement—to grow in value for your future benefit. However, the Company realizes you may need some of your savings when certain situations arise. Taking a loan from your account gives you limited access to your savings while you're an active employee.

When you borrow money from the Plan, you are essentially borrowing from yourself. You even pay yourself interest. Your account balance is used as collateral for securing the amount of your loan. If you take a loan, a loan origination fee of $5 and a loan maintenance fee of $2.50 per quarter will be deducted from your account. The origination fee is charged for each new loan outstanding. You may only have one loan outstanding at a time.

A-5.9.1. Who's Eligible?

You're eligible to take a loan from the Plan if you are an active Plan participant or a retiree.

A-5.9.2. Applying for a Loan

To apply for a loan, call the John Deere Savings Plan Service Center (1-800-354-3427) at Fidelity or log on to www.401k.com. Fidelity Investments will send your loan check and amortization schedule directly to you.

A-5.9.3. Loan Amount

The minimum loan amount is $1,000 as long as your account balance is $2,000 or more. The maximum loan amount is the lesser of one-half of your account balance, or $50,000 reduced by your highest outstanding loan balance in the previous twelve months. You may have only one loan outstanding at a time.

The automatic retirement contribution is not an eligible loan source.

A-5.9.4. Repaying the Loan

You can choose the term of your loan (6, 12, 18, 24, 30, 36, 42, 48, or 54 months, or 10 years for a mortgage loan), provided that your wages are sufficient to cover your loan amount. Your first repayment will occur the last payroll period following the month of application. The 10-year mortgage loan is not eligible for a tax deduction.

The rate of interest you pay is set when you take out the loan. It will not change over the course of the loan. The Plan Administrator

establishes the loan rate within the regulations set forth by the Department of Labor (DOL). The rate is based on the published national prime rate plus two percentage points.

If you repay the loan according to the terms of the loan agreement, your loan will not result in any income tax or excise tax liability.

A-5.9.5. Prepaying the Loan

Call the Service Center at (800) 354-3427 or log on to www.401k.com if you are interested in prepaying your loan.

A-5.9.6. Missed Payments and Defaulting

You repay your loan over a period of up to 54 months. A mortgage loan is repaid over a ten- year period.

Since your loan repayments are deducted from each paycheck, it's difficult to miss or default on repayments. However, if you are on unpaid leave, or if your wages aren't enough to cover the repayment amount, you may miss or default on repayments. Call the Service Center (800) 354-3427 if you wish to make up any missed payments.

If your loan is not repaid within the term of your loan, your loan will be defaulted and taxes and/or penalties may be due.

A-5.9.7. If You Leave the Company

If you leave the Company for any reason with an outstanding loan balance and choose not to continue repaying your loan following your separation from service, the outstanding amount of your loan will be reported as a taxable distribution. If you wish to continue to make loan payments, you can establish repayment through the financial institution of your choice. Call or log on to Fidelity to set up the automatic payment.

Anyone who retires from the Company and has a 401(k) balance can elect to take a loan. Call or log on to Fidelity to obtain additional information about this loan option.

A-5.10. Early Withdrawals

To meet the objective of providing you with a substantial personal investment, the Company encourages you to leave your account untouched for retirement – to grow in value for your future benefit. However, the Company realizes you may need some of your savings when certain situations arise. Taking a withdrawal from your account gives you limited access to your savings while you're an active employee.

Age 59 ½ In-Service Withdrawal

If you are an active employee and have reached age 59 ½, you may elect to take distribution of your vested account balance. Call the Fidelity Service Center for more information (1-800-354-3427).

Hardship Withdrawal

The Internal Revenue Service limits withdrawals from plans such as ours to situations of hardship. A hardship means that you have an immediate financial need that cannot be met from any other resources, including a loan from the Plan. You must provide proof of the hardship to the record keeper, and to the IRS in the case of an audit.

A hardship withdrawal results in a 6-month suspension from the Plan beginning on the effective date of the hardship withdrawal.

A-5.10.1. When Hardship Withdrawals Can Be Made

Withdrawals of your contributions (not earnings) from the Tax Deferred Savings Plan may be made once in a 12-month period for:

- Purchase (excluding mortgage payments) of your principal residence;
- Prevention of eviction from your principal residence or foreclosure on the mortgage of your principal residence;
- Payment of tuition for the next semester or quarter of post-secondary education for you, your spouse, or dependents who you claim on your federal tax return;
- Payment of medical expenses that you are obligated to pay and are not otherwise payable under any insurance coverage in force for you;
- Burial or funeral expenses;
- Repair to your principal residence qualifying as a casualty deduction;
- Any other reason acceptable under published IRS regulations and rulings.

A-5.10.2. How Hardship Withdrawals/Loans and Distributions Are Withdrawn from Investment Funds

When you request a TDSP loan, it will be withdrawn from the investment funds of your choice. If you do not choose a specific fund(s), then the TDSP loan will be withdrawn on a prorated basis across your investment funds. When you request a hardship withdrawal, you do not choose a specific fund(s); instead, the amounts will be withdrawn in accordance with the current distribution fund hierarchy (contact the Service Center at 1-800-354-3427 to learn more).

A-5.10.3. Taxes on Hardship Withdrawals

Financial hardship withdrawals are subject to ordinary income tax. If you take a hardship withdrawal before age 59-½, you also may owe a 10% early payment penalty on the amount of your withdrawal. Be sure to check with a tax advisor before taking a hardship withdrawal.

A-5.11. Distributions

You're always 100% vested in your contributions to the Tax Deferred Savings Plan account. This means you have full ownership rights to your whole account. Your account may be distributed:

- When you leave the Company;
- When you retire (normal, early, or disability retirement);
- If you die; or
- If the Plan ends.

When you leave the Company, you can choose when you want to receive payment of your account.

A-5.11.1. How Your Account Is Distributed

How your account is distributed is very important because of the tax implications of your choice. When you request a distribution, you will receive a document explaining your distribution options — and the corresponding tax implications — in greater detail.

A-5.11.2. Distribution Options

If you are separated from service, you must contact the John Deere Savings Plan Service Center at Fidelity Investments to request one or more of the following distribution options, or to obtain more information.

Lump Sum Distribution

Your entire account balance can be paid directly to you with the mandatory 20% withheld for Federal taxes. Or, you may elect to roll over all or part of your account to another qualified plan or IRA. Taxes are not withheld from distributions payable to another qualified plan or IRA, or any after-tax assets.

Scheduled Distributions

You may choose...

- A specific dollar amount paid out every month until your account balance reaches zero
- A specific period of time during which a decrementing amount will be paid out and at the end of which your account balance will be zero
- A fixed percentage paid out every month until your account balance reaches zero
- Life Expectancy in which an amount will be paid out monthly based on your estimated life
- A Minimum Required Distribution (MRD) which is based on actuarial calculations. If you are an active employee who reaches age 72 no distribution will be made. If you are separated from service and reach 72 a distribution is required. You will be notified by Fidelity regarding the distribution.

Unscheduled Distribution

A distribution any month. The amount you elect cannot be less than $1,000 or more frequent than once each month. Call the Service Center (800) 354-3427 for more information.

A-5.12. Assignment of Benefits

Your benefits from the Tax Deferred Savings Plan belong to you and may not be sold, assigned, transferred, pledged, or garnished, under most circumstances.

However, if you become divorced or separated, certain court orders could require that part of your benefits be paid to someone else — your spouse or children, for example. This is known as a Qualified Domestic Relations Order (QDRO). As soon as you are aware of any court proceedings that may affect your Tax Deferred Savings Plan benefits, contact the Fidelity Service Center for more information (800) 354-3427.

- Web review of one defined contribution plan order generated on the Fidelity QDRO website and not materially altered - $300/each
- Manual review of one defined contribution plan mentioned in an order that was not generated on the QDRO website or was generated on the website, but materially altered - $1,200/each

– Manual review of a combination of any two or more defined contribution plans mentioned in an order - $1,800

A-5.13. A Few Words About Taxes

Tax laws are complicated, and they affect people in different ways. Before you receive distributions from the Plan, it's important that you talk to a tax specialist for information on how your payment will be taxed.

Here are a few general guidelines to help you understand how payments are usually taxed. This information is based on current laws and is subject to change. And, these guidelines don't reflect every possible situation or interpretation.

A-5.13.1. General Tax Treatments

If your account balance is made up of pre-tax contributions and untaxed earnings, you will pay regular income taxes on the taxable portion of a distribution of your account in the year you receive it.

However, depending on your circumstances, some different tax treatments may apply:

– 20% mandatory withholding. In accordance with government regulations, your distribution will have a mandatory 20% withheld for federal taxes, unless you elect a direct rollover. See section A-4.5.

– 10% early payment penalty tax. The IRS places a 10% penalty tax on any payment you receive from the Plan before you are 59½ years old. The tax is in addition to your regular income taxes on the payment. However, this tax does not apply in some cases. For example, it doesn't apply if you die, become disabled, or end your employment during or after the calendar year in which you reach age 55.

Tax laws are very complex and they change often. You should contact your tax advisor for more information.

Paying Your Taxes

As mentioned earlier, when you receive distribution of your account, the IRS requires the Recordkeeper to withhold 20%, unless you elect a "direct rollover". If you are in a higher tax bracket, you may owe more taxes on the payment when you file that year's tax return. If you are in a lower tax bracket part or all of the amount withheld may be refunded or used as an offset to your federal income tax return for that year.

The 10% early withdrawal penalty tax, if applicable, is not withheld from your payment; you are responsible for paying this additional

tax when you file your tax return. Consult your tax advisor for information about your situation.

A-5.14. What Happens to Your Tax Deferred Savings Plan Account in Certain Situations

Your John Deere Tax Deferred Savings Plan account is affected when certain life events occur. Here is a summary of what happens. The official Plan documents contain all the details.

A-5.14.1. What Happens if You...Are Laid Off?

– If you have plan eligible pay during this time, contributions will continue based upon the deferral election you have on file.

A-5.14.2. What Happens if You...Take a Leave of Absence?

– If you have plan eligible pay during this time, contributions will continue based upon the deferral election you have on file.

– When you return from leave, contributions resume automatically.

A-5.14.3. What Happens if You...Are Disabled?

If you are on Weekly Indemnity:

– Contributions are suspended; you can continue to make transactions.

– When you return from disability, contributions resume automatically.

If you are on LTD:

– Contributions end; you can continue to make transactions.

– If you return from disability, eligibility resumes, re-enrollment is required.

A-5.14.4. What Happens if You...Leave the Company?

– Contributions end; you can continue to make transactions.

– Your full account value can be distributed, rolled over to another plan, or maintained in your account until a future distribution date.

A-5.14.5. What Happens if You...Take Early or Normal Retirement?

– Contributions end; you can continue to make transactions.

– Your full account value can be distributed, rolled over to another plan, or maintained in your account until a future distribution date.

A-5.14.6. What Happens if You…Die?

– Your account may be distributed immediately or deferred for up to five years from the date you die.

– If you haven't named a beneficiary, or if your beneficiary dies before you do, the full value of your account is distributed to:

- Your spouse, if any, or;
- if there is no surviving spouse, equally among the one or more of his relatives by blood, adoption or marriage according to the following hierarchy (a) children or grandchildren: (b) parents; (c) siblings; or
- Otherwise, paid to your estate,

When your account balance is paid to your beneficiary or beneficiaries, it is not subject to the 10% early withdrawal penalty tax. However, regular income tax will be due on the value of your account. Your beneficiary may defer current income taxes by rolling the distribution into an IRA.

For more information about distributions in the event of your death, your beneficiary should contact the Service Center (800) 354-3427.

Q: What is the "full value" of my account?

A: The "full value" of your account includes all your employee contributions as well as any employer contributions if you have three years of service credit at the time of your separation from service, plus or minus any investment earnings or losses.

A-6. Situations That Affect Your Pension Plan and Tax Deferred Savings Plan

A-6.1. Plan Maximums

Both plans have maximum benefit limits that apply. For the Pension Plan, see section A-3.3.3 or A-4.3.3. For the Tax Deferred Savings Plan, the IRS sets limits on the amount you can contribute to your account each year. These limits generally apply to higher-paid employees. You'll be notified if they affect you.

A-6.2. Top-Heavy Provisions

As required by law, alternate Plan provisions go into effect if either plan becomes top heavy. A plan is top heavy if more than 60% of accumulated account balances are payable to key employees. Key employees include employees who are highly paid stockholders and Company officers and their surviving spouses. You will be notified in the unlikely event that either plan becomes top heavy and of the corresponding consequences.

A-6.3. The Pension Benefit Guaranty Corporation (PBGC)

Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates; (3) benefits that are not vested because you have not worked long enough for the company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers. For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Customer Contact Center, P.O. Box 151750, Alexandria, VA 22315-1750 or call 800-400-7242 (toll-free) or 202-326-4000 (toll number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 800-400-7242. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at http://www.pbgc.gov.

The Tax Deferred Savings Plan is a "defined contribution" plan, which means the value of your account depends on the amount of contributions made and on gains and losses. Since benefits under the Tax Deferred Savings Plan are not determined by a formula, federal law does not provide for PBGC insurance.

A-6.4. Claims Appeal Process

If your request for benefits under this section of the plan is denied in whole or in part, your appeal will be processed in accordance with your collective bargaining agreement.

A-6.5. If a Plan Is Amended, Modified, Suspended, or Terminated

Deere & Company, subject to any collective bargaining agreement, reserves the right to suspend or terminate either Plan; to modify the Plans, or to amend the Plans in any respect. Changes may occur at any time, but will not affect your existing accrued benefit. Participants will be notified in due course concerning substantial changes. Amendment or termination of either plan can be effected only through a legal instrument authorized by the Board of Directors.

As a participant in the retirement plans, you have certain rights under ERISA. For more details, see Chapter H: Administrative Information.

If your application for benefits is denied, in whole or in part, you have the right to a full review. For more details, see Chapter H: Administrative Information.

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B-1. Health Care Highlights

Deere & Company health care benefits are designed to give you and your family financial protection in case of illness or injury. Your options are designed to encourage you to receive quality, cost-effective care.

Non-discrimination	The benefits offered under the Plan are nondiscriminatory. The Plan complies with the nondiscriminatory requirements under Section 1557 of the Affordable Care Act and does not discriminate on the basis of race, color, national origin, age, disability or sex. Benefits offered under the Plan will be offered in a neutral, nondiscriminatory manner.
Joining the Plan	You and your eligible dependents are eligible for medical and dental benefits effective the first day of the month following the 30 calendar days of employment for coverage at no premium. If you need coverage prior to this date, you are eligible to enroll in medical coverage at a full cost premium rate.
Your Medical Options	Deere offers a variety of medical options. Each medical option pays benefits for covered health care expenses, including hospital charges, doctors' bills, surgery, diagnostic tests, prescription drugs, and vision and hearing care. Certain exclusions and limitations apply, as described throughout this chapter. Deere offers these "managed care" options: • Deere Premier Active (Plan #0266) • UHC Choice Plus Active (Plan #0265) (only available outside of Deere Premier Active service area) • Deere Premier Retired (Plan #0256) • UHC Choice Plus Retired (Plan #0225) (only available outside of Deere Premier Retired service area) • UHC Dental High Max (Plan #2186) These options help lower costs by offering care through a group of providers who have agreed to provide health care services at contracted rates. The Deere Traditional option (Plan #0226) will be available to households outside of the Managed Care Option(s) service areas. You may also elect no coverage for medical or dental.
Dental Benefits	The Plan offers benefits for preventive dental expenses (such as exams and cleanings), basic dental expenses (such as fillings and crowns), and major dental expenses (such as orthodontia and dentures). It also offers a feature that allows you to learn in advance what the Plan will pay for extensive treatment.
Paying for Coverage	Deere pays the cost of coverage for eligible expenses.
Plan Document	For additional information on your healthplan, refer to the John Deere Health Benefit Plan for Wage Employees.
Filing a Claim	When you use a network(s) provider under a managed care option, no claim form is needed. You may need to complete and submit a claim form for claims from non-network(s) providers. These usually are Traditional option and dental benefit claims.

B-2. Health Care Terms You Should Know

– Allowed charge – The portion of a charge for a service or supply that is covered by the Plan. The allowed charge is usually the rate the network(s) has agreed to pay providers under a contract, or the reasonable and customary charge.

  Here's how the allowed charge is determined:

  1. First, if the network(s) and the provider have agreed to a contracted rate, the Plan pays benefits on that amount.
  2. If there is no contracted rate, then the Plan pays benefits up to the maximum allowable benefit.

  If the network(s) determines a charge is above the allowed charge and you think the charge is inappropriate, call the number on the back of your Health Benefit Card. The Company may be able to help you resolve disputes with providers.

– Coinsurance – The amount you and Deere pay for allowed charges after a deductible is met under the self-referral feature.

– Covered expenses – Any medical or dental procedure, service, or supply for which a benefit is payable under the Plan. This includes expenses that are partially covered (for example, charges covered at 80% or up to a set dollar amount) as well as charges that are 100% paid by the Plan.

– Covered prescription drugs – Prescription medicines which are selected by the network's pharmacy formulary committee based upon clinical effectiveness and cost. These medicines may be subject to quantity limitations and prior authorization as deemed appropriate by the network's pharmacy formulary committee. The formulary list is subject to periodic review and modification. The formulary will give providers an adequate range of choices to treat a given condition.

- Crown – A dental restoration usually covering the whole exposed portion of a tooth. Most often made of porcelain, gold, or non-precious metal.
- Custodial care – Care that consists of watching, maintaining, or protecting, or is for the purpose of providing personal needs rather than being able to cure (see section B-5.3 for a list of the types of care considered to be custodial).
- Deductible – The annual amount you must pay before you begin receiving certain benefits from the self-referral feature. The deductible is applied to allowed charges.
- Experimental or unproven care – Certain experimental, investigational, or unproven drugs, devices, medical treatment, or procedures, and care for complications arising from these procedures (see section B-5.4 for more details).
- Fixed bridgework – A non-removable replacement for a natural tooth.
- Generic drugs – Medications made from the same basic formulation as brand names, but sold at lower cost than brand name drugs.
- Maintenance drugs – Medications prescribed for you to take on a continuing basis over a long period.
- Maximum allowable benefit – The plan benefit payment accepted by in-network providers in the patient's region for similar covered services and supplied to individuals of similar age, sex, circumstances and medical condition.
- Medical emergency – The sudden and unexpected onset of condition(s) that could reasonably be expected by a prudent layperson to result in death or serious jeopardy to the mental or physical health of the individual. Symptoms must occur suddenly and unexpectedly and medical assistance must be sought immediately. Examples include:
  - Blocked airway
  - Heat stroke
  - Collapsed lung
  - High fever
  - Heart attack
  - Appendicitis
  - Blood clot
  - Shock
  - Severe loss of blood
  - Loss of consciousness
  - Kidney failure
- Medically necessary – Services that are:
  - Consistent with generally accepted principles of medical practice for the diagnosis and treatment of the patient's medical condition; and
  - Performed as cost effectively as possible in terms of treatment, method, setting, frequency, and intensity, taking into consideration the patient's medical condition.
- Mental or nervous disorder – Conditions such as neurosis, psychoneurosis, psychopathy, psychosis, and any other mental or emotional disease or disorder, as defined by the International Classification of Diseases of the U.S. Department of Health and Human Services.
- Orthodontia – Services performed by a dentist to prevent and correct all dental irregularities which result from anomalous growth and development of dentition and its related anatomic structures (or which results from accidental injury), and which require repositioning of teeth to establish normal occlusion.
- Out-of-pocket maximum – The annual limit on your out-of-pocket expenses under the self referral feature.
- Participating provider – Physicians, hospitals, pharmacies, and other health care providers who participate in the network(s). To obtain a list of participating providers, contact the healthplan.
- Period of disability – When you are ill or injured, your absence is considered a continuous period of disability. However, if you are medically released and return to work for at least one full day and are absent again, a new period of disability begins.
- For your covered dependents, a new period of disability begins if your dependent's successive illness or injury is entirely unrelated to the earlier disability, or if a period of at least 60 days has elapsed since treatment for your dependent's last disability has occurred.
- Periodontics – Treatment of diseases of the bone, gum, and tissues around the teeth.
- Physical therapist – A licensed (if required) graduate of a physical therapy program approved by the Council on Medical Education of the American Medical Association in connection with the American Physical Therapy Association (or its equivalent).

- Physician – A person who is legally licensed to practice medicine or perform surgery within the scope of his or her profession. A physician includes a medical doctor, doctors of osteopathy and doctors of podiatric medicine. Optometrists are recognized for covered emergency services and for routine vision services. Services by a dentist, including an oral surgeon, are recognized under the dental provisions of this Plan.
- Preauthorized referral – Written authorization provided by a network physician, and approved by the network(s), for medically necessary covered services from a non-network(s) provider. Payment under the plan will be made only if the referral is obtained from a participating physician prior to the time services are received, except in the case of a medical emergency.
- Prosthodontics – Replacement of missing teeth and construction or repair of bridges and dentures.
- Provider – Any certified professional who supplies health care services.
- Reasonable and customary – The portion of any charge that is within the amount charged for similar services and supplies in the area where the charge is made. Reasonable and customary is determined by using data from the Health Insurance Association of America (HIAA), which collects fee information based on zip codes from insurance companies covering more than 95 million individuals (applicable to the Traditional option and dental only).
- Residential or outpatient substance abuse facility – A facility that provides detoxification and rehabilitation for the treatment of substance abuse. To be covered by the Health Benefit Plan, services for inpatient substance abuse must be provided at a hospital or an approved residential substance abuse facility.
- Restoration – Repair and reconstruction of natural teeth, including fillings and crowns.
- Speech therapist – An audiologist who possesses a master's or doctorate degree in audiology and speech pathology from an accredited university, a Certificate of Clinical Competence in audiology from the American Speech and Hearing Association, and who is licensed by the state (where required).
- Substance abuse – A diagnosis of substance abuse-alcoholism or drug dependency-made according to the guidelines in the International Classification of Diseases (categories 303.0- 305.0), adopted for use in the United States by the U.S. Department of Health and Human Services.

B-3. Eligibility and Enrollment

B-3.1. Eligibility — For You

If you are a full-time wage employee of Deere & Company and actively working at one of the U.S. operations (as outlined in "Who This Document Is For"), you are eligible to enroll for health care benefits in Deere Premier Active (Plan #0266) or UHC Choice Plus Active (Plan #0265) if available or Deere Traditional (Plan #0226) if Deere Premier Active or UHC Choice Plus Active are not available to you. You are also eligible to enroll in UHC Dental High Max (Plan #2186).

B-3.2. Eligibility — For Your Dependents

If you have dependents, they may also be eligible for coverage. Your eligible dependents include:

- Your spouse, including a spouse who is an employee or retiree of the company that is not enrolled or receiving benefits from another company sponsored medical or dental plan;
- Your children under age 26 (natural born children, legally adopted children, stepchildren, or children for whom legal adoption proceedings have been initiated) who are not receiving benefits through another employee or retiree of the company.
- Your unmarried children who are totally and permanently disabled (regardless of age) as long as the disability starts while the child qualifies as a dependent. Also, these dependents must qualify for dependency status in the current year or have been reported on your most recent federal tax return, and are not receiving benefits through another employee or retiree of the company.
- Unmarried children under age 19 who are dependent on you for more than one-half of their support (as defined by the Internal Revenue Code), who reside in the household of which the employee is the head and who are related to you by blood or marriage or are under your legal guardianship, unless they are receiving benefits through another employee or retiree of the company. These dependents must qualify for dependency status in the current year or have been reported on your most recent federal tax return.
- Your children who are totally and permanently disabled who rely on you for at least 50% of their support.

"Total and permanent disability" means any medically determined physical or mental condition that prevents your dependent from being gainfully employed, which is expected to continue indefinitely or result in death, and that commences while otherwise covered as a dependent.

Your children are not eligible dependents if they are receiving benefits through a salaried employee or a salaried retiree (after 1 July 1993) of the Company. Proof of your dependent's eligibility may be requested from time to time.

B-3.2.1. Sponsored Dependents
In addition to the dependents described previously, you may also elect benefits coverage for a dependent who qualifies as a "sponsored dependent."

A sponsored dependent means any person (other than those described previously) who resides with you and who is dependent on you for more than one-half of his or her support, as defined by the Internal Revenue Code. To be eligible as a sponsored dependent, you must claim the person as a dependent on your federal tax return for either the current year or on the most recent tax return you've filed. Individuals who are eligible for Medicare cannot be enrolled as sponsored dependents.

To enroll a sponsored dependent in Deere health care benefits, you must request coverage at the time you enroll in the Plan or within 31 days of acquiring the sponsored dependent. At the time of enrollment, you'll be asked to certify that your sponsored dependent meets the eligibility requirements, and that you agree to pay the cost of sponsored dependent coverage. If you do not enroll a sponsored dependent when he or she first becomes eligible for coverage, you may elect coverage at a later date (with evidence of good health).

For more information on sponsored dependents, contact the John Deere Benefit Center.

B-3.2.2 Survivor of an active employee
The eligible spouse and/or eligible dependent children following the death of an active employee hired on or after 1 October 1997 will be eligible for six (6) months of continuation healthcare coverage at no cost. Following the six month of continuation coverage, the spouse and/or children will be offered COBRA.

B-3.3. Enrolling
To enroll in health care benefits, contact the John Deere Benefit Center.

B-3.4. When Coverage Begins
Here's when health care, dental, vision and hearing coverage begins for you and your dependents:

- For annual enrollments – every January 1.
- For new hires – On the first day of the month following 30 calendar days of employment, you will be eligible to enroll in medical and dental coverage at no premium. If you need coverage prior to this date, you are eligible to enroll in medical coverage at a full cost premium rate.

Special notes
Medical benefits for dependents (except newborns and children placed for adoption) who are hospitalized when coverage is scheduled to take effect, do not begin until the date of discharge from the hospital. Coverage for newborns and children placed for adoption takes effect the day they are born or when adoption proceedings are initiated. (If you enroll them for coverage within 31 days of their birth or when adoption proceedings are initiated.)

Special Enrollment for New Dependents
A new dependent due to marriage, birth, adoption, or placement for adoption triggers a special enrollment period for each family member who is eligible but not enrolled in the plan. In the case of a dependent due to marriage, coverage must begin no later than the first day of the month after the date the individual requests special enrollment. In the case of birth, adoption, or placement for adoption, coverage begins on the date the event occurs.

If you have a change in employment or family status, you should notify the John Deere Benefits Center within 31 days of the change. Your coverage is retroactive to the date of the approved family status change. If you wait longer than 31 days to notify the John Deere Benefits Center, an approved family status change is effective on the date of notification. No retroactive coverage is granted.

B-3.5. When There's Another Medical or Dental Plan
You or a covered dependent may be covered by more than one group medical or dental plan. The Health Benefit Plan has a coordination of benefits (COB) feature to prevent duplication of payments in these cases. See Chapter H: "Administrative Information" for details.

B-3.6. When Coverage Ends
Your coverage under Deere benefits stops when you no longer meet the eligibility requirements described in section B-3.1. Your dependents' coverage ends when they no longer meet the definition of a dependent, as described in section B-3.2.

Important information about how benefits can be continued in special cases is found in Chapter H: "Administrative Information."

B-4. Expenses Covered by All Medical Options

The following section applies to all Company-sponsored medical options. This information does not apply to outside MCOs offered by Deere.

The Health Benefit Plan pays benefits for a wide variety of medical services and supplies. These expenses are described in sections B-4.1 to B-4.20. The expenses listed are covered under all options; however, the level of benefits (the amount paid by the Plan) depends on the option you choose. Not all covered expenses are paid at 100%.

B-4.1. Hospital Charges

The Health Benefit Plan pays benefits for allowed charges you incur as an inpatient and as an outpatient in a hospital or other covered health care facility after any applicable per visit copayment. A hospital is a licensed facility that charges for its services and:

- Primarily provides medical care and treatment of the sick and injured;
- Provides regular overnight care and full diagnostic, surgical, medical, and therapeutic services;
- Is supervised by a staff of physicians legally licensed to practice medicine; and
- Provides 24-hour nursing service by registered nurses (R.N.s).

Unless they meet these guidelines, institutions like clinics, rest homes, nursing homes, and homes for drug addiction and alcoholism do not qualify as hospitals.

While you are confined to a hospital, the Health Benefit Plan covers room and board charges up to the hospital's semiprivate room rate. If semiprivate rooms are not available, the Health Benefit Plan pays benefits on the hospital's most frequent semiprivate room rate.

Benefits also are payable for the use of isolation facilities (when required due to a contagious condition and until a diagnosis is reached that the infectious condition no longer exists).

The Traditional option pays benefits for up to 365 days for each period of disability. There is no limit under the Health Benefit Plan. Successive hospital stays for the same or a related cause will be considered one period of disability.

The hospital stay for a birth may not be restricted to less than 48 hours for a normal delivery and 96 hours for a cesarean delivery. A provider can not obtain authorization to prescribe a stay less than 48 or 96 hours.

Successive hospital stays for the same or a related cause will be considered one period of disability.

Preauthorization Reminder

- If you're covered under the Traditional option or if you're using the self- referral feature of the Health Benefit Plan, you and/or your provider need to preauthorize your hospital stay prior to admission.
- Call for preauthorization for planned hospital admissions 10 days before being admitted.
- Call for preauthorization for emergency hospital admissions within 48 hours of being admitted.
- Call your network for preauthorization of maternity care.
- The number to call for these services is on the back of your Health Benefit Card.

University of Iowa Hospitals and Mayo Clinic Benefits

Special benefits may apply if you have a preauthorized referral to the University of Iowa Hospitals and clinics preauthorized referral and gap exception to the Mayo Clinic at Rochester, Minnesota. The Plan pays benefits for certain procedures and tests performed at these hospitals and for associated room and meal expenses (up to defined limits).

Once you have a preauthorized referral and a gap exception if necessary (or physician's referral under the Traditional option):

- The Health Benefit Plan option covers your medical expenses less any applicable copays.
- The Traditional option pays a medical benefit of $20; you pay the balance of any expenses.

B-4.2. Other Hospital Charges

These services and supplies also are covered when medically necessary:

- Hospital care and treatment such as blood transfusions, blood plasma and serums, and X-rays.
- Emergency room service (you pay a copayment per visit)
- Professional ambulance service to the nearest fully equipped facility.
- Anesthesia charges.

- Screening X-rays and public health tests required by the hospital.
- Charges for a radiologist (X-ray specialist) and pathologist (laboratory specialist) and hospital based physicians (when these charges are separately billed by these professionals).
- Outpatient treatment that has met required criteria.
- Medical tests performed before you're admitted are covered, as long as the tests relate to your condition or diagnosis, are ordered by your physician or are required by the hospital, and the tests are performed within 14 days of the date your admission is scheduled. Benefits will not be paid for preadmission tests if you or your dependent cancel the hospital admission.

B-4.3. Hospital Preauthorization

All of the medical options have features designed to help you manage the cost of your care. When you receive services from network(s) providers under the Health Benefit Plan, cost management procedures happen automatically. If you're in the Traditional option or you're using the self-referral feature of the Health Benefit Plan, non-emergency hospital admissions require preauthorization for you and your covered dependents. With the Traditional option or out-of-area care under the Health Benefit Plan, you should call the phone number on the back of your Health Benefit Card within 48 hours if you or someone in your family has had an emergency hospital admission.

The admission and proposed course of treatment will be reviewed by a registered nurse, physician, or other health care professional who is trained to make sure you receive the care you need in the most appropriate and cost-effective setting.

To preauthorize a hospital stay, you, a family member, your doctor, or the hospital must call a toll-free number and talk to one of the trained preauthorization specialists. The phone number is available to Plan participants. (If you do not have preauthorization information or if you need the toll-free number, call the number on the back of your Health Benefit Card.)

Concurrent Review

Once you're in the hospital, your stay will be monitored to make sure you don't stay longer than you have to. If your hospital stay extends beyond the approved number of days, the medical need for additional days will be evaluated and approved (if appropriate).

Case Management Services

If you or a covered dependent becomes ill with an extended or complex illness, the Health Benefit Plan will make sure you receive the best possible medical care for your situation. Case management may present alternatives to long-term hospital stays, such as home health care or care in an extended care facility that may be beneficial to you.

B-4.4. Organ/Tissue Transplant Services

The Health Benefit Plan requires the use of a network of facilities for all transplant services. "Centers of Excellence" are networks of facilities available for transplant services. Transplants performed outside of a center of excellence are not covered under the Plan without a gap exception.

There is a transplant nurse specialist who will work with you and your physician to choose the facility that is the most appropriate for your needs. Arrangements such as travel, overnight accommodations, and meal reimbursement also will be coordinated through the transplant specialist.

If the need for a transplant should arise, your physician must contact the transplant nurse specialist so that care is directed to a network transplant center that will best serve your needs.

Transplant services include all physician charges for evaluation and the transplant procedure. This includes pathology, radiology, anesthesia, surgical assists, and any other professional charges incurred, whether inpatient or outpatient, during the evaluation and procedure. Also, all professional, technical, and hospital charges submitted for follow-up care (6 to 12 months) are considered part of the transplant service.

For more information regarding transplant services, call the phone number on your Health Benefit Card.

B-4.4.1. Transplant Donors

The Health Benefit Plan provides coverage for services in conjunction with organ donation. Allowed charges include hospital, surgical, and physician services required. Coverage is provided for:

- Plan members who donate to Plan members;
- Plan members who donate to individuals who do not work for Deere, if the recipient's insurance does not provide coverage; and
- The donor to a Plan member, if the donation is not covered by other insurance.

In many instances the recipient's health insurance coverage will cover the donor's expenses. The Health Benefit Plan will coordinate payment with the recipient's carrier.

For more information regarding transplant services, call the phone number on your Health Benefit Card.

B-4.5. Extended Care Services

Skilled care in a qualified extended care facility, such as a nursing home, may be covered by the Health Benefit Plan for up to 730 days per disability. Allowed charges include semiprivate room and board, services and supplies, and medical care and treatment.

A qualified extended care facility is a health care facility that:

– Operates according to local laws;

– Provides room, board, and 24-hour-a-day nursing services;

– Is supervised at all times by either a physician or registered nurse (R.N.);

– Maintains accurate and up-to-date records;

– Is authorized to administer medications prescribed by a physician;

– Provides physician services (if not supervised by a physician); and

– Is accredited by the Joint Commission on Accreditation of Hospitals or participates in and is eligible to receive payments under Medicare.

You can be admitted to an extended care facility immediately following a hospital stay or directly from your home. If you're hospitalized for treatment of a medical condition for which you're later admitted to an extended care facility, then the 730-day limit on your stay under the Traditional option is reduced by two days for every day you spend in the hospital. There is no day-limit under the Health Benefit Plan.

B-4.5.1. When Extended Care Facility Benefits Are Not Paid

Benefits for care in an extended care facility, such as a nursing home, will not be paid if benefits are payable under other parts of the Health Benefit Plan, or if:

– The stay is primarily for custodial reasons (see section B-5.3);

– The charges are connected with alcohol addiction, drug addiction, chronic brain syndrome, or senility.

– The stay is due to assistance in the activities of daily living, such as walking, dressing, getting in and out of bed, bathing, eating, feeding, or using the toilet, or help with other functions of daily living or personal needs of a similar nature.

– The charges are in connection with the changes of dressings, diapers, protective sheets, or periodic turning or positioning in bed.

– The stay is of a non-medical nature.

B-4.6. Home Health Care

All home health care requests must be initiated by a physician and preauthorized by Case Management Services.

Home health care services are those medically necessary services rendered to a home- bound patient that are related to the treatment of certain medical conditions.

B-4.6.1. When Home Health Care Benefits Are Not Paid

Benefits for home health care will not be paid if benefits are payable under other parts of the Health Benefit Plan, or for private-duty or shift coverage.

B-4.7. Surgery Charges

Charges for covered surgical procedures performed either in or out of the hospital are covered by the Plan after any applicable per visit copayments. This includes charges from a free-standing surgical center that is licensed to operate within its community, and expenses associated with certain surgical procedures approved to be performed in a physician's office.

B-4.8. Maternity Charges

Maternity expenses incurred by employees or their covered spouses are covered under the Traditional option. The Health Benefit Plan covers maternity charges after any applicable per visit copayments for employees, their covered spouses, and their dependent children provided delivery occurs while the child is a covered dependent. Maternity benefits are not provided for sponsored dependents. Preventive prenatal care is covered at no cost for dependent children as required by the Affordable Care Act.

Allowed charges include:

– Physician's fees – for prenatal care, delivery and related procedures, and postnatal care.

– Hospital expenses – as covered for any other hospital stay.

Obstetrical procedures include:

– Delivery of a child or children;

– Caesarean section, including delivery;

– Abdominal operation for extrauterine or ectopic pregnancy;

– Miscarriage;

– False labor; and

– Therapeutic or threatened abortion.

No benefits are paid for routine medication (such as non-prescription vitamins) taken during pregnancy.

Federal law requires your insurance provider to cover in-hospital stays for no less than 48 hours following a vaginal delivery or 96 hours following a cesarean section.

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

B-4.9. Physician's Charges

The Plan pays benefits for medically necessary physician charges, including charges for:

– Daily visits – from your attending physician during a stay in a hospital or qualified extended care facility.

– Medically necessary consultations.

– Daily visits – from a physician called in to treat a condition not related to your hospital or qualified extended care facility stay.

– Medically necessary office visits (after applicable per visit copayment for primary care physician or specialist).

– Surgical procedures – to include post-operative hospital and office visits – or to assist in surgery (after applicable per visit copayment and when medically necessary).

– Emergency treatment – services provided during a medical emergency or immediately following an accident (after applicable per visit copayment).

– Allergy tests – needed to identify allergic reactions, also charges for injections.

– Telehealth services and virtual visits covered with designated network providers. Virtual visits are offered through UnitedHealthcare and contracted providers through a national service. Telehealth visits are a covered benefit that allow you to connect with a local network medical provider through live video conferencing or over the phone.

– Urgent care facilities.

– Nutritional counseling: three sessions per lifetime per condition.

A second or third opinion – after a surgeon has recommended major elective (nonemergency) surgery. The Health Benefit Plan covers second and third opinions by a plan physician for any major elective surgery. The Traditional option covers second and third opinions only for these procedures:

- Adenoidectomy and/or tonsillectomy
- Hysterectomy
- Cholecystectomy
- Inguinal hernia repair
- Bunionectomy
- Knee surgery
- Mastectomy
- Varicose vein ligation and/or stripping
- Sub mucous resection
- Thyroidectomy
- Cataract removal
- Colonoscopy

- Laminectomy
- Coronary artery bypass surgery
- Hemorrhoidectomy
- Myringotomy with insertion of drainage tubes
- Gastroscopy
- Foot surgery (when the total surgical fee for all recommended procedures exceeds $200)

A specialist's consultation for physical therapy
The consultation must be requested by the physician in charge of the case and be necessary for proper diagnosis and treatment. One consultation is covered for each series of treatments.

NOTE: If a physician bills for an office visit in conjunction with these services, the applicable office visit copayment would apply.

B-4.10. Laboratory Examinations, X-Rays, and Imaging

Laboratory examinations, X-rays, imaging (such as magnetic resonance imaging or MRIs), and other diagnostic procedures are covered by the Plan if the tests are ordered by a physician and they are used in connection with the diagnosis of an illness or accidental injury. These procedures may also be covered as part of preventive care. The procedures may be performed either in a physician's office or in or out of a hospital.

Procedures and tests not covered include the following items:

– Dental X-rays (covered under the Dental Plan).

– Tests covered by other Plan provisions.

B-4.11. Physical/Speech/Occupational Therapy

Benefits are payable for physical and occupational therapy for up to 60 outpatient treatment days per calendar year. Benefits are payable for speech therapy for up to 60 outpatient treatment days per calendar year.

To be eligible, physical, speech, and occupational therapy must be prescribed by a physician and performed by a licensed physical, speech, or occupational therapist. Treatment must be given in the outpatient facility of a hospital or qualified extended care facility, or in another facility approved by the network(s). (The Company does not approve facilities owned by physicians.)

In addition, to be covered by the Plan, speech therapy must be for a residual speech impairment resulting from a cerebral vascular accident, accidental head or neck injury, or surgery to the head or neck. For children under age six, benefits are also paid for congenital and severe developmental speech disorders when therapy is not available through public agencies (such as the state or a school district). Post cochlear therapy is covered.

Occupational therapy includes treatment to regain the use of upper extremities only; that is, your hands, arms, forearms, wrists, and shoulders. It does not include vocational, educational, or recreational therapy, or vocational rehabilitation. Cardiac rehabilitation for post myocardial infarction and post cardiac surgery are not subject to the physical therapy treatment day limitation.

B-4.12. Radiation Therapy

Treatment for radiation therapy is covered when performed by a physician in the outpatient department of a hospital. This includes chemotherapy treatment, which is the application or injection of chemicals to fight disease (usually cancer).

B-4.13. Prosthetic Devices

If an injury or illness causes the loss or impairment of part of your body, the Plan will provide benefits for an artificial substitute (prosthetic device) that is ordered by a physician and is an approved device by the Centers of Medicare and Medicaid Services (CMS)/ Medicare. Covered prosthetic devices include:

– Artificial limbs and eyes.

– Post surgical lenses used during convalescence from cataract surgery, and lenses for the treatment of keratoconus.

– Supplies (including bags, belts, tubing, and adhesive) necessary to furnish a colostomy or ureterostomy in the abdomen created surgically to aid discharge.

– Tracheostomy speaking valves.

– Ostomy supplies

Replacement and repair of devices and certain supplies to maintain effectiveness are also covered.

This part of the Plan does not cover expenses for dentures and other dental appliances, eyeglasses, and contact lenses to correct visual defects.

B-4.14. Durable Medical Equipment Rental

Rental of durable medical equipment, prescribed by a physician for medical treatment or physical mobility, is covered by the Plan. In some cases, the purchase of the equipment may be approved, if appropriate.

To be covered, the equipment must be able to withstand repeated use, serve a medical purpose, be appropriate for treatment at home, and be approved medical equipment by Centers of Medicare and Medicaid Services (CMS)/Medicare. Examples include oxygen tents, wheelchairs, crutches, canes, walkers, circulatory aids, and glucose monitors for insulin-dependent Type I diabetics. The Plan also covers:

- Cervical collars – one every two years.
- Pressure gradient supports – four times per year, for insufficient circulation in your extremities.
- Molded arch supports – one pair every two years.
- Augmentative and alternative communication devices where medically necessary.
- Passive motion devices.
- Special therapeutic shoes for severe diabetics.
- Orthotics (foot): one pair every two years regardless of diagnosis.
- Over-the-counter glucose test tablets, strips, reagent and stylets.

Durable medical equipment not covered includes:

- Diagnostic and therapeutic supplies such as thermometers, blood pressure kits, heating packs, etc.
- Dentures (covered by dental benefits).
- Hearing aids (covered by hearing benefits).
- Eyeglasses or contact lenses (covered by vision benefits).
- Heat lamps.
- Air conditioners.
- Environmental control units.
- Humidifiers or dehumidifiers.
- Post-surgical stockings.
- Ace bandages.
- Orthopedic shoes.
- Special pads or mattresses.
- Equipment used for hygienic purposes.
- Van modification for wheelchair patients.
- Wheelchair ramps.
- Other devices that do not serve a meaningful and necessary therapeutic purpose.
- Personal comfort and convenience items.
- Motorized mobility scooters.

B-4.15. Artificial Kidney Machine

The Plan also covers the use of an artificial kidney machine for a severely damaged or malfunctioning kidney – called hemodialysis treatment. Benefits are payable for treatment and supplies needed in the hospital or on an outpatient basis at a hospital or hemodialysis center. Benefits also are payable at home if the disease is irreversible and treatment is arranged by a physician.

B-4.16. Mental Health/Substance Abuse Services

The Plan pays benefits for the diagnosis, evaluation, and treatment of mental or nervous disorders and for substance abuse. To receive mental health and substance abuse benefits, advance approval or consulting ("triage") is required. If you do not use "triage", mental health and substance abuse benefits will not be paid. Call the number on the back of your Health Benefit Card for more details.

B-4.16.1 Inpatient Care

Inpatient mental health care is covered in a psychiatric hospital or in an acute care hospital. Inpatient substance abuse care is covered in an approved residential substance abuse facility or in an acute care hospital.

To be eligible for benefits, mental health and substance abuse services must be provided in a hospital or an approved substance abuse facility. Covered inpatient services include:

– Room, board, and nursing care.

– Laboratory tests – related to your treatment.

– Physician charges – for one visit per day while you are in the hospital.

– Drugs, solutions, serums and vaccines, and other biological products – dispensed by the facility for use during your stay.

– Care and treatment – from the facility's professional and trained staff.

– Counseling and therapy – for the patient and family members.

– Detoxification and rehabilitation – necessary services, supplies, and use of equipment, as long as they conform to a treatment plan written by a physician.

B-4.16.2. Professional and Other Staff Services

The Plan pays benefits for outpatient visits to a psychiatrist or psychologist. Psychological testing is covered when conducted by a psychologist.

A psychiatrist is a physician who is licensed to practice the study, diagnosis, and treatment of emotional and mental disorders.

A psychologist is an individual who is licensed or certified as a psychologist in the area where he or she is practicing. If there is no licensing or certification in the area where the psychologist is practicing, then the individual must be a member or fellow of the American Psychological Association, or be identified as a qualified clinical psychologist by the American Board of Examiners in Professional Psychology.

B-4.16.3. Outpatient Substance Abuse Care

The Plan pays benefits for outpatient visits to a network outpatient substance abuse facility that provides detoxification and rehabilitation services.

To qualify for benefits, a physician must examine the patient and diagnose the condition as substance abuse (alcoholism or drug dependency), as defined in section B-2. Also, treatment must be coordinated and supervised by a physician.

B-4.16.4. Mental Health Expenses Not Covered

The Plan does not pay mental health benefits for services:

– Not recommended by a network physician.

– Provided by someone who is not a psychiatrist or a psychologist (services by other paraprofessionals may be covered under the Health Benefit Plan; or through triage).

– Not diagnostic in nature.

– That seek results through practices that are generally not accepted by the health care profession.

B-4.16.5. Substance Abuse Care Not Covered

The Plan does not cover substance abuse expenses for:

– Diversional activities, such as sports, hobbies, or crafts.

– Services related primarily to the treatment of disorders or diseases that do not fit the Plan's definition of substance abuse.

B-4.17. Prescription Drug Benefits

The Plan pays prescription drug benefits according to this schedule:

– The active employee plan is $15 per generic, $30 per preferred brand and $60 per non-preferred brand.

– You pay the applicable copayment plus 25% of the amount over the applicable copayment for up to a 34-day supply of a Covered Prescription Drug from a non- participating pharmacy. Reimbursement will not exceed the benefit available through a participating pharmacy. (This section does not apply to the Traditional option.)

– You can fill up to a 100-day supply of maintenance medication through an in-network mail order pharmacy after two copayments, as described above.

B-4.17.1. Participating and Nonparticipating Pharmacies

Participating pharmacies have agreed to provide their services at a contracted rate. See your list of providers for a list of participating pharmacies.

B-4.17.2. Covered Medications

The following medications are covered by the Plan:

- All "legend" drugs – meaning the wording, "Caution: Federal law prohibits dispensing without a prescription," must appear on the container.
- "Nonlegend" drugs (Class V) – meaning they are regulated by state law and require a prescription in that state.
- Diabetic drugs and supplies – needed to treat a diabetic condition:
  - Injectable insulin and glucagon, if your need is verified by the pharmacist.
  - Disposable syringes and needles necessary to inject the amount of insulin or glucagon dispensed.
  - Over-the-counter glucose test tablets, strips, reagents, and stylets. These items are considered durable medical equipment under the Health Benefit Plan.
- "Maintenance drugs" – prescribed for you to take on a continuing basis over a long period.

In some cases the above medications are subject to review and may not be covered. This may include FDA-approved medications that are used outside their approved use, medications that have limited effectiveness, or medications with a strong history of inappropriate use.

B-4.17.3. Prescription Expenses Not Covered

The Plan does not pay benefits for some prescription drug expenses, including:

- Charges for the administration of prescription drugs.
- Contraceptive devices and other birth control products not listed on the network's formulary list.
- Therapeutic appliances and devices, bandages and similar supplies, support garments, and other non-medicinal supplies.
- Charges for quantities of more than a 34-day supply (or a 100-day supply for approved maintenance drugs).
- Refills that exceed the amount prescribed by the physician or that are provided more than one year after the physician's last order.
- Experimental drugs and drugs used for any treatment that hasn't been approved by the U.S. Food and Drug Administration. (See section B-5.4 for an explanation of experimental.)
- Drugs covered by Medicare.
- Drugs and medicines covered by another benefit plan.
- Prescriptions ordered by anyone not legally qualified to prescribe drugs or from an organization not licensed to dispense drugs.
- Syringes and needles, except those necessary to inject a covered supply of insulin or glucagon.
- Drugs prescribed for cosmetic purposes.
- Smoking cessation drugs.
- Drugs prescribed for infertility.
- Drugs that are fraudulently obtained or demonstrate abuse
- Drugs that are entirely consumed at the time and place of prescribing.
- Replacement of lost, stolen, damaged, or discarded drugs.
- Over the counter or other drugs not specifically approved for inclusion by the third party administrator (TPA)/MCO formulary committee.

B-4.17.4. Using Your Prescription Drug Benefit

For most prescriptions you fill, you can receive up to a 34-day supply per prescription. For approved maintenance drugs, you can receive up to a 100- day supply. Here's how you get prescription drug benefits:

- At participating pharmacies – When you fill a prescription, present your Health Benefit Card, and you will be charged the $5 or $20 copayment. No claim forms are needed. This includes a national network of pharmacies.

- At nonparticipating pharmacies– You must pay the full cost of your prescription, then submit a completed claim form to the address on the back of your Health Benefit Card. You will be reimbursed up to the benefit level paid by the Plan.
- Mail order program – You receive up to a 100-day supply of maintenance Covered Prescription Drugs for one copayment through participating mail order pharmacies.
- Variable Copay Program - Certain specialty medications are eligible for copayment assistance by drug manufacturers. The Claims Administrator may help you determine whether your specialty medication is eligible for Copayment assistance. If you receive copayment assistance from a drug manufacturer, your Copayment and/or Coinsurance may vary. Please contact the Claims Administrator using the telephone number on your ID card for a list of specialty medications available in this program. If you choose not to participate, you will pay the cost share as described in your the benefit summary. Amounts paid by drug manufacturers toward cost sharing will not count toward any deductible that applies or out-of-pocket limit.

B-4.18. Vision Care

Benefits for vision care are payable according to the schedule in section B-6.3. When you need vision care, you choose how you want to receive services from two options. You can:

- Continue to use the providers of your choice; or
- Participate in the Preferred Provider Arrangement (where available).

When you receive vision services and supplies from preferred providers, your out-of-pocket costs may be less.

B-4.18.1. If You Use Providers of Your Choice

To be eligible, vision services must be provided by a qualified eye doctor or specialist, including:

- Ophthalmologist. A physician who specializes in the diagnosis and medical or surgical treatment of eye diseases and defects.
- Optometrist. A specialist trained to test eyes and treat visual defects. Optometrists may prescribe and fit corrective lenses and other optical aids.
- Optician. A specialist trained only to fill prescriptions and fit corrective lenses.

The following expenses are covered, up to the levels indicated in the section describing your medical option:

- Eye examinations – by an optometrist or ophthalmologist, including complete eye measurements and tests.
- An additional eye examination – by an ophthalmologist, if an optometrist provides written referral and you visit that doctor within 60 days.
- Charges to prepare corrective lenses – up to two lenses per prescription.
- Charges for frames – if corrective lenses are prescribed.

B-4.18.2. If You Use United Healthcare Vision (where applicable)

To be eligible, vision services and supplies must be received from a participating United Healthcare Vision provider. Here's how the plan works:

- Call United Healthcare Vision at 1-800-203-3659 for a list of participating providers in your area.
- Schedule an appointment for an exam with a participating provider (identify yourself as a United Healthcare Vision participant).
- If you need glasses or contact lenses, you must be fitted for these (and make your frame selection) at the time of the exam.
- You pay the appropriate copayments to the provider when you receive services. No claim forms are needed.

Additional services and supplies are available through United Healthcare Vision at contracted or discounted rates. If you need a referral to an ophthalmologist, United Healthcare Vision pays the full cost of the exam if you're referred by a participating optometrist and if you receive the consultation within 60 days of the referring optometrist's exam.

PREAUTHORIZE VISION BENEFITS

To verify your eligibility for benefits, call United Healthcare Vision at

1-800-203-3659

B-4.18.3. Filing Vision Claims

When you use United Healthcare Vision providers, you do not file any claims. If you do not use United Healthcare Vision providers, you may need to pay directly to your provider the full cost of vision services and supplies you receive. You may be reimbursed up to the Health Benefit Plan benefit levels by:

– Obtaining a claim form from United Healthcare Vision;

– Presenting the claim form to your non-participating provider and requesting that it be completed; and

– Mailing your completed claim form with itemized receipts for services and supplies to:

Vision Claims Department
PO Box 30978
Salt Lake City, UT 841300

A check will be sent directly to you.

B-4.18.4. Vision Expenses Not Covered

Expenses that are not covered by the Plan include charges for:

– Lenses that don't require a prescription.

– Vision care that is covered by another part of the Plan.

– Special or unusual procedures (such as orthoptics, vision training, subnormal vision aids, and aniseikonia lenses).

– Services and materials ordered before you joined the Plan or after you no longer participate in the Plan (unless ordered while a Plan member and received within 30 days of termination).

– Services for which no charge would be made in the absence of vision care coverage.

– Failure to keep a scheduled visit with the eye doctor.

B-4.19. Hearing Care

Benefits for hearing care are payable according to the schedule in section B-6.3. To be eligible, hearing services must be provided by a qualified ear doctor, specialist, or hearing aid specialist/dispenser, including:

– Otologist – A physician who specializes in the diagnosis and medical or surgical treatment of ear diseases and defects.

– Otolaryngologist – A physician who specializes in ear, nose, and throat problems.

– Audiologist – A specialist who has an advanced degree in audiology (the science of hearing) or speech pathology (the study of speech defects and abnormalities). The audiologist must have a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association and be certified and qualified to conduct hearing tests and prescribe hearing aids.

B-4.19.1. Covered Hearing Expenses

The following expenses are covered, up to the levels indicated in the section describing your medical option:

– One audiometric exam – every 36 months by an ear doctor, audiologist, or hearing aid specialist/dispenser.

– One hearing aid evaluation – every 36 months performed by an ear doctor, audiologist, or hearing aid specialist/dispenser (including on follow-up visit).

– Hearing aid charges – for the purchase and dispensing of hearing aids (once every 36 months).

– Replacement of a hearing aid that is lost or broken if Plan benefits were not paid within the last 36 months

B-4.19.2. Hearing Expenses Not Covered

Expenses that are not covered by the Plan's hearing benefits include charges for:

– Hearing aids ordered while covered but delivered more than 60 days after coverage ends.

– Audiometric exams, hearing aid evaluation tests, and hearing aids:

- That do not meet professionally accepted standards or that are experimental;
- That are not necessary, according to professionally accepted standards, or that are not recommended or approved by the ear doctor;
- For which no charge is made or for which no charge would be made if there were no hearing coverage;

- Provided by a government agency at no cost (in compliance with any federal, state, or local law or regulation); or
- For which benefits are payable by any health care program supported by any federal, state, or local government.

– Replacement of a hearing aid that is lost, stolen, or broken if Plan benefits were paid within the last 36 months.

– Repairing a hearing aid and replacing its parts.

– Failure to keep a scheduled visit with an ear doctor or an audiologist.

– Medical or surgical treatment and drugs or other medication. (These expenses may be covered by another part of the Plan.)

– Audiometric exams and hearing aid evaluation tests performed, and hearing aids ordered, before you joined the Plan or after your coverage ends.

B-4.20. Dental Care

Dental benefits are designed to encourage good preventive care and help you maintain healthy teeth and gums. Dental services are covered by the Plan as described on the following pages only when performed by a dentist or dental professional (such as a hygienist). All dental services will be considered for coverage under these dental provisions only. Dental services are not covered by any of the medical options.

B-4.20.1. Preventive Expenses

Covered preventive services for each person include:

– Oral examinations – two check-ups each calendar year.

– Routine cleanings – two each calendar year; a maximum of four visits for cleaning during the 12 months following gum surgery or periodontal treatment.

– Fluoride treatments.

– Diagnostic X-rays – for bitewing X-rays, twice each calendar year; for full-mouth X- rays, once every 36 months.

– Dental sealants – will be covered for children age 5 through 16 for certain teeth.

B-4.20.2. Basic Expenses

Covered basic services for each person include:

– Fillings – amalgam (silver), gold, composite, or resin fillings; to restore the structure of teeth and prevent further decay.

– Extractions.

– Gum and mouth treatments – including surgery for the treatment of gum and mouth diseases. Also includes four visits for scaling and maintenance for one year following definitive periodontal treatment.

– Inlays, onlays, or crowns – porcelain, metal, or gold; used to restore the structure of teeth and prevent further decay.

– Root canal therapy.

– Space maintainers.

– Emergency examinations – as the result of accidental injuries.

– Repairs – to repair or recement crowns, inlays, bridgework, dentures, occlusal guards, and implants that were covered by the Plan; also relining of dentures.

– Oral surgery – including the removal of impacted teeth.

– General anesthesia – for oral surgery and for the removal of impacted teeth. Also covered when three or more simple extractions are done at the same time.

– Laboratory tests – related to oral surgery, including complete blood count, urinalysis, and blood sugar tests.

B-4.20.3. Major Services

Covered major services for each covered person include:

– Fixed bridgework – to install fixed bridgework, including inlays and crowns to form abutments.

– Dentures – to replace original teeth or to replace dentures that are more than five years old and no longer usable.

– Orthodontia – the use of braces and appliances, and examinations, extractions, and appliance adjustments to correct crooked, crowded, or protruding teeth.

B-4.20.4. How Dental Benefits Are Paid – A Quick Glance

Dental Service	Benefit Description The Plan Pays*:	Up to These Maximums	Some Examples
Preventive & Diagnostic	100%		Exams, Cleanings
Basic	100%	$1,650 per person annually**	Fillings, X-rays, Inlays, Crowns Extractions, Oral Surgery, Dentures, Bridgework
Major	50%		
Orthodontia	50%	$1,850 per person lifetime maximum	Orthodontia

*For allowed charges only **Oral Surgery not subject to annual maximum. Does not apply to annual maximum

B-4.20.5. Determining Benefits in Advance

You can learn in advance how much the Plan will pay for the dental care you need through a feature called predetermination of benefits.

You should use predetermination of benefits for proposed dental treatment that's expected to be $125 or more. Most dentists are familiar with this process, so they will not be surprised when you ask about it.

Ask your dentist to complete a dental claim form describing the proposed course of treatment and related charges, and send it to the address on the back of your Dental Benefit Card. The recommended treatment will be reviewed, and you and your dentist will be notified of how much the Plan will pay. You and your dentist should discuss the treatment plan as well as any alternatives before you decide which treatment is best for your dental needs.

Predetermining benefits eliminates financial guesswork for you. Any dental charges that are more than the predetermined benefit amount are your responsibility. Predetermination helps prevent surprises and makes good consumer sense.

For more information on allowed charges, see the definition in section B-2.

B-4.20.6. Filing a Dental Claim

To file a dental claim, follow these steps:

1. Work through your dentist and use the dental form approved for use by the American Dental Association (ADA).
2. You or your dentist submits the form to the address on your Dental Benefit Card.

B-4.20.7. If a Claim Is Denied

If a claim for benefits is denied, in whole or in part, you are entitled to a full review. For information about the process for reviewing denied claims, see Chapter H: "Administrative Information".

B-5. Health Care Expenses Not Covered

Exclusions that apply only to a certain benefit type are listed in that benefit description section.

B-5.1. Medical Expenses Not Covered

- Expenses above the allowed charge or maximum allowed benefit.
- Charges due to accidental injuries related to your work or illness for which you can receive benefits from government programs (such as Workers' Compensation).
- Charges for cosmetic surgery (and complications arising from such surgery), except for reconstructive surgery resulting from injuries sustained in an accident or to correct a functional impairment from a birth defect or disease.
- Charges for cosmetic surgery (procedures or services that change or improve appearance without significantly improving physiological function and complications arising from such surgery), except for reconstructive surgery resulting from injuries sustained in an accident or to correct a functional impairment from a birth defect or disease or for procedures meeting established medical necessity guidelines (Generally Accepted Standards of Medical Practice based on scientific clinical evidence, prevailing medical standards and clinical guidelines) for improving or restoring physiologic function (where the organ or body part is made to work better), as well as mandated coverage for breast reconstruction under the Women's Health and Cancer Rights Act of 1998; the forgoing exclusions shall not apply to benefits otherwise covered under the Plan that are approved for treatment of gender dysphoria
- Charges for services, treatment, technology, prescription drugs, or supplies that are not medically necessary (medically necessary is defined in section B-2).

- Charges incurred while confined to a government hospital that are the result of a military-service-connected disability.
- Convenience or personal comfort items.
- Routine care such as periodic checkups, physical exams, or immunizations (unless specifically listed as a covered expense by a Health Benefit Plan option.
- Charges that you (or John Deere) are not legally required to pay.
- Charges that are related to a hospital stay that started before the coverage takes effect.
- Services for which no charge is normally made or that are performed by an immediate family member.
- Charges for weight loss clinics or programs and diet counseling unless provided as a preventive benefit for qualifying individuals within the benefit plan.
- Biofeedback treatment and relaxation therapy.
- Nonprescription vitamins, nutritional supplements, and special diets except for enteral nutrition. Enteral nutruition benefits are covered for enteral formula and low protein modified food products, administered orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. It also includes prescription or over-the-counter formula when a physician or written order stating the formula or product is medically necessary for the therapeutic treatment of a condition requiring specialized nutrients, quantity, and duration.
- Exercise equipment or devices.
- Special shoes unless attached to a brace, corset, other article of clothing, or cosmetic device.
- Court ordered services unless medically necessary and approved by a physician.
- Artificial insemination, in vitro fertilization, GIFT, or other artificial fertilization techniques including any related fertility services or treatment (and complications arising from these treatments).
- Reversal of voluntary sterilizations (and complications from this procedure).
- Charges for the treatment of Temporomandibular Joint (TMJ) dysfunction except where Orthognathic surgery is needed for the treatment of congenital anomaly, deformity resulting from chromosomal abnormality, acute traumatic injury, accident, dislocation, tumors, cancer or the result of cancer treatment, results of medical or surgical treatment that has left an individual with impaired critical functions or obstructive sleep apnea. The purpose of orthognathic surgery for these conditions must meet the definition of reconstructive surgery and are not deemed to be cosmetic.
- Charges for surgery to the cornea to improve vision by changing the refraction (e.g., radial keratotomy).
- Services for mental retardation or nontreatable mental deficiency and for mental disorders that are not likely to improve through accepted psychiatric practice.
- Services for learning problems, family or marital counseling, antisocial behavior, aggressive or nonaggressive conduct disorders (unless there is an associated psychiatric disorder) with exception to services that cover Intensive Behavior Therapy or Applied Behavior Analysis for participants diagnosed with Autism Spectrum Disorder.
- Services for diversional activities or for general counseling or advice.
- Services that can be performed in the setting by someone who does not have professional qualifications, but has been trained to perform the service.
- Sublingual allergy provocative testing and treatment.
- Charges for sickness or injury resulting from war or any act of war (declared or undeclared).
- Charges for completing insurance forms.
- Charges that are covered by other group insurance.
- Charges incurred by someone who is not covered by the Plan.
- Hospital utilization fees.
- Interest and taxes.
- Treatment or services for which you or your dependents have no financial responsibility or that would be provided without charge in the absence of coverage.
- Charges for wigs.
- Any services not specified in this Plan.

B-5.2. Dental Expenses Not Covered

There are some dental services and supplies that are not covered by the Plan. Excluded expenses are:

- Services in excess of allowed charges.
- Services or treatments that are not medically necessary (medically necessary is defined in section B-2).
- Dental implants, except when strict health criteria are met.
- Treatment of temporomandibular joint dysfunction (TMJ).
- Special or unusual techniques, including bite registration and bite opening.
- Instructions for plaque control, oral hygiene, or diet.
- Drugs and medicines, except antibiotic injections.
- Services that are solely cosmetic in nature, including charges for personalization or characterization of crowns or dentures.
- Bridges, dentures, and crowns that are installed more than 60 days after coverage ends, that unnecessarily replace an existing device, or that replace a lost, missing, or stolen device.
- Charges for failure to keep a scheduled visit with the dentist.
- Treatment or services for which you or your dependents have no financial responsibility or that would be provided without charge in the absence of coverage.
- Services of a dental laboratory or expanded dental auxiliary, unless licensed to operate in your area.
- Treatment resulting from any act of war (declared or undeclared).
- Treatment or services that are paid for or furnished by the United States government or one of its agencies (except as required under Medicaid provisions or federal law).
- Services provided by any person who is not a dentist or dental hygienist, or provided by any person in your or your dependent's immediate family.
- Replacement of a lost, missing, or stolen prosthetic device.
- Treatment or services covered by Workers' Compensation or similar law.
- Charges for infection control.
- Charges for consultations (except as an orthodontic benefit).
- Charges for temporary partial dentures.
- Charges for bleaching of teeth.
- Emergency exams (except as the result of accidental injury).
- Services or treatment for asymptomatic conditions.

B-5.3. Custodial Care

Custodial care is care that consists of watching, maintaining, or protecting, or is for the purpose of providing personal needs rather than being able to cure. The Plan does not pay for a person to provide the following:

- Assistance in the activities of daily living, such as walking, dressing, getting in and out of bed, bathing, eating, feeding, or using the toilet, or help with other functions of daily living or personal needs of a similar nature.
- Services that do not seek to cure, or which are provided during periods when the medical condition(s) of the patient who requires the service is not changing.
- Changes of dressings, diapers, protective sheets, or periodic turning or positioning in bed.
- Administration of or help in using or applying medications, creams, and ointments whether oral, inhaled, topical, rectal, or injected.
- Administration of oxygen.
- Care or maintenance in connection with casts, braces, or other similar devices.
- Care in connection with ostomy bags or devices or in-dwelling catheters.

- Feeding by tube, including cleaning and care of the tube site.
- Tracheostomy care, including cleaning and care of the tube site.
- Urinary bladder catheterization.
- Monitoring, routine adjustments, maintenance, or cleaning of an electronic or mechanical device used to support a physiological function including, but not limited to, a ventilator, phrenic nerve, or diaphragmatic pacer.
- General supervision of exercise programs, including the carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

B-5.4. Experimental/investigational or Unproven Care

Charges in connection with certain experimental, investigation, or unproven drugs, devices, medical treatment, or procedures, and for complications arising from these procedures are not covered by the Plan except as noted in B-5.4.1. The exception as noted in 5-4.1 does not apply to the Traditional plan.

A drug, device, medical treatment, or procedure is experimental, investigational, or unproven if:

- The drug or device requires approval of the Food and Drug Administration, and the drug or device has not been approved to be lawfully marketed for that use when furnished (a drug or device approved for investigational use is deemed to be experimental, investigational, or unproven); or
- Reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I, II, or III clinical trials for the patient's medical condition (except for National Cancer Institute-approved Phase III clinical trials for cancer); or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis for the patient's medical condition.
- Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.
- Participants must notify the third-party administrator as soon as the possibility of participation in a clinical trial arises.
  If the third-party administrator is not notified, the participant will be responsible for paying all charges and no benefits will be paid.

B-5.4.1. Qualifying Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Participant is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:
- Medically Necessary Allowed Charges for which Benefits are typically provided absent a clinical trial;
- Medically Necessary Allowed Charges required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Medically Necessary Allowed Charges needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:
- The Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices; 47 *01576 Plan 501.DOC/ 10/2013*
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with our medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

– a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and

– items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria below.

– Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

  - *National Institutes of Health* (NIH). (Includes *National Cancer Institute* (NCI));
  - *Centers for Disease Control and Prevention* (CDC);
  - *Agency for Healthcare Research and Quality* (AHRQ);
  - *Centers for Medicare and Medicaid Services* (CMS);
  - a cooperative group or center of any of the entities described above or the *Department of Defense* (DOD) or the *Veterans Administration* (VA);
  - a qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
  - The Department of *Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria: 48 *01576 Plan 501.DOC/ 10/2013*
    – comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
    – ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

– The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;

– The study or investigation is a drug trial that is exempt from having such an investigational new drug application;

The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial; or

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of Medically Necessary Allowed Charges and is not otherwise excluded under the Plan.

Participants must notify the Third Party Administrator as soon as the possibility of participation in a clinical trial arises. If the Third Party Administrator is not notified, the Participant will be responsible for paying all charges and no benefits will be paid.

B-5.5. Excluded Providers

Deere may, in its discretion, exclude any provider. If this happens, the Company will not pay benefits (to you or the provider) for any services or supplies given or ordered by an excluded provider. Call the number on the back of your Health Benefit Card if you have any questions about a provider being excluded.

B-6. How the Health Benefit Plan Works

Section B-6 (including B-6.1, B-6.2, B-6.3, and B-6.4) provides information on the Health Benefit Plan.

At most locations, medical coverage is available through the Health Benefit Plan. Under this option, you and your family receive most of your basic, everyday medical care through a network(s) physician. The network(s) has a panel of specialists available for referrals.

The Health Benefit Plan pays 100% of allowed charges after applicable per visit copayments for most covered services provided by or referred by network physicians.

B-6.1. Health Benefit Plan Services

The Health Benefit Plan provides a broad range of physician and laboratory services, including:

– Physical exams – routine, well-baby care, and child care.

– Diagnostic exams – for sickness and injuries.

- Immunizations and allergy injections.
- X-rays and basic laboratory work – such as blood tests, throat cultures, EKGs, and Pap tests.
- Treatment of some fractures.
- Minor outpatient surgery – such as the removal of warts, cysts, and moles.

B-6.1.1. Prescription Services

The Health Benefit Plan provides a national network(s) of participating pharmacies to fill prescriptions written by your physician. Mail order pharmacies are available for filling your maintenance medication.

B-6.2. Using the Health Benefit Plan

When you enroll in the Health Benefit Plan, you establish a relationship with a network(s) physician who provides care to you and your dependents. All network(s) physicians are board certified or board eligible by the American Board of Family Practice and have completed a family practice residency.

For scheduled visits, you will see the same physician. If you need an appointment and your family physician is not available, you can decide between scheduling a later appointment with him or her, or an earlier appointment with another network(s) physician. If some family members prefer to see different physicians, their preferences will be accommodated.

B-6.2.1. Scheduling an Appointment

To schedule an appointment, call your network physician's office. For patients with immediate health care needs, same-day appointments may be available. If you need a same-day appointment and your physician is not available, you can choose between the next available appointment with him or her, or an appointment with another network physician.

In other situations, when an advance appointment is feasible (routine physical, for example), your visit should be scheduled within a few weeks of your request.

B-6.2.2. Virtual Visits

Virtual visits and telehealth services are available but only when such services are delivered through a designated virtual network provider.

B-6.2.3. Network(s) Physician Referrals

As a member of the Health Benefit Plan, your family's primary care will be provided by your network(s) physician. But there may be times when you'll need the care of another specialist. For this reason, a panel of selected local specialists is available to provide your care. When medically necessary, you'll also have access (by preauthorized referral and gap exception if necessary) to other providers including the Mayo Clinic and other regional health care operations.

B-6.2.4. Hospital Services

To receive maximum Plan benefits, you will need to use a hospital that has established a relationship with the network(s). Full Plan benefits also will be paid for emergency treatment at hospitals or other facilities that do not have a relationship with the network's physicians (see the following section for proper emergency procedures).

B-6.2.5. Special Maternity Provision

If you or your spouse is pregnant and your coverage under this option ends (for example, you leave the Company), you will still be eligible to receive maternity benefits under this option for hospital charges and the delivery. However, coverage must have been in effect when you or your spouse became pregnant. Benefits would not be payable for the newborn.

B-6.2.6. In Case of Emergency

If you have a medical emergency, you should seek care immediately. The Plan will pay 100% of allowed charges for your network(s) physician or at a hospital emergency room after a $150 copayment. Generally, a medical emergency means an illness or injury that requires immediate care from a physician (see section B-2. for a more detailed definition).

If possible, you should contact your networks physician for care. Visits to the emergency room should not be used as a substitute for care you could receive from your network(s) physician during office hours.

If you have an emergency, you should seek treatment immediately from an emergency facility and notify your network(s) physician as soon as possible.

B-6.2.7. Out-of-Area Services

If you're outside the network(s) service area — while you're on vacation, or when a dependent is away at college, for example — charges by other providers for care that needs immediate medical attention are covered at 100% of allowed charges after any applicable copayments. This includes medical emergencies and illnesses or injuries that require medical care.

Routine physical exams and certain other elective health care services provided by non- network providers are not covered by the Plan. These services must be performed by a network physician. (Some elective, out-of-area services may be payable under the self-referral feature, described below.)

B-6.2.8. Self-Referral Benefits

When you join the Health Benefit Plan, you can choose to go to non-network providers without authorization and receive benefits for some services. This is called the self-referral feature.

Here's how the self-referral feature works:

- When you use non-network providers without authorization, you first pay a $250-per- person ($500-per-family) annual deductible before the Plan pays benefits.
- Once you meet your annual deductible, the Plan pays 80% of most physician and hospital charges (up to the maximum allowable benefit defined in section B-2).
- If your out-of-pocket expenses for self-referred care reach $1,000 ($2,000 for families) in a calendar year, the Plan pays 100% of maximum allowable benefit for the rest of the year.

B-6.2.9. Exclusions and Limitations

The Plan does not pay self-referral benefits for routine physicals, mammograms, Pap tests, well-child care, immunizations, allergy testing and injections, home health care, durable medical equipment and prosthetic devices, organ transplants, or hearing care.

All self-referred hospital stays must be preauthorized. See section B-4.3 for more information on precertification, concurrent review, and case management services and requirements.

B-6.3. Special Benefit Levels/Limitations Health Benefit Plan

Benefits you receive for certain medical services and supplies have specific limitations or are paid at predetermined levels under the Health Benefit Plan. To receive the benefits indicated in section B-6.3, you must use a network(s) physician or be referred to other providers (except for routine vision and chiropractic care). For more information on each of these benefits, turn to the section indicated.

Medical Service/Supply	Benefit Description John Deere Health Benefit Plan
Vision Care Services	**John Deere Vision Benefits** Benefits paid to you up to these amounts: – Exam by optometrist ___________ $45.70 (100% for children under age 19) – Exam by ophthalmologist ________ $45.70 – Single vision, per lens ___________ $20.50 – Bifocals, per lens ______________ $29.25 – Trifocals, per lens ______________ $38.00 – Lenticular lens, per lens _________ $46.70 – Contacts, per lens______________ $29.25 – Frames _______________________ $27.80 **United Healthcare Vision Copayments (where available)** When you use United Healthcare Vision providers, your payment could be as low as: – Vision exam __________________ $5.00 (waived for children under age 19) – Lenses, per pair ________________ $10.00 – Frames _______________________ $10.00 – Contact lens fitting fee__________ $50.00 Exam, lenses, and frames are covered every 12-months for active employees and every 24-months for retirees and LTD employees. Date of payable exam determines 12-month or 24-month period. *For more information, see section B-4.18.*
Preventive Care	Routine physical ____________________________________ 100% of allowed charges. Mammograms and Pap tests __________________________ 100% of allowed charges. Well-child and newborn care__________________________ 100% of allowed charges. Expanded Women's Preventive care ___________________ 100% of allowed charges. Immunizations; allergy testing and injections _____________ 100% of allowed charges. Note: Based on U.S. Preventive Services Task Force and Affordable Care Act guidelines. If a physician bills for an office visit in conjunction with these preventative services, the applicable office visit copayment would apply.
Hearing Aids	Benefits paid once every 36 months, according to this schedule (through a panel of exclusive providers): – Audio exam_______________________________100% – Hearing aid evaluation ____________________100% – Hearing aid______________________________100% (for predetermined hearing aid) – Dispensing fee ___________________________100% – Binaural hearing aid _______________________100% (for predetermined hearing aid) – Binaural dispensing fee____________________100% Eligibility for replacement hearing aids is based on the date of the last claim. *For more information, see section B-4.19.*
Mental Health Services	**Inpatient** _________________________________100% of allowed charges. **Outpatient** ________________________________100% of allowed charges; psychological testing is covered. Advance approval or consulting ("triage") is required to identify the proper source of care. *For more information, see section B-4.16.*
Substance Abuse Services	**Inpatient** _________________________________100% of allowed charges. **Outpatient** ________________________________100% of allowed charges. Advance approval or consulting ("triage") is required to identify the proper source of care. *For more information, see section B-4.16.*
Chiropractic Care	Office visits, manipulations, modalities, other Chiropractic services, Imaging and laboratory services provided at 100% of allowed charge for employees and dependents after applicable per visit copay subject to maximum of six (6) visits annually.
Prescription Drugs	*For more information, see section B-4.17.*

B-6.4. Claiming Your Benefits

When you use the Health Benefit Plan, you do not need to file a claim for benefits. If you use the self-referral feature or you have an emergency and you're out of the network(s) service area, then you may need to submit a claim to receive benefits. Follow the steps for filing claims described in section B-9. All claims for vision care are processed by United Healthcare Vision regardless of whether or not you use a United Healthcare Vision provider.

B-6.4.1. If a Claim is Denied
If a claim for benefits is denied, in whole or in part, you are entitled to a full review. For information about the process for reviewing denied claims, see Chapter H: "Administrative Information".

B-6.4.2. Timeframe for Deciding Urgent Care Claims
The network(s) (the "Plan") will notify you of its benefit decision regarding an Urgent Care Claim as soon as a decision is made, but not later than 72 hours after the Plan receives the claim.

If additional information is needed to evaluate your claim, you will be notified within 24 hours after the Plan receives the claim. The notice will identify the specific information needed for the Plan to make a benefit decision. The Plan will make a benefit decision within 48 hours after the Plan receives the specified information. You will have 48 hours from receipt of the notice to provide the additional information. The Plan will make a benefit decision within 48 hours after the receipt of the needed information. If the needed information is not received, the Plan will make a benefit decision within 48 hours after the conclusion of the 48-hour period.

B-6.4.3. Timeframe for Deciding Concurrent Care Decisions
If the Plan has approved an ongoing course of treatment (i.e., period of time or number of treatments to be provided), you will be notified if the ongoing course of treatment is to be reduced or terminated. You will be notified far enough in advance for you to appeal the decision and to obtain a determination on review before the benefit is reduced or terminated.

Any request by you to extend the course of treatment involving urgent care will be decided as soon as possible, taking into account the medical circumstances. The Plan will notify you of the benefit determination within 24 hours after receipt of the claim, provided the claim is made at least 24 hours prior to the expiration of treatment. Urgent Care Claims received by the Plan less than 24 hours prior to the expiration of the treatment will be handled according to the procedures described in section B-6.4.2. Timeframe for Deciding Urgent Care Claims.

B-6.4.4. Timeframe for Deciding Pre-Service Claims (Non-Urgent Care Claims)
The Plan will make a benefit determination and will notify you regarding the decision within 15 days of the Plan's receipt of a Pre-Service Claim ("Pre-Service Claim Determination Period"). The Pre-Service Claim Determination Period may be extended one time for up to 15 days, due to circumstances beyond the control of the Plan. You will be notified of the reason(s) for the extension within 15 days of the Plan's receipt of a Pre-Service Claim.

If the reason for the extension is that additional information is required to decide the claim, you will be advised of the specific information needed within 15 days of the Plan's receipt of a Pre-Service Claim. You will have 45 days from receipt of the notice to provide the additional information. The Pre-Service Claim Determination Period will be tolled until the Plan receives the requested information. The Plan will make a benefit decision within 15 days after the receipt of the needed information. If the needed information is not received, the Plan will make a benefit decision within 15 days after the conclusion of the 45-day period.

B-6.4.5. Timeframe for Deciding Post-Service Claims
The Plan will make a benefit determination and will notify you regarding the decision within 30 days of the Plan's receipt of a Post-Service Claim ("Post-Service Claim Determination Period"). The Post-Service Claim Determination Period may be extended one time for up to 15 days, due to circumstances beyond the control of the Plan. You will be notified of the reason(s) for the extension within 30 days of the Plan's receipt of a Post-Service Claim.

If the reason for the extension is that additional information is required to decide the claim, you will be advised of the specific information needed within 30 days of the Plan's receipt of a Post-Service Claim. You will have 45 days from receipt of the notice to provide the additional information. The Post-Service Claim Determination Period will be tolled until the Plan receives the requested information. The Plan will make a benefit decision within 15 days after the receipt of the needed information. If the needed information is not received, the Plan will make a benefit decision within 15 days after the conclusion of the 45-day period.

B-6.4.6. Other Important Claim Filing Information
If a charge is made to you by a network provider for a service covered under the Summary Plan Description beyond any applicable Co-payments, Coinsurance and Deductibles, submit written proof of these charges to the address on the back of your Health Benefit Card.

B-6.4.7. How to Appeal an Adverse Benefit Determination
Contact your Union representative if you are notified that a claim for benefits under the Plan is denied, in whole or in part (See Chapter H: Administrative Information). Your Union representative can assist you in resolving the claim with the Plan and can also file an appeal under the collective bargaining agreement.

B-7. How the Traditional Option Works

The following sections B-7.1. to B-7.5., provides information on the Traditional Medical option.

Deere offers the Traditional option outside the managed care option(s) service area(s). Under this option, the Company pays the major part of your covered expenses. The level of coverage may be lower than coverage provided under the Health Benefit Plan, but you are not limited to network(s) providers.

As with the other medical options, you and your eligible dependents are eligible for medical and dental coverage as of the first day of the month following 30 calendar days of employment for at no premium. If you need coverage prior to this date, you are eligible to enroll in medical coverage at a full cost premium rate.

B-7.1. Basic Benefits

The Plan pays 100% of most of the following services, when medically necessary:

– Hospital charges (for up to 365 days of continuous disability);

– Maternity charges;

– Surgical charges; and

– Related physician's charges.

B-7.2. Special Maternity Provision

If you or your spouse is pregnant and your coverage under this option ends (for example, you leave the Company), you will still be eligible to receive maternity benefits under this option for hospital charges and the delivery. However, coverage must have been in effect when you or your spouse became pregnant. Benefits would not be payable for the newborn.

B-7.3. In Case of Emergency

If you have a medical emergency, the Plan will pay 100% of allowed charges for medical care and treatment provided as soon as possible after the onset of the medical emergency. Generally, a "medical emergency" means an illness or injury that requires immediate care from a physician (see section B-2 for a more detailed definition).

B-7.4. Special Benefit Levels/Limitations

Under the Traditional option, benefits you receive for certain medical services and supplies have specific limitations or are paid at predetermined levels. The chart in this section highlights the benefit levels for these expenses. For more information on each of these benefits, turn to the section number indicated.

Medical Service/Supply	Benefit Description Traditional Option
Vision Care Services	**John Deere Vision Benefits** Benefits paid to you up to these amounts: – Exam by optometrist ___________ $45.70 – Exam by ophthalmologist ________ $45.70 – Single vision, per lens ___________ $20.50 – Bifocals, per lens ______________ $29.25 – Trifocals, per lens ______________ $38.00 – Lenticular lens, per lens _________ $46.70 – Contacts, per lens______________ $29.25 – Frames _______________________ $27.80 **United Healthcare Vision Copayments (where available)** When you use United Healthcare Vision providers, your payment could be as low as: – Vision exam __________________ $5.00 – Lenses, per pair ________________ $10.00 – Frames _______________________ $10.00 – Contact lens fitting fee__________ $50.00 Exam, lenses, and frames are covered every 24-months for retirees and LTD employees enrolled in the traditional plan. Date of payable exam determines 24-month period.. *For more information, see section B-4.18.*
Preventive Care	**Mammograms and Pap tests** — Plan pays 100% of allowed charge for each test. One Pap test covered every 12 months from the date of the last exam; mammograms covered according to this minimum schedule: Age 35-39 — One baseline mammogram. Age 40-49 — One mammogram every 24 months. Age 50 and over — One mammogram every 12 months. **Newborn care** ______________________________________ 100% of allowed charges. **Allergy testing** ______________________________________ 100% of allowed charges.
Hearing Aids	Benefits paid once every 36 months to you up to these amounts: – Audio exam_______________________________ $30 – Hearing aid evaluation ____________________ $40 – Hearing aid______________________________ $225 plus a dispensing fee of $125 – Binaural hearing aid _______________________ $450 plus a dispensing fee of $190 Eligibility for replacement hearing aids is based on the date of the last claim. *For more information, see section B-4.19.*
Mental Health Services	**Inpatient** ____________________________________ 100% of allowed charges for up to 45 days per disability in a psychiatric hospital or 365 days in an acute care hospital. **Outpatient** ___________________________________ 100% of allowed charges. Psychological testing is covered. Advance approval or consulting ("triage") is required to identify the proper source of care. *For more information, see section B-4.16.*
Substance Abuse Services	**Inpatient** ____________________________________ 100% of allowed charges. **Outpatient** ___________________________________ 100% of allowed charges. Advance approval or consulting ("triage") is required to identify the proper source of care. *For more information, see section B-4.16.*
Chiropractic Care	Imaging and laboratory services provided at 100% of allowed charges for employees and dependents.
Prescription Drugs	*For more information, see section B-4.17.*

B-7.5. Filing a Claim

To receive benefits, you may need to file a claim. Follow the steps described for the Traditional option in section B-9. Whenever a claim is processed, you will receive an Explanation of Benefits (EOB) statement. This will give you information about the benefits that were paid.

B-7.5.1. If a Claim is Denied
If a claim for benefits is denied, in whole or in part, you will be notified on your Explanation of Benefits. You are entitled to a full review. For information about the process for reviewing denied claims, see Chapter H: "Administrative Information".

B-7.5.2. Timeframe for Deciding Urgent Care Claims
United Healthcare (the "Plan") will notify you of its benefit decision regarding an Urgent Care Claim as soon as a decision is made, but not later than 72 hours after the Plan receives the claim.

If additional information is needed to evaluate your claim, you will be notified within 24 hours after the Plan receives the claim. The notice will identify the specific information needed for the Plan to make a benefit decision. The Plan will make a benefit decision within 48 hours after the Plan receives the specified information. You will have 48 hours from receipt of the notice to provide the additional information. The Plan will make a benefit decision within 48 hours after the receipt of the needed information. If the needed information is not received, the Plan will make a benefit decision within 48 hours after the conclusion of the 48-hour period.

B-7.5.3. Timeframe for Deciding Concurrent Care Decisions
If the Plan has approved an ongoing course of treatment (i.e., period of time or number of treatments to be provided), you will be notified if the ongoing course of treatment is to be reduced or terminated. You will be notified far enough in advance for you to appeal the decision and to obtain a determination on review before the benefit is reduced or terminated.

Any request by you to extend the course of treatment involving urgent care will be decided as soon as possible, taking into account the medical circumstances. The Plan will notify you of the benefit determination within 24 hours after receipt of the claim, provided the claim is made at least 24 hours prior to the expiration of treatment. Urgent Care Claims received by the Plan less than 24 hours prior to the expiration of the treatment will be handled according to the procedures described in section B-7.5.2 Timeframe for Deciding Urgent Care Claims.

B-7.5.4. Timeframe for Deciding Pre-Service Claims (Non-Urgent Care Claims)
The Plan will make a benefit determination and will notify you regarding the decision within 15 days of the Plan's receipt of a Pre-Service Claim ("Pre-Service Claim Determination Period"). The Pre-Service Claim Determination Period may be extended one time for up to 15 days, due to circumstances beyond the control of the Plan. You will be notified of the reason(s) for the extension within 15 days of the Plan's receipt of a Pre-Service Claim.

If the reason for the extension is that additional information is required to decide the claim, you will be advised of the specific information needed within 15 days of the Plan's receipt of a Pre-Service Claim. You will have 45 days from receipt of the notice to provide the additional information. The Pre-Service Claim Determination Period will be tolled until the Plan receives the requested information. The Plan will make a benefit decision within 15 days after the receipt of the needed information. If the needed information is not received, the Plan will make a benefit decision within 15 days after the conclusion of the 45-day period.

B-7.5.5. Timeframe for Deciding Post-Service Claims
The Plan will make a benefit determination and will notify you regarding the decision within 30 days of the Plan's receipt of a Post-Service Claim ("Post-Service Claim Determination Period"). The Post-Service Claim Determination Period may be extended one time for up to 15 days, due to circumstances beyond the control of the Plan. You will be notified of the reason(s) for the extension within 30 days of the Plan's receipt of a Post-Service Claim.

If the reason for the extension is that additional information is required to decide the claim, you will be advised of the specific information needed within 30 days of the Plan's receipt of a Post-Service Claim. You will have 45 days from receipt of the notice to provide the additional information. The Post-Service Claim Determination Period will be tolled until the Plan receives the requested information. The Plan will make a benefit decision within 15 days after the receipt of the needed information. If the needed information is not received, the Plan will make a benefit decision within 15 days after the conclusion of the 45-day period.

B-7.5.6. Other Important Claim Filing Information
If a charge is made to you by a network provider for a service covered under the Summary Plan Description beyond any applicable Co-payments, Coinsurance and Deductibles, submit written proof of these charges to the Company's designated insurance carrier or third party administrator.

B-7.5.7. How to Appeal an Adverse Benefit Determination
Contact your Union representative if you are notified that a claim for benefits under the Plan is denied, in whole or in part (See Chapter H: Administrative Information). Your Union representative can assist you in resolving the claim with the Plan and can also file an appeal under the collective bargaining agreement.

B-8. Medical Benefits in Retirement or on Long-Term Disability (LTD)

If you were hired prior to 10-01-1997and retire from the Company or are placed on LTD, you may continue to receive medical coverage in Deere Premier Retired (Plan #0256) or UHC Choice Plus Retired (Plan #0225) if available or Deere Traditional (Plan #226) if eligible. You are also eligible to enroll in UHC Dental High Max (Plan #2186).

B-8.1. Participation

When you retire or are placed on LTD, your health care benefit changes to the plan available to you in retirement or LTD as outlined in B-8. Generally, you reenroll for coverage once each year during open enrollment, usually in the fall. Like active employees, you can choose a new medical option during enrollment, when available.

B-8.2. Your Coverage

Your health care coverage in retirement or LTD will be similar to the coverage provided for active employees. The copayments and maximum out-of-pocket expenses will be different as described in you benefit summary.

B-8.3. A Word About Medicare

Once you or your spouse turns age 65, you will be eligible for Medicare in addition to benefits from the Health Benefit Plan. (You, your spouse, or your dependents also may be eligible for Medicare before age 65 as a result of a disability.) Benefits will be paid under the Health Benefit Plan for charges that are not payable by Medicare but would have been payable under this Plan in the absence of Medicare. In addition, benefits are payable for any charges not otherwise payable under the Traditional option but which are used to satisfy any Medicare deductibles or coinsurance. As long as you are an active employee or the spouse of an active employee, the Health Benefit Plan will be your primary plan.

Deere & Company provides your healthcare coverage through a Medicare Advantage Part C Plan and a Medicare Prescription Drug Part D Plan. These plans are designed specifically for Medicare eligible retirees. In these plans, members will receive a single integrated Explanation of Benefit (EOB) for medical benefits and a separate EOB for prescription drug.

You are required to enroll with Medicare Part A and B. However, enrollment in a non-Deere sponsored Part C and/or Part D plan could result in your removal from the Deere sponsored Part C and part D plan.

As a member of the Medicare Part C plan you only have to pay your cost sharing amount when you obtain covered services. The plan does not allow providers who participate in Medicare to add additional separate charges, called “balance billing.”

B-8.3.1. Medicare Part B Premiums

Medicare coverage is divided into two parts. Part A provides coverage for hospital bills and Part B pays benefits for physicians’ charges and other eligible medical expenses. Part A benefits are yours automatically when you turn age 65 (you pay no premium). If you are a retiree or disabled employee hired prior to 1 October 1997, the Health Benefit Plan provides partial reimbursement for Medicare Part B premiums for you, your spouse and your disabled dependent. The premium reimbursement you and/or your dependents will receive from the Company is equal to the actual charge up to a maximum of $132.69.

You will want to be sure to enroll in Medicare Part B to have this coverage. The Health Benefit Plan does not pay for benefits that would be covered under Medicare.

ENROLLING FOR MEDICARE PART B COVERAGE
In order to receive Medicare Part B coverage, you must enroll. You can do this by answering the enrollment questions on your application for Social Security benefits, completing an enrollment form (available from your local Social Security office), or signing a statement of request.

B-8.3.2. Claiming Medicare Benefits

If you enroll in the Health Benefit Plan and you use network providers, you do not need to file claims. In other cases, your provider may file claims for you.

B-9. Filing a Claim

If you enroll in Health Benefit Plan and you use a network provider, you do not need to submit a claim for benefits. In and out of network providers who participate in Medicare bill the insurance carrier directly, and they should ask you only for your share of the cost.

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask the insurance carrier to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back whenever you've paid more than your share of the cost for medical services that are covered by the plan.

When you get a bill from a provider for the full cost of medical care, you should send this bill to the insurance carrier instead of paying it. They will look at the bill and decide whether the services should be covered. If they decide it should be covered, they will pay the provider directly.

Please refer to the Medicare Advantage Evidence of Coverage (EOC) sent to you from the insurance carrier for instructions on how and where to send a request for reimbursement related to your Medicare Advantage coverage.

B-10. If a Plan is Amended, Modified, Suspended, or Terminated

Deere & Company, subject to any collective bargaining agreement, reserves the right to suspend or terminate the Plan; to modify or to amend the Plan in any respect. Changes may occur at any time. Participants will be notified in due course concerning substantial changes. Amendment or termination of the Plan can only be effected by a legal instrument authorized by the Board of Directors.

B.11. John Deere Employee Benefits – Healthcare Benefit Summary

Plan #0225 - UHC Choice Plus Retired
Plan #0226 - UHC Traditional Wage
Plan #0256 – Deere Premier Retired
Plan #0265 - UHC Choice Plus Active
Plan #0266 – Deere Premier Active
Plan #2186 – UHC Dental HighMax

Plan #0225 | UHC Choice Plus Retired | 1-888-JDEERE1

Benefit	In-Network	Out-of-Network
Annual Deductible	None	$250 per individual and $500 per family per calendar year
Maximum Out-of-Pocket Expense *Does not include vision, hearing or charges in excess of reasonable & customary*	$2,500 per individual and $5,000 per family per calendar year	$2,500 per individual and $5,000 per family per calendar year
Physician Services - General		
Office Visits	*100% of allowed covered charge after $15 copayment per visit with Primary Care Physician (PCP); 100% of allowed covered charge after $25 copayment per visit with Specialist.*	*80% of allowed covered charge**
Hospital Visits	*100% of allowed covered charge**	*80% of allowed covered charge**
Surgical Procedures		
• Office	*100% of allowed covered charge after $15 copayment per visit with Primary Care Physician (PCP); 100% of allowed covered charge after $25 copayment per visit with Specialist.*	*80% of allowed covered charge**
• Outpatient	*100% of allowed covered charge*	*80% of allowed covered charge**
• Inpatient	*100% of allowed covered charge*	*80% of allowed covered charge**
Maternity Care	*100% of allowed covered charge*	*80% of allowed covered charge**
Allergy Testing	*100% of allowed covered charge*	*80% of allowed covered charge**
Allergy Injections	*100% of allowed covered charge*	*80% of allowed covered charge**
	Note: If a provider bills for an office visit in conjunction with these general services, the $15 PCP/$25 Specialty office visit copayment would apply.	
Physician Services - Preventative**		
Routine Physicals	*100% of allowed covered charge*	*Not covered*
Mammograms	*100% of allowed covered charge*	*Not covered*
Pap Tests	*100% of allowed covered charge*	*Not covered*
Well-Child Care	*100% of allowed covered charge*	*Not covered*
Immunizations	*100% of allowed covered charge*	*Not covered*
Expanded Women's preventive health	*100% of allowed covered charge*	*Not covered*
***Based upon U.S. Preventive Services Task Force (USPSTF) guidelines and the Affordable Care Act guidelines.*	*Note: If a provider bills for an office visit in conjunction with these preventive services, the $15 PCP/$25 Specialty office visit copayment would apply.*	
Hospital Services		
Inpatient Care	*100% of allowed covered charge*	*80% of allowed covered charge**
Outpatient Care	*100% of allowed covered charge*	*80% of allowed covered charge** *(Prior authorization required)*
Emergency Room	*100% of allowed covered charge after $40 copayment – waived if admitted to observation room confinement or acute inpatient*	
Emergency Ambulance	*100% of allowed covered charge to nearest facility*	
Skilled Nursing Care	*100% of allowed covered charge*	*80% of allowed covered charge** *(Prior authorization required)*
Home Health Care	*100% of allowed covered charge*	*Not covered*
Hospice	*100% of allowed covered charge*	*Not covered*
Durable Medical Equipment	*100% of allowed covered charge*	*Not covered*
Prosthetic Devices	*100% of allowed covered charge*	*Not covered*
Physical/Occupational Therapy	*100% of allowed covered charge (Maximum 60 combined treatment days per calendar year in- and out-of-network)*	*80% of allowed covered charge* (Maximum 60 combined treatment days per calendar year in- and out-of-network)*
Speech Therapy	*100% of allowed covered charge (Maximum 60 treatment days per calendar year in-and out-of-network)*	*80% of allowed covered charge* (Maximum 60 treatment days per calendar year in- and out-of-network)*

*Deductible applies. Allowed covered charge depends on provider network status and may be the calculated rate, Maximum Allowable Benefit, reasonable and customary, or billed charge.

This is a summary only. If there are differences between this summary and your plan documents, your plan documents will take precedence.

Plan #0225 | UHC Choice Plus Retired | 1-888-JDEERE1 (continued)

Benefit	In-Network	Out-of-Network
Cardiac/Pulmonary Therapy	*100% of allowed covered charge* *Maximum 36 treatment days per calendar year in- and out-of-network*	*80% of allowed covered charge** *Maximum 36 treatment days per calendar year in- and out-of-network*
Imaging and Laboratory Services	*100% of allowed covered charge*	*80% of allowed covered charge**
Organ Transplants *(Must use a URN provider)*	*100% of allowed covered charge* *(Must be approved by UHC)*	*Not covered*
Mental Health Services		
Office Visit	*100% of allowed covered charge after $25 copayment per visit with psychiatrist; 100% of allowed covered charge per visit with all other mental health professionals*	*80% of allowed covered charge**
Inpatient Care	*100% of allowed covered charge*	*80% of allowed covered charge**
Outpatient Care	*100% of allowed covered charge* *(Must triage through United Behavioral Health)*	*80% of allowed covered charge** *(Must triage through United Behavioral Health)*
Substance Abuse Services		
Office Visit	*100% of allowed covered charge after $25 copayment per visit with psychiatrist; 100% of allowed covered charge per visit with all other substance abuse professional*	*80% of allowed covered charge**
Inpatient Care	*100% of allowed covered charge*	*80% of allowed covered charge**
Outpatient Care	*100% of allowed covered charge* *(Must triage through United Behavioral Health)*	*80% of allowed covered charge** *(Must triage through United Behavioral Health)*
Chiropractic Services		
Imaging & Laboratory	*100% of allowed covered charge*	
Office Visits, Manipulations, Modalities, Other Chiropractic Services	*100% of allowed covered charge after $40 copayment per visit. Maximum six (6) visits.*	
Prescription Drugs *A 100-day supply is available for listed drugs. There is one copayment for a 100-day supply through mail order.*	Participating Pharmacy *$5 Generic copayment* *$20 Brand copayment*	Non-Participating Pharmacy *75% of allowed covered charge* *(reimbursement not to exceed benefit available through Participating Pharmacy)*
Hearing (Benefit payable once every 36 mths)		
Exam	*100% of allowed covered charge - $70 benefit maximum*	
Hearing Aids	*100% of allowed covered charge - $640 ($320 per ear) benefit maximum*	
Hearing Aid Mgmt Svcs (HAMS) Network (where available)	(Contact UHC for a list of providers)	
Exam	*100% of allowed covered charge*	
Hearing Aids *(Contact UHC for a list of providers)*	*100% of allowed covered charge for pre-determined hearing aids*	
Vision Care	Participating UHC Vision Provider	Non-Participating UHC Vision Provider
Exam	*100% of allowed covered charge after $5 copayment for adults age 19 and over. Copay is waived for children under age 19.*	*100% of allowed covered charge for children under age 19. $45.70 maximum reimbursement for adults age 19 and over.*
Single Vision Lenses	*100% of allowed covered charge after $10 copayment*	*$41.00 maximum reimbursement per pair*
Bifocal Vision Lenses	*100% of allowed covered charge after $10 copayment*	*$58.50 maximum reimbursement per pair*
Trifocal Vision Lenses	*100% of allowed covered charge after $10 copayment*	*$76.00 maximum reimbursement per pair*
Lenticular Vision Lenses	*100% of allowed covered charge after $10 copayment*	*$93.40 maximum reimbursement per pair*
Contact Lenses	*100% of allowed covered charge after $50 copayment*	*$58.50 maximum reimbursement per pair*
Frame	*100% of allowed covered charge after $10 copayment*	*$27.80 maximum reimbursement*
	Lenses (glasses or contacts) and frames once per 24 months, combined in and out-of-network. *Exam every 24 months if age 19 or older; otherwise, every 12 months, combined in and out-of-network.*	*Lenses (glasses or contacts) and frames once per 24 months, combined in and out-of-network.* *Exam every 24 months if age 19 or older; otherwise, every 12 months, combined in and out-of-network.*
Dental Services	*Services provided through UnitedHealthcare*	
Coordination of Benefits	*Standard Coordination (Come Out Whole)*	

*Deductible applies. Allowed covered charge depends on provider network status and may be the calculated rate, Maximum Allowable Benefit, reasonable and customary, or billed charge.

This is a summary only. If there are differences between this summary and your plan documents, your plan documents will take precedence.

Plan #0226 | UHC Traditional Wage | 1-888-JDEERE1

Benefit	
Annual Deductible	*Not applicable*
Maximum Out-of-Pocket Expense	*Not applicable*
Physician Services - General	
Office Visits	*Not covered*
Hospital Visits	*100% of allowed covered charge*
Surgical Procedures	
• Office	*100% of allowed covered charge*
• Outpatient	*100% of allowed covered charge*
• Inpatient	*100% of allowed covered charge*
Maternity Care	*100% of allowed covered charge (For employee and spouse only) (Dependents are not eligible)*
Allergy Testing	*100% of allowed covered charge*
Allergy Injections	*Not covered*
Physician Services - Preventative	
Routine Physicals	*Not covered*
Mammograms (test only)	*100% of allowed covered charge*
Pap Tests (test only)	*100% of allowed covered charge*
Well-Child Care	*Not covered*
Immunizations	*Not covered*
Hospital Services	
Inpatient Care	*100% of allowed covered charge*
Outpatient Care	*100% of allowed covered charge* *(Prior authorization required)*
Emergency Room	*100% of allowed covered charge for initial medical care*
Emergency Ambulance	*100% of allowed covered charge to nearest facility*
Home Health Care	*80% of allowed covered charge** *(Prior authorization required)*
Skilled Care	*100% of allowed covered charge* *(Prior authorization required)*
Hospice	*100% of allowed covered charge* *(Prior authorization required)*
Durable Medical Equipment	*100% of allowed covered charge*
Prosthetic Devices	*100% of allowed covered charge*
Physical/Occupational Therapy	*100% of allowed covered charge* *(Maximum 60 combined treatment days per calendar year)*
Speech Therapy	*100% of allowed covered charge* *(Maximum 60 treatment days per calendar year)*
Cardiac/Pulmonary Therapy	*100% of allowed covered charge* *(Maximum 36 treatment days per calendar year)*
Imaging and Laboratory Services	*100% of allowed covered charge*
Organ Transplants *(Must use a URN provider)*	*100% of allowed covered charge* *(Must be approved by UHC)*

*Benefits are paid according to reasonable and customary. Billed charges in excess of reasonable and customary charges are the members responsibility (subject to review). Allowed charge means, in order, contracted rates, reasonable and customary charges and billed charges.
This is a summary only. If there are differences between this summary and your plan documents, your plan documents will take precedence.

Plan #0226 | UHC Traditional Wage | 1-888-JDEERE1 (continued)

Benefit		
Mental Health Services *Inpatient Care* *Outpatient Care*	*100% of allowed covered charge* *100% of allowed covered charge* *(Must triage through United Behavioral Health)*	
Substance Abuse Services *Inpatient Care* *Outpatient Care*	*100% of allowed covered charge* *100% of allowed covered charge* *(Must triage through United Behavioral Health)*	
Chiropractic Services *Imaging & Laboratory*	*100% of allowed covered charge*	
Prescription Drugs *A 100-day supply is available for listed drugs. There is one copayment for a 100-day supply through mail order.*	Participating Pharmacy *$5 Generic copayment* *$20 Brand copayment*	
Hearing *Exam* *Hearing Aids*	*100% of allowed covered charge - $70 benefit maximum every 36 months* *100% of allowed covered charge - $640 ($320 per ear) benefit maximum every 36 months*	
Vision Care	Participating UHC Vision Provider	Non-Participating UHC Vision Provider
Exam	*100% of allowed covered charge after $5 copayment for adults age 19 and over. Copay is waived for children under age 19.*	*100% of allowed covered charge for children under age 19. $45.70 maximum reimbursement for adults age 19 and over.*
Single Vision Lenses	*100% of allowed covered charge after $10 copayment*	*$41.00 maximum reimbursement per pair*
Bifocal Vision Lenses	*100% of allowed covered charge after $10 copayment*	*$58.50 maximum reimbursement per pair*
Trifocal Vision Lenses	*100% of allowed covered charge after $10 copayment*	*$76.00 maximum reimbursement per pair*
Lenticular Vision Lenses	*100% of allowed covered charge after $10 copayment*	*$93.40 maximum reimbursement per pair*
Contact Lenses	*100% of allowed covered charge after $50 copayment*	*$58.50 maximum reimbursement per pair*
Frame	*100% of allowed covered charge after $10 copayment*	*$27.80 maximum reimbursement*
	Lenses (glasses or contacts) and frames once per 24 months, combined in and out-of-network. *Exam every 24 months if age 19 or older; otherwise, every 12 months, combined in and out-of-network.*	*Lenses (glasses or contacts) and frames once per 24 months, combined in and out-of-network.* *Exam every 24 months if age 19 or older; otherwise, every 12 months, combined in and out-of-network.*
Dental Services	*Services provided through UnitedHealthcare*	
Coordination of Benefits	*Standard Coordination (Come Out Whole)*	

*Benefits are paid according to reasonable and customary. Billed charges in excess of reasonable and customary charges are the members responsibility (subject to review). Allowed charge means, in order, contracted rates, reasonable and customary charges and billed charges.

This is a summary only. If there are differences between this summary and your plan documents, your plan documents will take precedence.

Plan #0256 | Deere Premier Retired | 1-888-JDEERE1

Benefit	In-Network	Out-of-Network
Annual Deductible	None	$250 per individual and $500 per family per calendar year
Maximum Out-of-Pocket Expense *Does not include vision, hearing, and charges in excess of maximum allowable benefit*	$2,500 per individual and $5,000 per family per calendar year	$2,500 per individual and $5,000 per family per calendar year
Physician Services - General		
Office Visits	*100% of allowed covered charge after $15 copayment per visit with Primary Care Physician (PCP); 100% of allowed covered charge after $25 copayment per visit with Specialist.*	*80% of allowed covered charge**
Hospital Visits	*100% of allowed covered charge**	*80% of allowed covered charge**
Surgical Procedures		
Office	*100% of allowed covered charge after $15 copayment per visit with Primary Care Physician (PCP); 100% of allowed covered charge after $25 copayment per visit with Specialist.*	*80% of allowed covered charge**
Outpatient	*100% of allowed covered charge*	*80% of allowed covered charge**
Inpatient	*100% of allowed covered charge*	*80% of allowed covered charge**
Maternity Care	*100% of allowed covered charge*	*80% of allowed covered charge**
Allergy Testing	*100% of allowed covered charge*	*80% of allowed covered charge**
Allergy Injections	*100% of allowed covered charge*	*80% of allowed covered charge**
	Note If a provider bills for an office visit in conjunction with these general services, the $15 PCP/$25 Specialty office visit copayment would apply.	
Physician Services - Preventative**		
Routine Physicals	*100% of allowed covered charge*	*Not covered*
Mammograms	*100% of allowed covered charge*	*Not covered*
Pap Tests	*100% of allowed covered charge*	*Not covered*
Well-Child Care	*100% of allowed covered charge*	*Not covered*
Immunizations	*100% of allowed covered charge*	*Not covered*
Expanded Women's preventive health	*100% of allowed covered charge*	*Not covered*
***Based upon U.S. Preventive Services Task Force (USPSTF) guidelines and the Affordable Care Act guidelines.*	*Note: If a provider bills for an office visit in conjunction with these preventive services, the $15 PCP/$25 Specialty office visit copayment would apply.*	
Hospital Services		
Inpatient Care	*100% of allowed covered charge*	*80% of allowed covered charge**
Outpatient Care	*100% of allowed covered charge*	*80% of allowed covered charge** *(Prior authorization required)*
Emergency Room	*100% of allowed covered charge after $40 copayment for initial medical care – waived if admitted to observation room confinement or acute inpatient*	
Emergency Ambulance	*100% of allowed covered charge to nearest facility*	
Skilled Care	*100% of allowed covered charge*	*80% of allowed covered charge** *(Prior authorization required)*
Home Health Care	*100% of allowed covered charge* *(Must be approved by Case Management)*	*Not covered*
Hospice	*Must be approved by Case Management*	*Not covered*
Durable Medical Equipment	*100% of allowed covered charge*	*Not covered*
Prosthetic Devices	*100% of allowed covered charge*	*Not covered*
Physical/Occupational Therapy	*100% of allowed covered charge* *(Maximum 60 combined treatment days per calendar year in- and out-of-network)*	*80% of allowed covered charge** *(Maximum 60 combined treatment days per calendar year in- and out-of-network)*
Speech Therapy	*100% of allowed covered charge* *(Maximum 60 treatment days per calendar year in-and out-of-network)*	*80% of allowed covered charge** *(Maximum 60 treatment days per calendar year in-and out-of-network)*

*Deductible applies. Allowed covered charge depends on provider network status and may be the calculated rate, Maximum Allowable Benefit, reasonable and customary, or billed charge.
This is a summary only. If there are differences between this summary and your plan documents, your plan documents will take precedence.

Plan #0256 | Deere Premier Retired | 1-888-JDEERE1 (continued)

Benefit	In-Network	Out-of-Network
Imaging and Laboratory Services	*100% of allowed covered charge*	*80% of allowed covered charge**
Organ Transplants *(Must use a URN provider)*	*100% of allowed covered charge* *(Must be approved by UHC)*	*Not covered*
Mental Health Services *Office Visit* *Inpatient Care* *Outpatient Care*	 *100% of allowed covered charge after $25 copayment per visit* *100% of allowed covered charge* *100% of allowed covered charge* *(Must triage through United Behavioral Health)*	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge**
Substance Abuse Services *Office Visit* *Inpatient Care* *Outpatient Care*	 *100% of allowed covered charge after $25 copayment per visit* *100% of allowed covered charge* *100% of allowed covered charge* *(Must triage through United Behavioral Health)*	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge**
Chiropractic Services *Imaging & Laboratory* *Office Visits, Manipulations, Modalities, Other Chiropractic Services*	 *100% of allowed covered charge* *100% of allowed covered charge after $40 copayment per visit. Maximum six (6) visits*	
Prescription Drugs *A 100-day supply is available for listed drugs. There is one copayment for a 100-day supply through mail order.*	Participating UHC-Medco Pharmacy *$5 Generic copayment* *$20 Brand copayment*	Non-Participating Pharmacy *75% of allowed covered charge* *(reimbursement not to exceed benefit available through Participating Pharmacy)*
Hearing *Exam* *Hearing Aid Evaluation* *Hearing Aid* *Dispensing Fee* *Binaural Hearing Aid* *Binaural Dispensing Fee*	Participating HAMS Provider *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge*	*Not covered*
Vision Care (Administered by UHC Vision) *Exam* *Single Vision Lenses* *Bifocal Vision Lenses* *Trifocal Vision Lenses* *Lenticular Vision Lenses* *Contact Lenses* *Frame*	Participating UHC Vision Provider *100% of allowed covered charge after $5 copayment for adults age 19 and over. Copay is waived for children under age 19.* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $50 copayment* *100% of allowed covered charge after $10 copayment* *Lenses (glasses or contacts) and frames once per 24 months, combined in and out-of-network.* *Exam every 24 months if age 19 or older; otherwise, every 12 months, combined in and out-of-network.*	Non-Participating UHC Vision Provider *100% of allowed covered charge for children under age 19. $45.70 maximum reimbursement for adults age 19 and over.* *$41.00 maximum reimbursement per pair* *$58.50 maximum reimbursement per pair* *$76.00 maximum reimbursement per pair* *$93.40 maximum reimbursement per pair* *$58.50 maximum reimbursement per pair* *$27.80 maximum reimbursement* *Lenses (glasses or contacts) and frames once per 24 months, combined in and out-of-network.* *Exam every 24 months if age 19 or older; otherwise, every 12 months, combined in and out-of-network.*
Dental Services	*Services provided through UnitedHealthcare*	
Coordination of Benefits	*Standard Coordination*	

*Deductible applies. Allowed covered charge depends on provider network status and may be the calculated rate, Maximum Allowable Benefit, reasonable and customary, or billed charge.

This is a summary only. If there are differences between this summary and your plan documents, your plan documents will take precedence.

Plan #0265 | UHC Choice Plus Wage Active | 1-888-JDEERE1

Benefit	In-Network	Out-of-Network
Annual Deductible	None	$250 per individual and $500 per family per calendar year
Maximum Out-of-Pocket Expense *Does not include vision, hearing and charges in excess of reasonable & customary*	$2,500 per individual and $5,000 per family per calendar year	$2,500 per individual and $5,000 per family per calendar year
Physician Services - General		
Office Visits	*100% of allowed covered charge after $40 copayment per visit with Primary Care Physician (PCP); 100% of allowed covered charge after $50 copayment per visit with Specialist.*	*80% of allowed covered charge**
Hospital Visits	*100% of allowed covered charge**	*80% of allowed covered charge**
Surgical Procedures		
• Office	*100% of allowed covered charge after $40 copayment per visit with Primary Care Physician (PCP); 100% of allowed covered charge after $50 copayment per visit with Specialist.*	*80% of allowed covered charge**
• Outpatient	*100% of allowed covered charge*	*80% of allowed covered charge**
• Inpatient	*100% of allowed covered charge*	*80% of allowed covered charge**
Maternity Care	*100% of allowed covered charge*	*80% of allowed covered charge**
Allergy Testing	*100% of allowed covered charge*	*80% of allowed covered charge**
Allergy Injections	*100% of allowed covered charge* *Note: If a provider bills for an office visit in conjunction with these general services, the $40 PCP/$50 Specialty office visit copayment would apply.*	*80% of allowed covered charge**
Physician Services - Preventative**		
Routine Physicals	*100% of allowed covered charge*	*Not covered*
Mammograms	*100% of allowed covered charge*	*Not covered*
Pap Tests	*100% of allowed covered charge*	*Not covered*
Well-Child Care	*100% of allowed covered charge*	*Not covered*
Immunizations	*100% of allowed covered charge*	*Not covered*
Expanded Women's preventive health	*100% of allowed covered charge*	*Not covered*
***Based upon U.S. Preventive Services Task Force (USPSTF) guidelines and the Affordable Care Act guidelines.*	*Note: If a provider bills for an office visit in conjunction with these preventive services, the $40 PCP/$50 Specialty office visit copayment would apply.*	
Hospital Services		
Inpatient & Observation Admit	*100% of allowed covered charge after $150 copay*	*80% of allowed covered charge**
Outpatient Surgery	*100% of allowed covered charge after $100 copay*	*80% of allowed covered charge**
Outpatient Diagnostic	*100% of allowed covered charge* *(Pre-notification required)*	*(Prior authorization required)*
Emergency Room	*100% of allowed covered charge after $150 copayment – waived if admitted to observation room confinement or acute inpatient*	
Emergency Ambulance	*100% of allowed covered charge to nearest facility*	
Skilled Nursing Care	*100% of allowed covered charge*	*80% of allowed covered charge** *(Prior authorization required)*
Home Health Care	*100% of allowed covered charge*	*Not covered*
Hospice	*100% of allowed covered charge*	*Not covered*
Durable Medical Equipment	*100% of allowed covered charge*	*Not covered*
Prosthetic Devices	*100% of allowed covered charge*	*Not covered*
Physical/Occupational Therapy	*100% of allowed covered charge* *(Maximum 60 combined treatment days per calendar year in- and out-of-network)*	*80% of allowed covered charge** *(Maximum 60 combined treatment days per calendar year in- and out-of-network)*
Speech Therapy	*100% of allowed covered charge* *(Maximum 60 treatment days per calendar year in-and out-of-network)*	*80% of allowed covered charge** *(Maximum 60 treatment days per calendar year in- and out-of-network)*

*Deductible applies. Allowed covered charge depends on provider network status and may be the calculated rate, Maximum Allowable Benefit, reasonable and customary, or billed charge.

This is a summary only. If there are differences between this summary and your plan documents, your plan documents will take precedence.

Plan #0265 | UHC Choice Plus Wage Active | 1-888-JDEERE1 (continued)

Benefit	In-Network	Out-of-Network
Cardiac/Pulmonary Therapy	*100% of allowed covered charge (Maximum 36 treatment days per calendar year in- and out-of-network)*	*80% of allowed covered charge* (Maximum 36 treatment days per calendar year in- and out-of-network)*
Imaging and Laboratory Services	*100% of allowed covered charge*	*80% of allowed covered charge**
Organ Transplants *(Must use a URN provider)*	*100% of allowed covered charge (Must be approved by UHC)*	*Not covered*
Mental Health Services		
Office Visit	*100% of allowed covered charge after $50 copayment per visit with psychiatrist; 100% of allowed covered charge per visit with all other mental health professionals*	*80% of allowed covered charge**
Inpatient Care	*100% of allowed covered charge*	*80% of allowed covered charge**
Outpatient Care	*100% of allowed covered charge (Must triage through United Behavioral Health)*	*80% of allowed covered charge* (Must triage through United Behavioral Health)*
Substance Abuse Services		
Office Visit	*100% of allowed covered charge after $50 copayment per visit with psychiatrist; 100% of allowed covered charge per visit with all other substance abuse professional*	*80% of allowed covered charge**
Inpatient Care	*100% of allowed covered charge*	*80% of allowed covered charge**
Outpatient Care	*100% of allowed covered charge (Must triage through United Behavioral Health)*	*80% of allowed covered charge* (Must triage through United Behavioral Health)*
Chiropractic Services		
Imaging & Laboratory	*100% of allowed covered charge*	
Office Visits, Manipulations, Modalities, Other Chiropractic Services	*100% of allowed covered charge after $40 copayment per visit. Maximum six (6) visits*	
Prescription Drugs *A 100-day supply is available for listed drugs. There are two copayments for a 100-day supply through mail order.*	Participating Pharmacy *$15 Generic copayment $30 Preferred Brand copayment $60 non-Preferred Brand copayment*	Non-Participating Pharmacy *75% of allowed covered charge (reimbursement not to exceed benefit available through Participating Pharmacy)*
Hearing (Benefit payable once every 36 months)		
Exam	*100% of allowed covered charge - $70 benefit maximum*	
Hearing Aids	*100% of allowed covered charge - $640 ($320 per ear) benefit maximum*	
Hearing Aid Mgmt Svcs (HAMS) Network (where available)	*(Contact UHC for a list of providers)*	
Exam	*100% of allowed covered charge*	
Hearing Aids	*100% of allowed covered charge for pre-determined hearing aids*	
Vision Care (Administered by UHC Vision)	Participating UHC Vision Provider	Non-Participating UHC Vision Provider
Exam	*100% of allowed covered charge after $5 copayment for adults age 19 and over. Copay is waived for children under age 19.*	*100% of allowed covered charge for children under age 19. $45.70 maximum reimbursement for adults age 19 and over.*
Single Vision Lenses	*100% of allowed covered charge after $10 copayment*	*$41.00 maximum reimbursement per pair*
Bifocal Vision Lenses	*100% of allowed covered charge after $10 copayment*	*$58.50 maximum reimbursement per pair*
Trifocal Vision Lenses	*100% of allowed covered charge after $10 copayment*	*$76.00 maximum reimbursement per pair*
Lenticular Vision Lenses	*100% of allowed covered charge after $10 copayment*	*$93.40 maximum reimbursement per pair*
Contact Lenses	*100% of allowed covered charge after $50 copayment*	*$58.50 maximum reimbursement per pair*
Frame	*100% of allowed covered charge after $10 copayment*	*$27.80 maximum reimbursement*
	Exams, lenses (glasses or contacts) and frames once per 12 months, combined in and out-of-network.	*Exams, lenses (glasses or contacts) and frames once per 12 months, combined in and out-of-network.*
Dental Services	*Services provided through UnitedHealthcare*	
Coordination of Benefits	*Standard Coordination (Come Out Whole)*	

*Deductible applies. Allowed covered charge depends on provider network status and may be the calculated rate, Maximum Allowable Benefit, reasonable and customary, or billed charge.

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Plan #0266 | Deere Premier Active | 1-888-JDEERE1

Benefit	In-Network	Out-of-Network
Annual Deductible	None	$250 per individual and $500 per family per calendar year
Maximum Out-of-Pocket Expense *Does not include vision, hearing, and charges in excess of maximum allowable benefit*	$2,500 per individual and $5,000 per family per calendar year	$2,500 per individual and $5,000 per family per calendar year
Physician Services - General		
Office Visits	*100% of allowed covered charge after $40 copayment per visit with Primary Care Physician (PCP); 100% of allowed covered charge after $50 copayment per visit with Specialist.*	*80% of allowed covered charge**
Hospital Visits	*100% of allowed covered charge**	*80% of allowed covered charge**
Surgical Procedures		
• Office	*100% of allowed covered charge after $40 copayment per visit with Primary Care Physician (PCP); 100% of allowed covered charge after $50 copayment per visit with Specialist.*	*80% of allowed covered charge**
• Outpatient	*100% of allowed covered charge*	*80% of allowed covered charge**
• Inpatient	*100% of allowed covered charge*	*80% of allowed covered charge**
Maternity Care	*100% of allowed covered charge*	*80% of allowed covered charge**
Allergy Testing	*100% of allowed covered charge*	*80% of allowed covered charge**
Allergy Injections	*100% of allowed covered charge* *Note: If a provider bills for an office visit in conjunction with these general services, the $40 PCP/$50 Specialty office visit copayment would apply.*	*80% of allowed covered charge**
Physician Services - Preventative**		
Routine Physicals	*100% of allowed covered charge*	*Not covered*
Mammograms	*100% of allowed covered charge*	*Not covered*
Pap Tests	*100% of allowed covered charge*	*Not covered*
Well-Child Care	*100% of allowed covered charge*	*Not covered*
Immunizations	*100% of allowed covered charge*	*Not covered*
Expanded Women's preventive health	*100% of allowed covered charge*	*Not covered*
***Based upon U.S. Preventive Services Task Force (USPSTF) guidelines and the Affordable Care Act guidelines.*	*Note: If a provider bills for an office visit in conjunction with these preventive services, the $40 PCP/$50 Specialty office visit copayment would apply.*	
Hospital Services		
Inpatient & Observation Admit	*100% of allowed covered charge after $150 copay*	*80% of allowed covered charge**
Outpatient Surgery	*100% of allowed covered charge after $100 copay*	*80% of allowed covered charge**
Outpatient Diagnostic	*100% of allowed covered charge*	*80% of allowed covered charge** *(Prior authorization required)*
Emergency Room	*100% of allowed covered charge after $150 copayment for initial medical care – waived if admitted to observation room confinement or acute inpatient*	
Emergency Ambulance	*100% of allowed covered charge to nearest facility*	
Skilled Care	*100% of allowed covered charge*	*80% of allowed covered charge** *(Prior authorization required)*
Home Health Care	*100% of allowed covered charge* *(Must be approved by Case Management)*	*Not covered*
Hospice	*(Must be approved by Case Management)*	*Not covered*
Durable Medical Equipment	*100% of allowed covered charge*	*Not covered*
Prosthetic Devices	*100% of allowed covered charge*	*Not covered*
Physical/Occupational Therapy	*100% of allowed covered charge* *(Maximum 60 combined treatment days per calendar year in- and out-of-network)*	*80% of allowed covered charge** *(Maximum 60 combined treatment days per calendar year in- and out-of-network)*
Speech Therapy	*100% of allowed covered charge* *(Maximum 60 treatment days per calendar year in-and out-of-network)*	*80% of allowed covered charge** *(Maximum 60 treatment days per calendar year in- and out-of-network)*

*Deductible applies. Allowed covered charge depends on provider network status and may be the calculated rate, Maximum Allowable Benefit, reasonable and customary, or billed charge.

This is a summary only. If there are differences between this summary and your plan documents, your plan documents will take precedence.

Plan #0266 | Deere Premier Active | 1-888-JDEERE1 (continued)

Benefit	In-Network	Out-of-Network
Imaging and Laboratory Services	*100% of allowed covered charge*	*80% of allowed covered charge**
Organ Transplants *(Must use a URN provider)*	*100% of allowed covered charge* *(Must be approved by UnitedHealthcare)*	*Not covered*
Mental Health Services *Office Visit* *Inpatient Care* *Outpatient Care*	 *100% of allowed covered charge after $50 copayment per visit* *100% of allowed covered charge* *100% of allowed covered charge* *(Must triage through United Behavioral Health)*	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge**
Substance Abuse Services *Office Visit* *Inpatient Care* *Outpatient Care*	 *100% of allowed covered charge after $50 copayment per visit* *100% of allowed covered charge* *100% of allowed covered charge* *(Must triage through United Behavioral Health)*	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge**
Chiropractic Services *Imaging & Laboratory* *Office Visits, Manipulations, Modalities, Other Chiropractic Services*	 *100% of allowed covered charge* *100% of allowed covered charge after $50 copayment per visit. Maximum six (6) visits.*	
Prescription Drugs *A 100-day supply is available for listed drugs. There are two copayments for a 100-day supply through mail order.*	Participating UHC-Medco Pharmacy *$15 Generic copayment* *$30 Preferred Brand copayment* *$60 non-Preferred Brand copayment*	Non-Participating Pharmacy *75% of allowed covered charge* *(reimbursement not to exceed benefit available through Participating Pharmacy)*
Hearing *Exam* *Hearing Aid Evaluation* *Hearing Aid* *Dispensing Fee* *Binaural Hearing Aid* *Binaural Dispensing Fee*	Participating HAMS Provider *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *Hearing Benefit – every 36 months*	*Not covered*
Vision Care (Administered by UHC Vision) *Exam* *Single Vision Lenses* *Bifocal Vision Lenses* *Trifocal Vision Lenses* *Lenticular Vision Lenses* *Contact Lenses* *Frame*	Participating UHC Vision Provider *100% of allowed covered charge after $5 copayment for adults age 19 and over. Copay is waived for children under age 19.* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $50 copayment* *100% of allowed covered charge after $10 copayment* *Exams, lenses (glasses or contacts) and frames once per 12 months, combined in and out-of-network*	Non-Participating UHC Vision Provider *100% of allowed covered charge for children under age 19. $45.70 maximum reimbursement for adults age 19 and over.* *$41.00 maximum reimbursement per pair* *$58.50 maximum reimbursement per pair* *$76.00 maximum reimbursement per pair* *$93.40 maximum reimbursement per pair* *$58.50 maximum reimbursement per pair* *$27.80 maximum reimbursement* *Exams, lenses (glasses or contacts) and frames once per 12 months, combined in and out-of-network*
Dental Services	*Services provided through UnitedHealthcare*	
Coordination of Benefits	*Standard Coordination*	

*Deductible applies. Allowed covered charge depends on provider network status and may be the calculated rate, Maximum Allowable Benefit, reasonable and customary, or billed charge.

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Plan #2186 | UHC Dental – HighMax | 1-888-JDEERE1

Benefit	
Annual Deductible	*Not applicable*
Calendar Year Maximum	*$1,650 per individual*
Orthodontic Lifetime Maximum	*$1,850 per individual*
Preventive and Diagnostic	
• *Examinations* *Twice per calendar year*	*100% of allowed covered charge*
• *X-rays* *Bitewings twice per calendar year* *Panoramic/full mouth every 36 months*	*100% of allowed covered charge*
• *Sealants* *(Children under age 19)*	*100% of allowed covered charge - One per tooth every three years – Limited to certain teeth (2, 3, 14, 15, 18, 19, 30, 31)*
• *Fluoride treatment*	*Preventive and diagnostic services are not subject to the calendar year maximum.*
Basic/Restorative	
• *Fillings*	*100% of allowed covered charge*
• *Space maintainers*	*100% of allowed covered charge*
• *Non-surgical periodontal procedures*	*100% of allowed covered charge*
• *Injection of non-anesthetic medication*	*100% of allowed covered charge*
• *Occlusal adjustment*	*100% of allowed covered charge*
• *Occlusal guards*	*100% of allowed covered charge*
• *Authorized general anesthesia*	*100% of allowed covered charge*
• *Application of desensitizing medications*	*100% of allowed covered charge*
• *Extractions – simple*	*100% of allowed covered charge*
• *Crowns/inlays (repair/re-cement crowns and inlays)*	*100% of allowed covered charge*
• *Root canal/pulp caps*	*100% of allowed covered charge*
• *Scaling, curettage, maintenance cleaning following perio surgery* *– four times first year* *– two times annually, thereafter if needed in place of prophylaxis*	*100% of allowed covered charge*
• *Repair, recement, adjust denture/ bridgework and reline dentures*	*100% of allowed covered charge*
• *Guided tissue regeneration*	*100% of allowed covered charge*
• *Laboratory tests related to oral surgery*	*100% of allowed covered charge*
Prosthodontics (limit one every five years)	
• *Dentures – full or partial, over dentures*	*50% of allowed covered charge*
• *Bridgework*	*50% of allowed covered charge*
• *Precision attachments*	*50% of allowed covered charge*
• *Prosthodontic devices*	*50% of allowed covered charge*
Orthodontics	
• *Orthodontic exams/consultation*	*50% of allowed covered charge*
• *Extractions for orthodontic reasons*	*50% of allowed covered charge*
• *Orthodontic work-up*	*50% of allowed covered charge*
• *Orthodontic treatment*	*50% of allowed covered charge*
Organ Transplants *(Must use a URN provider)*	*100% of allowed covered charge* *(Must be approved by UHC)*

Reasonable and customary applies to all services.

This is a summary only. If there are differences between this summary and your plan documents, your plan documents will take precedence.

Plan #2186 | UHC Dental – HighMax | 1-888-JDEERE1 (continued)

Benefit	
Oral Surgery (Partial List)	
• *Apicoectomy*	*100% of allowed covered charge*
• *General anesthesia associated with removal of impacted tooth/teeth*	*100% of allowed covered charge*
• *Removal of impactions*	*100% of allowed covered charge*
• *Biopsies*	*100% of allowed covered charge*
• *Alveoloplasty*	*100% of allowed covered charge*
• *Tooth reimplantation/stabilization as the result of an accident*	*100% of allowed covered charge*
• *Removal of tumors, cysts, neoplasms and bone tissue*	*100% of allowed covered charge*
• *Treatment of fractures, foreign bodies, sutures*	*100% of allowed covered charge*

Reasonable and customary applies to all services.
This is a summary only. If there are differences between this summary and your plan documents, your plan documents will take precedence.

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C-1. Life Insurance, AD&D, Survivor and Disability Benefits Highlights

Survivor and disability benefits provide you and your family with important income protection when you're away from work because of illness or injury, or in the event of your death.

Group Life and AD&D Benefits	The Company automatically provides **group life insurance** for employees equal to one year's earnings (minimum $30,000). In addition to group life insurance, you will also have **Accidental Death & Dismemberment coverage**. For employees hired prior to 1 October 1997, your AD&D coverage will be equal to your group life insurance (maximum $50,000) for accidents that are not job-related and AD&D coverage equal to one-half of your group life insurance (maximum $25,000) for job-related accidents. For employees hired on or after 1 October 1997, your AD&D coverage will be equal to your group life insurance (maximum $25,000) for accidents that are not job- related and AD&D coverage equal to one-half of your group life insurance (maximum$12,500) for job-related accidents. For employees hired prior to 1 October 1997, the Company also provides monthly benefits for your survivors to help ease the financial burden following your death. There are two types of **monthly survivor benefits**.
Survivor Transition & Bridge Benefits	Generally, *transition* benefits are paid to your survivor(s) in the first 24 months immediately following your death. Also, if eligible, your survivor can receive bridge benefits after transition benefits end and before Social Security benefits start.
Disability Benefits	A portion of your earnings automatically continues while you recover from illness or injury. **Weekly Indemnity benefits** pay a portion of your earnings for up to 52 weeks. **Long-Term Disability (LTD)** benefits provide a portion of your pay when Weekly Indemnity benefits end.

C-2. Terms You Should Know

These are important terms you should know about your income protection benefits.

- Beneficiary – A person designated to receive life insurance benefits. You may name more than one person to receive benefits.
- Continuous employment – Your employment period starting on the date you last began work with any unit of Deere & Company, including its domestic and foreign subsidiaries.
- One year's earnings – For purposes of the group life coverage, the highest total of all of your straight-time wage payments in any of the three most recent calendar years preceding either your death or the last day worked before your total and permanent disability. This amount includes vacation, personal absence, shift premium, and unworked holiday pay, but not any reductions in your earnings resulting from participation in the Tax Deferred Savings Plan.
- Service credit – If you work at least 500 hours in any completed anniversary year, you receive a year of service credit that is credited on your next anniversary date, provided you are still working for the Company. Service credit is used by the LTD Plan to determine the amount of your LTD benefit and your eligibility for Plan benefits.

You do not receive additional service credit:

- When you work less than 500 hours in any completed anniversary year;
- After you retire;
- When your employment ends for any reason;
- When you fail to return from a leave of absence or military leave;
- When you fail to return from a layoff with five days notice from the Company; or
- After you die.

You do not receive additional service credit:

- When you work for a unit of the Company for more than 500 hours and work for another unit of the Company for more than 500 hours during the anniversary year.
- When you earn service credit under the Plan and then transfer to a unit of the Company to salaried status, you will continue to earn service credit under the new plan. However, at retirement, you will receive the full earned service credit.
- If you worked for a unit of the Company that had a defined Contribution Plan, your time at that unit will be credited only for determining your eligibility for retirement.

If you become totally and permanently disabled, you continue to earn service credit which is credited to you at normal or early retirement, subject to certain limitations. If you return to work, your service credit continues unbroken. You also receive credit for any additional foundry service credit, and partial years of service (earned) in the year you retire, leave the Company, or die.

– Survivor – Generally, your surviving spouse, dependent children, or dependent parents are eligible to receive benefits after your death.

– Total and permanent disability – A physical or mental condition caused by an illness or injury that leaves you unable to work for the Company. The condition can be work- related or not, as long as you have medical evidence satisfactory to the Company to support it.

C-3. Your Life Insurance, AD&D and Survivor Benefits

Group life and AD&D insurance pays benefits to you if you are seriously injured or to your survivors in the case of your death. For employees hired prior to 1 October 1997, Deere & Company also provides monthly benefits; called transition and bridge, for your survivors to help ease the financial burden immediately following your death.

C-3.1. Eligibility

If you are a full-time wage employee of Deere & Company, and actively working at one of the U.S. operations (as outlined in "Who This Document Is For"), you are eligible for group life and AD&D insurance. Coverage starts on your date of hire.

For employees hired prior to 1 October 1997, your eligible survivors are entitled to monthly survivor benefits if at the time of your death you are either:

– Covered by the Group Life and AD&D Insurance Plan and have worked at least one month;

– Younger than age 55 and retired under the John Deere Pension Plan for Wage Employees; or

– Receiving a disability benefit under the John Deere Pension Plan for Wage Employees.

Participation in survivor benefits is automatic. The Company pays the full cost of your coverage while you are eligible.

C-3.2. Group Life Insurance

The Company provides you with group life insurance in the amount equal to one year's earnings (minimum $30,000), if you have one or more years of service credit.

If you haven't worked three years for the Company, your one year's earnings are the highest of the calendar years you have worked. If you have less than one year of service credit, your coverage is $30,000.

C-3.3. Disability Payments from Life Insurance

The group life and AD&D plan will pay benefits to you if you become totally and permanently disabled and are not eligible for normal, early, or disability retirement under the John Deere Pension Plan for Wage Employees. (You are eligible for disability retirement once you have 10 years of service credit and if you're under age 68.)

Life insurance disability benefits are paid in monthly installments. They are deducted from the value of your life insurance. Each installment equals $20 for each $1,000 of your life insurance. For example, if your insurance is $15,000, then each monthly installment is $300. If you die while installments are being paid, your beneficiary will receive your unpaid life insurance.

C-3.4. AD&D Coverage

AD&D coverage pays a benefit to you if you suffer certain injuries in an accident, or to your beneficiary if you die as a result of an accident. AD&D benefits are paid in addition to group life benefits in the case of your death.

If you die within one year of an accident that is not job-related, your beneficiary will receive an AD&D benefit equal to your one year's earnings the same as your life insurance benefit up to a maximum of $50,000 for employees hired prior to 1 October 1997 or a maximum of $25,000 for employees hired on or after 1 October 1997.

If you die within one year of a job-related accident, your beneficiary will receive a benefit equal to one-half of your one year's earnings up to a maximum of $25,000 for employees hired prior to 1 October 1997 or a maximum of $12,500 for employees hired on or after 1 October 1997, in addition to any Workers' Compensation benefits.

AD&D benefits will be paid to you if you suffer a loss within one year of an accident:

Type of Loss	Benefit Paid
Both hands, both feet, or sight in both eyes	One year's earnings
One hand and one foot, one hand and sight in one eye, or one foot and sight in one eye	One year's earnings
One hand or one foot	One-half of one year's earnings
Sight in one eye	One-half of one year's earnings

Only one benefit payment — the largest — will be made for any one accident.

AD&D benefits will not be paid for losses caused by:

– Bodily or mental infirmity;

– Disease or its treatment;

– Infection (except infection from an accidental cut or wound);

– Any armed conflict, war, or any act of war (declared or undeclared); or

– Intentionally self-inflicted injuries (while sane or insane).

C-3.5. Monthly Survivors Benefits for Employees Hired Prior to 1 October 1997

Survivors who are eligible for your monthly survivor benefits include:

– Your spouse who was married to you at least one year immediately prior to your death.

– Your unmarried children who are younger than age 21. Your unmarried children include natural born (prior to the first of the month following your death) and legally adopted children, stepchildren, and children for whom legal adoption proceedings have been started. Also included are children under age 21 who are related by blood or marriage and are under your legal guardianship.

– Your unmarried children ages 21 to 25 who are living with you and who are dependent on you for more than one-half of their support (as defined by the Internal Revenue Code).

– Your totally and permanently disabled children (regardless of age) who are living with you and who are dependent on you for more than one-half of support (as defined by the Internal Revenue Code).

  "Totally and permanently disabled" means any medically determined physical or mental condition that prevents your dependent from being gainfully employed and which is expected to continue indefinitely or result in death.

– Your parents who are dependent on you for more than one-half of support (as defined by the Internal Revenue Code).

C-3.5.1. Transition Benefits for Employees Hired Prior to 1 October 1997

Transition benefits are the first survivor benefits to be paid. Payments are made to your survivor(s) each month for 24 months starting on the first of the month following your death. Your survivor will need to provide the Company with written proof of your death.

The monthly benefit is $700. If your survivor or survivors are eligible for disability, survivor, or unreduced retirement benefits from Social Security, then the benefit is $400.

The Plan pays your transition benefits in this order:

– To your spouse; or if none

– To your children; or if none

– To your dependent parents

If your survivors die while receiving benefits, the next survivor will receive the balance of any of the monthly payments. Transition benefits end after 24 full months following your death or when no survivors remain.

Special rules govern how transition benefits are shared between two or more children or two parents. Contact Deere Direct for more information on sharing transition benefits.

C-3.5.2. Bridge Benefits

Bridge benefits are designed to "bridge the gap" between the end of transition benefits and the start of Social Security benefits. Bridge benefits are paid only to your surviving spouse. The monthly payment is $700. To receive bridge benefits, your spouse must be eligible for transition payments and:

- Be at least age 45 when you die;
- Be any age and severely disabled — not able to perform responsibilities at home or be gainfully employed; or
- Your spouse's age and your service credits at your death total more than 55.

Bridge benefits begin the month following the 24th transition payment and end when your spouse reaches age 62, dies, remarries, or receives full widow/widower's benefits from Social Security.

C-3.6. Naming a Beneficiary

When you join the Company, you will be asked to designate one or more beneficiaries — these are the people who will receive group life and AD&D benefits if you die. You may change your beneficiaries at any time. If you have not named a beneficiary at the time of your death, benefits will be paid to your estate.

Be sure to keep your beneficiary designation current. Group life insurance benefits are designed to provide financial security for your loved ones. Make sure these benefits go to the person(s) of your choosing. You can designate a life insurance beneficiary by selecting the tile on the UPoint site at www.yourbenefitsreources.com/deere.

C-3.7. When Benefits Are Paid

Group life insurance and AD&D benefits are paid to your beneficiary in a lump sum, unless monthly or annual installment payments are arranged. If payments are made in installments, interest is credited to the unpaid balance of the insurance amount each year. If your beneficiary dies while receiving installment payments, the unpaid balance of the insurance benefit will be paid to your beneficiary's estate.

C-3.8. When You Retire

Your group life insurance is reduced by 2% each month after you retire or when you reach age 65, whichever is later. For example, if you retire with $40,000 of group life insurance, the monthly reduction would be 2% x $40,000 or $800 — a $9,600 reduction each year. Group life insurance continues to be reduced until your coverage is equal to 1½% times the original amount times your years of service credit. In the example above, if you retired with 30 years of service credit, your group life insurance coverage would not be less than 1½% x $40,000 x 30, or $18,000.

For employees hired prior to 1 October 1997, your coverage in retirement is never less than $7,500 and the reduced insurance balance is in effect for the rest of your life.

If you become totally and permanently disabled and retire under the John Deere Pension Plan for Wage Employees, your group life insurance coverage continues until your disability pension is redetermined, but no later than age 68. At that time, your coverage will be reduced as described above.

For employees hired on or after 1 October 1997, your coverage in retirement is $7,500. AD&D coverage stops automatically when you reach age 65 or retire, whichever is later.

Claims for group life, AD&D, and monthly survivor benefits must be made in writing. For more information about receiving benefits, your beneficiary should contact the John Deere Benefit Center at 1-844-689-7833.

C-4. Your Disability Benefits

Your income is protected automatically during your disability through Weekly Indemnity and Long-Term Disability (LTD) benefits. The Company pays the entire cost of coverage.

C-4.1. Eligibility

If you are a full-time wage employee of Deere & Company and actively working at one of the U.S. operations as outlined in "Who This Document Is For", you are eligible for Weekly Indemnity and LTD benefits starting the first day of the month following the date you establish seniority.

Your participation is automatic. The Company pays the full cost of your disability benefits while you are eligible.

C-4.2. How Disability Benefits Are Determined

Disability benefits are determined by your earnings bracket during the calendar quarter in which disability benefits start.

C-4.2.1. How Benefits are Determined for Hourly Paid Employees

If you are a wage paid employee, your earnings rate will be your average straight time hourly earnings. This earnings rate determines your bracket.

Your earnings rate on...	...determines your disability benefit payments that start:
April 1	May, June, July
July 1	August, September, October
October 1	November, December, January
January 1	February, March, April

C-4.3. Weekly Indemnity Benefits

If you are away from work because of a nonoccupational illness or injury, a portion of your regular earnings are continued for up to 52 weeks.

Weekly Indemnity payments start on the eighth day in the case of an injury. If you are hospitalized or treated by a physician for the injury in the first seven days, benefits begin on the first day of your disability. Benefits for outpatient surgery begin on the same day as the surgery, if the charges for the surgery are at least $25 and covered under Deere's Health Benefit Plan for Wage Employees. For illnesses, payments begin on the eighth day of your disability, if you are treated by a physician.

Weekly Indemnity benefits continue for up to 52 weeks if you have at least one year of continuous employment with Deere. If you have less than one year of continuous employment, you'll receive Weekly Indemnity benefits up to the length of your continuous employment. Partial weeks are paid as daily increments dividing the weekly benefit by five.

C-4.3.1. Weekly Indemnity Earnings Bracket

If your earnings bracket is:	Your weekly indemnity benefit for claims is:
Less than 9.50	*$221*
$9.50 but less than $9.80	$227
$9.80 but less than $10.10	$233
$10.10 but less than $10.40	$239
$10.40 but less than $10.70	$245
$10.70 but less than $11.00	$251
$11.00 but less than $11.30	$257
$11.30 but less than $11.60	$263
$11.60 but less than $11.90	$269
$11.90 but less than $12.20	$275
$12.20 but less than $12.50	$281
$12.50 but less than $12.80	$287
$12.80 but less than $13.10	$293
$13.10 but less than $13.40	$299
$13.40 but less than $13.70	$305
$13.70 but less than $14.00	$311
$14.00 but less than $14.30	$317
$14.30 but less than $14.60	$323
$14.60 but less than $14.90	$329
$14.90 but less than $15.20	$335
$15.20 but less than $15.50	$341
$15.50 but less than $15.80	$347

If your earnings bracket is:	Your weekly indemnity benefit for claims is:
$15.80 but less than $16.10	$353
$16.10 but less than $16.40	$359
$16.40 but less than $16.70	$365
$16.70 but less than $17.00	$371
$17.00 but less than $17.30	$377
$17.30 but less than $17.60	$383
$17.60 but less than $17.90	$389
$17.90 but less than $18.20	$395
$18.20 but less than $18.50	$401
$18.50 but less than $18.80	$407
$18.80 but less than $19.10	$413
$19.10 but less than $19.40	$419
$19.40 but less than $19.70	$425
$19.70 but less than $20.00	$431
$20.00 but less than $20.30	$437
$20.30 but less than $20.60	$443
$20.60 but less than $20.90	$449
$20.90 but less than $21.20	$455
$21.20 but less than $21.50	$461
$21.50 but less than $21.80	$467
$21.80 but less than $22.10	$473
$22.10 but less than $22.40	$479

If your earnings bracket is:	Your weekly indemnity benefit for claims is:
$22.40 but less than $22.70	$485
$22.70 but less than $23.00	$491
$23.00 but less than $23.30	$497
$23.30 but less than $23.60	$503
$23.60 but less than $23.90	$509
$23.90 but less than $24.20	$515
$24.20 but less than $24.50	$521
$24.50 but less than $24.80	$527
$24.80 but less than $25.10	$533
$25.10 but less than $25.40	$539

If your earnings bracket is:	Your weekly indemnity benefit for claims is:
$25.40 but less than $25.70	$545
$25.70 but less than $26.00	$551
$26.00 but less than $26.30	$557
$26.30 but less than $26.60	$563
$26.60 but less than $26.90	$569
$26.90 but less than $27.20	$575
$27.20 but less than $27.50	$581
$27.50 but less than $27.80	$587
$27.80 but less than $28.10	$593
$28.10 and over	$599

C-4.3.2. Coordinating With Social Security

Your Weekly Indemnity benefits are reduced by the weekly equivalent of any primary benefit (not any of your family's benefits) you are eligible to receive from Social Security. You only need to be entitled to Social Security benefits, not receive them, for your Weekly Indemnity benefits to be reduced. Social Security benefits can start 22 weeks after your disability begins, however, your disability must be expected to last at least 12 months.

C-4.4. Benefits for Occupational Illness or Injury

You do not receive Weekly Indemnity benefits for an occupational illness or injury. If your injury or illness is related to your work, you may be eligible for benefits from Workers' Compensation and Company-provided Supplemental Weekly Indemnity benefits.

C-4.4.1. Workers' Compensation

Workers' Compensation benefits are regulated by state law and paid for by the Company. Benefit amounts vary from state to state, but generally include medical expense, disability income, and death benefits. Notify your Personnel/Human Resources Department if you suffer from a work-related injury or illness.

C-4.4.2. Supplemental Weekly Indemnity Benefits

The Company will supplement your Workers' Compensation benefit to give you a total benefit equal to what Weekly Indemnity benefits would pay had your disability not been work-related. Supplemental benefits can continue for up to 52 weeks.

C-4.5. Long-Term Disability Benefits

LTD benefits provide a source of income while you recover from occupational and nonoccupational injuries and illnesses. LTD benefits are paid to you each month while you continue on disability. These benefits begin when Weekly Indemnity benefits end, generally after your 52nd week of disability.

For claims incurred prior to 1 October 2009, benefits will be payable as provide in the prior Agreement. For claims incurred on or after 1 October 2009, benefits will be paid for not longer than the first to occur of the dates listed below:

– If you have less than two years of continuous employment, at the start of your disability, your benefits are paid for up to 12 months, or

– If you have two or more years of continuous employment at the start of your disability, LTD benefits are paid for 12 months, plus an additional month for each month of employment beyond two years, or

– The following schedule:

If Disability commences at:	Benefits payable until:
Prior to attainment of age 61 1/2	Attainment of age 65
On or after 611/2 but before attainment of age 63	First to occur of attainment of age 65 or the date the 42nd monthly benefit is payable
Age 63	The date the 36th monthly benefit is payable
Age 64	The date the 30th monthly benefit is payable
Age 65	The date the 24th monthly benefit is payable
If Disability commences at:	**Benefits payable until:**
Age 66	The date the 21st monthly benefit is payable
Age 67	The date the 18th monthly benefit is payable
Age 68	The date the 15th monthly benefit is payable
Age 69 or older	The date the 12th monthly benefit is payable

- Or, the date of your death, or
- The date you no longer satisfy the disability requirement.

Your monthly LTD benefit:

C-4.5.1. LTD Earnings Bracket

If your earnings bracket is:	Your monthly LTD benefit for claims is:
Less than 9.50	*$800*
$9.50 but less than $9.80	$825
$9.80 but less than $10.10	$850
$10.10 but less than $10.40	$875
$10.40 but less than $10.70	$900
$10.70 but less than $11.00	$925
$11.00 but less than $11.30	$950
$11.30 but less than $11.60	$975
$11.60 but less than $11.90	$1,000
$11.90 but less than $12.20	$1,025
$12.20 but less than $12.50	$1,050
$12.50 but less than $12.80	$1,075
$12.80 but less than $13.10	$1,100
$13.10 but less than $13.40	$1,125
$13.40 but less than $13.70	$1,150
$13.70 but less than $14.00	$1,175
$14.00 but less than $14.30	$1,200
$14.30 but less than $14.60	$1,225
$14.60 but less than $14.90	$1,250
$14.90 but less than $15.20	$1,275
$15.20 but less than $15.50	$1,300
$15.50 but less than $15.80	$1,325
$15.80 but less than $16.10	$1,350
$16.10 but less than $16.40	$1,375
$16.40 but less than $16.70	$1,400
$16.70 but less than $17.00	$1,425
$17.00 but less than $17.30	$1,450
$17.30 but less than $17.60	$1,475
$17.60 but less than $17.90	$1,500
$17.90 but less than $18.20	$1,525
$18.20 but less than $18.50	$1,550
$18.50 but less than $18.80	$1,575

If your earnings bracket is:	Your monthly LTD benefit for claims is:
$18.80 but less than $19.10	$1,600
$19.10 but less than $19.40	$1,625
$19.40 but less than $19.70	$1,650
$19.70 but less than $20.00	$1,675
$20.00 but less than $20.30	$1,700
$20.30 but less than $20.60	$1,725
$20.60 but less than $20.90	$1,750
$20.90 but less than $21.20	$1,775
$21.20 but less than $21.50	$1,800
$21.50 but less than $21.80	$1,825
$21.80 but less than $22.10	$1,850
$22.10 but less than $22.40	$1,875
$22.40 but less than $22.70	$1,900
$22.70 but less than $23.00	$1,925
$23.00 but less than $23.30	$1,950
$23.30 but less than $23.60	$1,975
$23.60 but less than $23.90	$2,000
$23.90 but less than $24.20	$2,025
$24.20 but less than $24.50	$2,050
$24.50 but less than $24.80	$2,075
$24.80 but less than $25.10	$2,100
$25.10 but less than $25.40	$2,125
$25.40 but less than $25.70	$2,150
$25.70 but less than $26.00	$2,175
$26.00 but less than $26.30	$2,200
$26.30 but less than $26.60	$2,225
$26.60 but less than $26.90	$2,250
$26.90 but less than $27.20	$2,275
$27.20 but less than $27.50	$2,300
$27.50 but less than $27.80	$2,325
$27.80 but less than $28.10	$2,350
$28.10 and over	$2,375

C-4.5.2. Working For Rehabilitation

LTD benefits allow someone who's disabled to ease back into a work routine. With written approval, you can undergo vocational rehabilitation by doing paid work that is primarily training-oriented. LTD benefits continue while you're in rehabilitation.

C-4.6. Other Disability Coverage

Weekly Indemnity and LTD benefits you receive from the Company are reduced by any disability payments you are eligible to receive from Workers' Compensation (including State of California Unemployment Compensation Disability Law — U.C.D.), Social Security (primary benefit only), the John Deere Pension Plan, or any other sources.

C-4.7. Disability Payments from Life Insurance

The group life and AD&D plan will pay benefits to you if you become totally and permanently disabled before age 70 and are not eligible for normal, early, or disability retirement under the John Deere Pension Plan for Wage Employees. (You are eligible for disability retirement once you have 10 years of service credit and if you're under age 68.) See section C-3 in this chapter for more information on this benefit.

C-4.8. Disability Retirement

If you become totally and permanently disabled, you may qualify for disability retirement under the John Deere Pension Plan for Wage Employees. To be eligible, you must be under age 68 and have at least 10 years of service credit. For more information on disability retirement, see Chapter A: "Retirement".

C-5. Situations Affecting Your Survivor and Disability Benefits

C-5.1. Situations Affecting Your Survivor and Disability Benefits — Overview

Life insurance and disability benefits are designed to help protect you and your family's financial security. However, there are some situations that could cause a loss of benefits.

Here are some circumstances that could affect your income protection benefits:

- You must notify Occupational Health to receive Weekly Indemnity benefits.

LTD benefits are not payable for disabilities resulting from:

- Any armed conflict, war, or any act of war (declared or undeclared); or Service in the armed forces, unless you've been employed by the Company at least 10 years since you left the service.

C-5.2. Applying for Benefits

C-5.2.1. For Group Life/AD&D and Monthly Survivor Benefits

A claim form must be submitted to the John Deere Benefit Center before any benefits are paid. If you die, a certified copy of the death certificate (if applicable) is required.

Securian Financial will explain to your beneficiary what benefits are payable and the form of payment. Your beneficiary may elect a lump sum payment or installment payments.

C-5.2.2. For Weekly Indemnity and LTD Benefits

For Weekly Indemnity benefits, you must contact your Occupational Health as soon as you're away from work due to illness or injury. LTD benefits are payable only after a written claim has been filed and approved.

Written proof of your disability may be required before benefit payments begin. The Company may require you to take either a psychiatric or physical examination from a Company- designated physician in an effort to determine your eligibility for disability benefits. Mental or non-organic disease as a cause for total disability must have a psychiatrist's certification that the employee's infirmity is of major and psychotic degree.

If a claim is denied, in whole or in part, you or your beneficiary are entitled to a full review. For information about the process for reviewing denied claims, see "Chapter H: Administrative Information".

C-5.3. If the Plan is Amended, Modified, Suspended, or Terminated

Deere & Company, subject to any collective bargaining agreement, reserves the right to suspend or terminate the Plan; to modify or to amend the Plan in any respect. Changes may occur at any time. Participants will be notified in due course concerning substantial changes. Amendment or termination of the Plan can only be effected by a legal instrument authorized by the Board of Directors.

Chapter D: Supplemental Unemployment Benefits

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D-1. Supplemental Unemployment Benefit Highlights

The Supplemental Unemployment Benefit Plan provides financial security during layoffs for eligible wage employees.

Eligibility	You may be eligible for Supplemental Unemployment Benefits (SUB) if you have one or more years of continuous employment, you are on a qualifying layoff, and you meet certain other eligibility requirements.
Type of Benefits	SUB Benefits provided under the Plan are a supplement to benefits provided under the state unemployment system and are paid for periods of layoff.
Applying for Benefits	You must apply for benefits within 60 days of the week for which you're claiming a benefit.
Paying for Coverage	SUB benefits are provided by the Company.

D-2. Terms You Should Know

- Active employment – Your status in any pay period for which you're paid by the Company, including periods when you're on vacation, personal leave of absence, sick leave, or disciplinary suspension.
- Other compensation – While on layoff, any pay you receive from the Company, and pay that you could have earned for hours made available by the Company but not worked, after reasonable notice. Also included are earnings from another employer above $10 or 20 percent of those earnings (whichever is higher), or military pay in excess of $10. If you earned pay from another company or the military for hours that were available for you to work at Deere & Company, your other compensation may be based on the amount you could have earned by working those hours at Deere. Contact Deere Direct if you have questions.
- State system benefit – An unemployment benefit payable under any system or program established under state or federal law.
- Weekly after-tax pay – The expected amount of your average straight-time hourly earnings (as determined in Article XVIII, Section 11 of the Collective Bargaining Agreement) multiplied by forty (40) minus all federal and state taxes and contributions required to be withheld by the Company.
- Work week – The seven consecutive days starting on Monday at the regular starting time of the shift to which you were assigned immediately before being laid off.

D-3. Benefits

D-3.1. Eligibility

You may be eligible for benefits under the Plan if you:

- Have at least one or more years of continuous employment;
- Are on a qualifying layoff from a bargaining unit because of:
  - A reduction in force (including closing of a plant or operation),
  - A temporary layoff, or
  - Your inability to do work offered by the Company, even though you're able to perform other work in the plant that you would be entitled to if you had enough seniority;
- Have registered or reported, if required, at a state employment office (this eligibility provision does not apply if you're ineligible for a state system benefit due to your pay, the period you worked, or military service of 30 days or less, or if your state system benefit would be $2 or less);
- Have applied for regular benefits (either in person or by mail);
- Qualify for a regular benefit of at least $2; and
- Did not receive (and was not eligible to receive) an unemployment benefit from another employer or another SUB plan offered by the Company.

D-3.1.1. State Unemployment Compensation (UC) Benefits

In addition to the eligibility requirements described in the prior section, you must have received a state UC benefit, or be ineligible for one because you:

- Did not work long enough or have earnings to qualify for state UC benefits;
- Have exhausted your state UC benefits;
- Worked or had earnings in the week that disqualified you for state UC benefits or waiting-week credit;
- Were employed full time by an employer other than the Company;
- Are serving a waiting-week under the state UC system;
- Are on a layoff because you're unable to do your regular job, or other work offered by the Company, provided you're able to do other work in the plant that you would be entitled to if you had enough seniority;
- Have failed to claim a state UC benefit because pay from the Company would result in a state UC benefit of less than $2;
- Are receiving pay for military service for a period following your release from active duty or were on short-term active duty of 30 days or less;
- Are entitled to benefits for statutory retirement or disability that would be payable while you're working full time; and
- Have been denied a state UC benefit and it would go against the Plan's intent to deny you a benefit.

The terms "state unemployment compensation (UC) benefit" and "state system benefit" throughout this chapter exclude programs established to provide education or vocational training and any state system benefits payable only because the person is undergoing approved training.

D-3.1.2. If You Exhaust State UC Benefits

Some special rules apply if you exhaust your state unemployment compensation and apply for SUB benefits. In this case, you must:

- Be able to work, be available for work, and maintain an active registration for work with the state employment service;
- Do what a reasonable person would do to obtain work; and
- Apply for or accept suitable work that the state employment service or the Company lets you know is available.

D-3.2. When You're Not Eligible

You're not eligible for regular benefits if you:

- Are laid off:
  - For disciplinary reasons;
  - Because of a strike, slowdown, work stoppage, picketing (whether or not by employees) or concerted action (at a Company plant or plants), or any dispute involving Deere or represented employees at a Company plant or elsewhere;
  - Through your own fault;
  - Because of any war or hostile action of a foreign power;
  - Because of sabotage or insurrection; or
  - Beyond the first two consecutive weeks of layoff for which a benefit is payable in any period of layoff because of any act of God.
- Refuse a Company offer of work that you cannot refuse under the Collective Bargaining Agreement or refuse other available work at a Deere plant in the same labor market.
- Are in military service or on a military leave (other than short-term duty of 30 days or less).
- Are eligible for or claiming any statutory accident or sickness benefit, other disability benefit (other than a disability benefit you would get even if working full time or a lost- time Workers' Compensation benefit while not disabled), or a Company retirement benefit. (Your eligibility for a regular early or normal retirement benefit if you're not yet receiving the benefit, however, will not disqualify you.)
- Are receiving SUB payments from another employer or are eligible to receive them from another employer with whom you have more seniority than you have with the Company.
- Are receiving or are eligible to receive SUB payments under any other Deere SUB plan.

D-3.3. How Long Benefits Are Paid and Amount of Benefit

The length of time Supplemental Unemployment Benefits are paid is based on your years of continuous employment.
If you were hired prior to 1 October 1997:

- With ten (10) or more years of continuous employment at the time of layoff, you will be guaranteed a maximum benefit of up to $200/250 (depending upon your eligibility for unemployment compensation) for up to a maximum of 52 weeks.
- Employees who are laid off for more than six weeks in an Employment Security Program year because of a scheduled Temporary Inventory Adjustment Shutdown/Layoff will have their benefits computed as provided in the Supplemental Unemployment Benefit Plan, except that the maximum benefit amount that any eligible laid-off employee may receive will be $300.00 per week for the scheduled weeks in excess of six.

No benefit will be payable to you if you have been on layoff for a continuous period of 24 months, except that if at the expiration of the 24-month period you are receiving benefits, the weekly benefit will continue up to the allotted maximum.

If you were hired on or after 1 October 1997, and laid-off after 1 October 2021:

- With less than five (5) years of continuous employment at the time of layoff, you will be paid a maximum of 26 weekly benefits at $150 per week.
- With five (5) or more years but less than ten (10) years of continuous employment at the time of layoff, you will be paid a maximum of 39 weekly benefits at $200 per week.
- With ten (10) or more years but less than fifteen (15) years of continuous employment at the time of layoff, you will be paid a maximum of 52 weekly benefits at $250 per week.
- With fifteen (15) or more years of continuous employment at the time of layoff, you will be paid a maximum of 78 weekly benefits at $300 per week.

The length of time Transitional Assistance Benefits are paid is based on your years of continuous employment.
If you were hired on or after 1 October 1997:

- With one year or more of continuous employment at the time of layoff, you will receive Transitional Assistance Benefits, less applicable taxes, equal to fifty percent (50%) of the Average Earnings Rate as provided in Article XVIII, Section 12 of the Master Labor Agreement in effect at the time of layoff (based upon a forty (40) hour work week) equal to a maximum of fifty-two (52) weeks from the date of exhausting SUB benefits. The Transitional Assistance Benefit will be offset by any State System Benefits paid. The total of SUB benefits and Transitional Assistance Benefits will not exceed seventy-eight (78) weeks.

D-3.3.1. Reduced Benefit

If you are ruled ineligible for regular benefits for part of the week, you may be eligible to receive one-fifth of your regular weekly benefit for each day of the week you are eligible. Contact Deere Direct for more information.

D-3.3.2. Benefits for Periods of Less Than One Week

Benefits for temporary inventory adjustment shutdown or layoff periods of less than one week are paid at a daily rate of one-fifth of the combined benefits you would have received had you been eligible for a state system benefit and your weekly SUB benefit as described above.

D-3.4. Applying for Benefits

You must apply for benefits in person or by mail. You must apply within 60 calendar days after the end of the week for which you claim the benefit.

You may apply after this time limit if you later become eligible for state UC benefits or your state UC benefit amount is adjusted retroactively, which affects your eligibility or benefit amount under this Plan.

Application forms are available from Deere Direct. You must submit a new application form each week you claim a benefit. Benefit payments are mailed to your home.

D-3.4.1. About the Application Form

The application form asks for:

- The amount of any state UC and other benefits you have received, such as Workers' Compensation, retirement plan benefits, trade readjustment allowances, benefits under any other SUB plans, and state or federal disability payments;
- The amount of any earnings you receive from another source; and
- Information about your dependents (i.e., your spouse or anyone you claim as an exemption for federal income tax purposes).

You also must submit evidence that shows you have received or are entitled to receive a state UC benefit, or you're ineligible for a state UC benefit for a reason under the Plan (as listed in section D-3.1).

D-3.4.2. How to Appeal an Adverse Benefit Determination

Contact your Union representative if your claim for benefits under the Plan is denied in whole or in part. Your Union representative can assist you in resolving the issue, and you can file a grievance in accordance with Article XII of the Collective Bargaining Agreement.

Chapter E: Tuition Assistance Program

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E-1. Tuition Assistance Program Highlights

Covered Expenses	The Tuition Assistance Program will reimburse you for tuition, registration fees, and activity and laboratory fees for approved courses.
Eligibility	You are eligible for the Tuition Assistance Program after one year of continuous employment. You can still participate if you don't have at least one year of continuous employment, but reimbursement will be withheld until you have completed one year of employment.
Approved Schools and Courses	Both credit and noncredit regular, extension, and correspondence courses offered by accredited and approved colleges and universities are covered. Enrollment in high schools, accredited technical schools and area colleges will also be accepted if approved by your supervisor, and the John Deere Benefits Center.

E-2. Terms You Should Know

- Continuous employment – Your employment period starting on the date you last began work with any unit of Deere & Company, including its domestic and foreign subsidiaries.
- Credit course – A course that is job-related or designed to help you prepare for a future assignment with the Company, and is part of a curriculum leading to a degree in a job-related field.
- Noncredit course – A course that is job-related or designed to help you prepare for a future assignment with the Company, but is not part of a curriculum leading to a degree in a job- related field.
- Tuition Assistance Program – Tuition reimbursement program for a variety of credit and non-credit courses or self-development programs.

E-3. If You Want to Continue Your Education

Both you and the Company benefit when you continue your education. The Tuition Assistance Program reimburses you for tuition, registration fees, and activity and laboratory fees for approved courses.

E-3.1. Eligibility

You are eligible for the Tuition Assistance/Advanced Education Program after one year of continuous employment. If you don't have at least one year of continuous employment, you can still participate, but reimbursement will be withheld until you have completed one year of employment.

E-3.2. Approved Schools and Courses

Both credit and noncredit regular, extension, and correspondence courses offered by accredited and approved colleges and universities are covered. Enrollment in high schools, accredited technical schools and area colleges will also be accepted if approved by the employee's supervisor and the John Deere Benefits Center. Contact the John Deere Benefits Center at 844-689-7833 or log on to UPoint® at www.yourbenefitsresources.com/deere for more information.

Since only courses outside of work hours are eligible for approval, a schedule will be approved only when it is reasonably certain that the course work will not affect your job performance and does not exceed nine credit hours per academic period.

In all cases, the course work must be preapproved by the employee's supervisor. The tuition assistance enrollment process is administered through the UPoint website: www.yourbenefitsresources.com/deere.

Amount Reimbursed	When Reimbursement Is Made
66-2/3%	*1/3 upon course approval and 1/3 upon satisfactory course completion*

E-3.3. What's Not Covered by the Program

Some services and supplies are not covered by the Tuition Assistance Program. Excluded expenses are:

- Meals and lodging;
- Textbooks and materials;
- Examination fees;
- Transportation; and
- Expenses eligible to be paid or reimbursed in some other way, such as by scholarships, grants, or by G.I. educational benefits (unless you prove that you intend to use G.I. benefits for full-time study on campus at some later date in connection with an educational leave of absence).

Chapter F: Profit Sharing Compensation Plan for Wage Employees

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F-1. Profit Sharing Plan Highlights

The Profit Sharing Plan provides contingent benefits to employees to reflect their efforts in contributing to the profitability of Deere & Company.

Eligibility	You may be eligible for a Profit Sharing payment if you have completed one or more years of Company service and you are an active employee on the last day of the Plan Year. Employees who are otherwise eligible, but who die, retire, or were employed at a facility of the Company which was sold during the Plan Year are treated as though they were an active employee on the last day of the Plan Year.
Amount of Benefit	The amount of benefit is determined by multiplying the following elements: 1. The number of hours worked in the Plan Year by the participant; 2. The average straight time hourly rate of pay for a participant; and 3. The Profit Sharing Benefit as determined by the Return on Assets for the North American Agricultural, Construction & Forestry and Worldwide Operations.
Payment of Benefit	The Profit Sharing payment will be made no later than 31 December.

F-2. Terms You Should Know

- Company service – The total period elapsed since the employee's first date of hire including any periods of layoff, but excluding any period of suspension, discharge, resignation or quit, if later reinstated. An employee "severs his service" on the date he quits, retires, is discharged, dies or otherwise terminates his employment.
- Fiscal accounting year

Fiscal 2022: 01 NOV 2021 through 30 OCT 2022
Fiscal 2023: 31 OCT 2022 through 29 OCT 2023
Fiscal 2024: 30 OCT 2023 through 27 OCT 2024
Fiscal 2025: 28 OCT 2024 through 02 NOV 2025
Fiscal 2026: 03 NOV 2025 through 01 NOV 2026
Fiscal 2027: 02 NOV 2026 through 31 OCT 2027

- Participant – A member of the bargaining unit becomes a participant on the first day of any payroll period after the date he has completed one or more years of Company service.
- Plan year – The fiscal accounting year.

F-3. Eligibility for Benefits

You may be eligible for benefits under the Plan if you:

- Have at least one year of Company service;
- Meet the requirements of being a participant under the Plan;
- Are considered an active employee on the last day of that Plan Year or are on leave of absence or layoff on the last day of that Plan Year or die or retire or are employed at a facility of the Company which is sold during the Plan Year.

F-4. Amount of the Benefit

The amount of benefit is determined by multiplying the following three elements:

- The number of hours worked in the Plan Year by the participant;
- Average straight time hourly rate of pay for a participant, and;
- The Profit Sharing Benefit Percent as determined from the chart below times 50%.

The total benefit will equal the addition of the 50% benefit determined from the combined North American Agricultural & Turf and Construction & Forestry rate schedule, plus the 50% benefit determined from the Worldwide rate schedule.

Worldwide Return on Assets		
At Least	But Less Than	Profit Sharing Benefit Percent
0.01%	2.65%	0.14%
2.65	2.87	0.29
2.87	3.10	0.46
3.10	3.32	0.64
3.32	3.55	0.81
3.55	3.77	0.99
3.77	4.00	1.16
4.00	4.22	1.34
4.22	4.45	1.51
4.45	4.67	1.69
4.67	4.90	1.86
4.90	5.12	2.04
5.12	5.35	2.21
5.35	5.57	2.39
5.57	5.80	2.56
5.80	6.02	2.74
6.02	6.25	2.91
6.25	6.47	3.09
6.47	6.70	3.26
6.70	6.92	3.44
6.92	7.15	3.61
7.15	7.37	3.79
7.37	7.60	3.96
7.60	7.82	4.14
7.82	8.05	4.31
8.05	8.27	4.49
8.27	8.50	4.66
8.50	8.72	4.84
8.72	8.95	5.01
8.95	9.17	5.19
Etc.	Etc.	Etc.

N.A. Agricultural & Turf & Construction & Forestry Return on Assets		
At Least	But Less Than	Profit Sharing Benefit Percent
0.01%	1.60%	0.14%
1.60	1.90	0.29
1.90	2.20	0.46
2.20	2.50	0.64
2.50	2.80	0.81
2.80	3.10	0.99
3.10	3.40	1.16
3.40	3.70	1.34
3.70	4.00	1.51
4.00	4.30	1.69
4.30	4.60	1.86
4.60	4.90	2.04
4.90	5.20	2.21
5.20	5.50	2.39
5.50	5.80	2.56
5.80	6.10	2.74
6.10	6.40	2.91
6.40	6.70	3.09
6.70	7.00	3.26
7.00	7.30	3.44
7.30	7.60	3.61
7.60	7.90	3.79
7.90	8.20	3.96
8.20	8.50	4.14
8.50	8.80	4.31
8.80	9.10	4.49
9.10	9.40	4.66
9.40	9.70	4.84
9.10	10.00	5.01
10.00	10.30	5.19
Etc.	Etc.	Etc.

F-5. Payment of the Benefit

The Profit Sharing benefit amount which is payable for any year shall be paid to an eligible participant not later than 15 January of the year following the Plan Year for which the benefit amount is computed.

Chapter G: Legal Services

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G-1. Legal Services Highlights

The John Deere Legal Services Plan for Wage Employees gives you access to personal legal services provided by attorneys.

Participation	You, your spouse, and your eligible dependents are eligible for legal services after you complete one year of continuous employment.
Obtaining Legal Services	Attorneys are provided for by MetLife Legal Plans, Inc. If you need an attorney, call MetLife Client Service Center at 1-800-821-6400. In most cases, you will be given the name and phone number of an attorney or law firm. You must use the attorney specified by MetLife in order to receive services.
Covered Services	The plan covers attorney fees for a variety of personal legal services, including legal advice and consultation, will preparation, drafting and settling of divorce agreements, sale or purchase of a home, and uncontested adoption and guardianship. Some legal services are available at a reduced fee.
Paying For Coverage	Attorney fees for covered services are paid for as part of the Plan. You, your spouse, and eligible dependents do not pay attorney fees for covered services.
Filing a Claim	When you use participating attorneys, you do not need to file a claim. Plan attorneys bill MetLife directly for covered services. If participating attorneys are not available in your area, and you have called MetLife's Client Service Center prior to using a non-plan attorney, you will be sent a Fee Reimbursement Form to seek reimbursement for covered services (up to a set dollar amount).

G-2. Terms You Should Know

- Bankrupt – The state or condition of being unable to pay your debts when they're due.
- Custody – The care, control, and maintenance of a child that may be awarded by a court to one of the parents, such as in a divorce or separation proceeding.
- Defendant – The person who is accused of a crime in a criminal case, or the person against whom relief or recovery is sought in a court action or lawsuit.
- Demand letter – A letter asserting your legal rights or another person's legal obligation. It may request that someone pay a debt, perform a service, or stop doing certain acts.
- Felony – A crime that is generally more serious than a misdemeanor. Under federal and many state laws, it includes any crime that is punishable by imprisonment for more than a year.
- Guardian – A person who legally has been given the responsibility and power to take care of another person and manage his or her property or estate (or both). Guardians may be appointed for children or for adults who are unable to care for themselves or their affairs.
- Litigation – A lawsuit and all the necessary proceedings needed to settle or try the suit.
- Living will – A short document that expresses your wishes concerning medical treatment if there is no reasonable expectation that you'll recover from a medical condition.
- Misdemeanor – A crime that is not as serious as a felony. Punishment for misdemeanors is generally a fine or jail, but not in a penitentiary.
- Plaintiff – The person who files a complaint or lawsuit against another person or organization (in civil cases) alleging his or her rights have been violated or that there has been an injury.
- Probate – This refers to all proceedings relating to the administration of an estate after a death or as part of a guardianship.
- Title – The right to or ownership of land. The term also may refer to the documents that show evidence of ownership.
- Will – In general, the legal declaration of how you want your property divided when you die.

G-3. Eligibility

G-3.1. Eligibility For You

You are eligible for legal services under the John Deere Legal Services Plan for Wage Employees if you have at least one year of continuous employment and you are:

- Actively employed, including days you are not at work due to time off for vacation, excused personal absence, bereavement, paid leave, jury duty, unexcused temporary absence, short-term illness, or on workers' compensation;
- On Weekly Indemnity or long-term disability;

– On layoff (eligibility ceases 18 months after the month in which your layoff began);

– On leave of absence (up to the first 30 days); or

– On leave of absence for Union business.

If you are currently retired and were eligible for legal services at the time of retirement you are eligible to continue receiving the legal services benefit during retirement.

G-3.2. Eligibility For Your Dependents

If you have dependents, they may also be eligible for legal services under the Plan. Your eligible dependents include:

– Your spouse.

– Your unmarried children under age 19. Your "unmarried children" include both natural born and legally adopted children, stepchildren, and children for whom legal adoption proceedings have been started. Also included are children under age 19 who are dependent on you for more than one-half of their support (as defined by the Internal Revenue Code) who are related to you by blood or marriage, or are under your guardianship. (These dependents must qualify for dependency tax status in the current year or have been reported on your most recent federal tax return.)

– Your unmarried children who are ages 19 through 24 or totally and permanently disabled (regardless of age) and who are dependent on you for at least one half of their support (as defined by the Internal Revenue Code), qualify for dependency tax status in the current year or have been reported on your most recent federal tax return.

The surviving spouse of an eligible employee or retiree is eligible for legal services under the plan if he or she has not remarried and:

– The employee or retiree had at least five years of service credit at the time of death; or

– The surviving spouse is eligible for transition benefits.

G-4. How the Plan Works

Legal services under the Plan are provided for by MetLife Legal Plans, Inc. To get legal assistance, follow these steps:

1. Call MetLife Legal Plans' Client Service Center at 1-800-821-6400 between 8 a.m. and 8 p.m. (Eastern time), Monday through Friday.
2. Tell the client service representative you are a member of the John Deere Legal Services Plan for Hourly and Incentive Paid Employees and give your Social Security number. (Eligible dependents also need to give your Social Security number.)
3. The client service representative will give you an authorization number and refer you to a participating attorney in your area.
4. Call the attorney to whom you have been referred to make an appointment. If you use another attorney, the Plan will not pay your legal fees.

Q: Why do I have to call MetLife's Client Service Center?

A: The MetLife client-service representatives serve several important roles, including verifying your eligibility and making an initial determination of whether or not your case is covered under the Plan. The representative also gives you an authorization number (a new authorization number is required for each new case you have) and answers any questions you have about the Plan.

DON'T FORGET...

...Each time you use the Legal Plan for a new legal matter, you must call MetLife Legal Plans at 1-800-821-6400 before you call an attorney. Plan benefits will be denied if you don't call first.

G-4.1. Plan Benefits

The Plan pays the full cost of attorney fees for covered legal services when you use an attorney referred by MetLife. There are no deductibles, copayments, or claims to file. Your attorney will submit your bill to the Plan. Some services are covered on a reduced fee basis. That means you must pay the attorney's fees. However, these services are provided at a discount (as described on section G-4.2).

If you live in an area where there are no Plan attorneys, you choose your own attorney after you call MetLife's Client Service Center. MetLife will send you a packet of information describing this procedure. The packet also will include a fee schedule describing the maximum amount of reimbursement for each covered service and a Fee Reimbursement Form, which must be completed and returned to MetLife with the attorney's final bill after the case is completed.

G-4.2. Covered Services – All Participants

The John Deere Legal Services Plan for Wage Employees covers a wide range of personal legal services. This section describes covered services for all Plan participants and any limitations on those benefits. Except where noted, the Plan pays 100% of the attorney fees for these covered services:

Advice and Consultation

You may seek advice and consultation from an attorney as often as desired for any type of personal legal problem that is not specifically excluded under the Plan. The Plan attorney will provide advice on how the law relates to your situation and what actions might be taken to solve the problem. The attorney will then identify any further coverage available under the Plan and represent you, if you wish. If representation is recommended but is not covered by the Plan, the attorney will provide a written fee statement in advance. You may choose to retain the Plan attorney at your expense, seek outside counsel, or do nothing. Consultations are provided in person in the attorney's office.

Tenant Negotiations and Eviction Defense

The Plan pays attorney's fees for you and your eligible dependents (as tenants) to negotiate leases and to solve problems with security deposits, repairs, or other disputes with a residential landlord. The Plan will not pay for representation as a plaintiff in a lawsuit against the landlord.

If you are evicted by your residential landlord, the Plan will pay attorney's fees to represent you and your dependents up to and including a trial (if necessary).

Document Preparation

Preparation of deeds, notes, mortgages, and powers of attorney (when you or your dependents are granting the power) are covered for you and your dependents. The Plan does not cover preparation of any other documents, except those listed elsewhere as covered services.

Name Changes

Legal services are covered for all necessary pleadings and court hearings for a legal name change for you and your dependents.

Debt Collection Defense

You and your dependents are covered for a wide range of consumer debt situations, including:

- Negotiating with creditors to arrange a repayment schedule;
- Limiting harassment by bill collectors; and
- Defending any lawsuit against you for personal debt collection, foreclosure, repossession, replevin, or garnishment.

The benefit does not cover defense against a judgment, vacating a judgment, counter-claims, cross-claims, bankruptcy, matters arising out of divorce or post-decree actions, or any matter where the creditor is affiliated with Deere or the represented employees.

Protection of Driving Privilege

The Plan provides representation in certain traffic-related cases:

- Defense of any traffic ticket or drunk driving charge, including court hearings, negotiation with the prosecutor, and trial (if necessary);
- Petitions to restore a driver's license.

Consumer Matters

You and your dependents can be represented as a plaintiff in matters involving warranties and other disputes over contracts for consumer goods and services where the amount involved is more than $300. Coverage includes representation in a trial. You are not covered in disputes over real estate, construction, or insurance.

Insurance Claims

You and your dependents can obtain legal assistance making insurance claims with your insurance carrier, as long as the carrier is not affiliated with the represented union of the Plan or Deere & Company. The plan will not pay for representation in lawsuits.

Demand Letters

The Plan covers preparation of letters that state a demand for money, property, or any other personal legal matter in which you or your eligible dependents have an interest. The demand letter may be drafted for signature by you, your dependent, or your attorney. This benefit does not cover legal matters that are specifically excluded by the plan, nor does it include follow-up letters, telephone calls, or negotiations with a third party.

Civil Litigation Defense
The Plan covers your (or your dependent's) defense in civil proceedings:

– In a trial court;

– Before an administrative agency; or

– Before a local, state, or federal agency.

The Plan does not cover civil proceedings when legal services are available or are being provided through a homeowner or vehicle insurance policy. This provision also does not include divorce or post-divorce defense or litigation of a job-related incident. (Coverage for divorce defense is provided for the employee only, and is described in section G-4.4).

Misdemeanors
Representation for you and your eligible dependents is covered in defense of any misdemeanor charge, including court hearings, negotiation with the prosecutor, and trial (if needed). The Plan does not cover defense of any felony charge (except traffic matters and drunk driving), even if the charge is later reduced to a misdemeanor.

Juvenile Court
In juvenile court matters, representation will be provided for your eligible dependent/child if there is no conflict of interest with you, in which case the benefit does not apply.

Reduced Fee Benefits
Legal services in the following cases are available for a reduced fee paid by you, if allowed under state law and court rules:

– Suspension or termination of Social Security benefits-you pay 10% less than the prevailing fee;

– Probate matters — you pay 10% less than the prevailing fee; and

– Personal injury or property damage — you pay 25% of the gross award.

G-4.3. Covered Services – Employee and Spouse

This section describes covered services for you and your spouse and any limitations on those benefits.

Wills and Codicils
Preparation of wills and codicils (amendments to your will), is covered by the Plan. Tax and financial planning or the documentation required for estates larger than the Federal estate tax exemptions, and the creation of testamentary trusts (other than simple support trusts for minor children), are not covered by the Plan.

Living Wills
The plan includes the preparation of living wills for you and your spouse.

Living Trusts
The Plan includes the preparation of living trusts for you and your spouse. This benefit does not include tax planning or financial planning or the documentation required for estates larger than the Federal estate tax exemptions.

Enforcement or Modification of Support Order
An attorney will represent you or your spouse in enforcing, defending, or modifying a court's award of support or alimony, whether you or your spouse is a plaintiff or a defendant.

Uncontested Custody Order
After a divorce judgment has been entered, the Plan covers preparation of custody petitions, consent forms and waivers, and representation at court hearings for you or your spouse only if all parties are in agreement. If the proceeding becomes contested, you or your spouse must pay all additional legal fees.

Uncontested Adoption and Guardianship
Representation for uncontested governmental agency or step-parent adoptions is covered for you and your spouse. If the adoption becomes contested, you or your spouse must pay all additional legal fees directly to your attorney.

The Plan also covers legal services you or your spouse need in order to establish a guardianship over a person and his or her estate. This includes obtaining a temporary guardianship (if needed), gathering any necessary medical evidence, preparing the paperwork, and attending the hearing.

If the proceedings become contested, you or your spouse must pay all additional legal fees directly to your attorney. This benefit does not include representation of the person over whom guardianship is sought or any proceedings involving annual accountings once guardianship has been established.

Bankruptcy
These legal services relating to bankruptcy are covered:

- Personal pre-bankruptcy planning;
- Preparation and filing of personal bankruptcy petitions;
- Necessary court hearings; and
- Chapter 13 wage earner plans (including planning, preparation, and filing of the plan, and all necessary court hearings).

Services not covered:
The Plan does not cover:

- Defense against a judgment or efforts to vacate or set aside a judgment.
- Bankruptcy petitions for any corporation or partnership in which you or your spouse may have an interest.
- Cases in which the creditor is affiliated with Deere & Company or the represented union of the Plan.
- Bankruptcy cases that would result in the discharge or delay of a debt owed to any affiliate of Deere & Company or the represented union of the Plan.

G-4.4. Covered Services – Employee Only

The following legal services are covered for you only.

Separation or Divorce
The Plan covers:

- Preparation and filing of all necessary pleadings, motions, and affidavits;
- Drafting the settlement agreement; and
- Representation at a hearing or trial, whether you are a plaintiff or a defendant. Separation or divorce services are not covered for your spouse or dependents.

Sale or Purchase of a Home
The following services relating to the sale or purchase of your primary residence are covered:

- Review or preparation by your Plan Attorney of all relevant documents, including the purchase agreement, mortgage, deed, and documents pertaining to the title, insurance, recording the sale or purchase, and taxation; and
- Attendance of an attorney at closing (in cities where this is customary).

This benefit does not include services provided by an attorney representing a lending institution or title company, refinancing, home equity loans, purchase of a second home or vacation property, or the sale or purchase of unimproved land, rental property, or property held for business or investment.

Boundary or Title Disputes
An attorney will represent you in boundary or title disputes involving your primary residence through trial, if necessary.

G-5. Services and Fees Not Covered

The Plan does not cover the following services and fees:

- Expenses owed to someone other than the attorney, such as court costs, witness fees, transcripts, recording fees, filing fees, fines, penalties, judgments, or any other monetary awards ordered by any court.
- Appeals, class actions, interventions, derivative actions, and amicus curiae filings.
- Business, farm, or commercial transactions (including rental property), including any legal services that are deductible under the Internal Revenue Code as a necessary expense of doing business.
- Matters related to admiralty, patents, trademarks, and copyrights.
- Tax return preparation and filing fees.

- Any claim, proceeding, or action against the Company, its subsidiaries or affiliates, or any of its officers, directors, or agents.
- Any claim, proceeding, or action against the represented union of the Plan or any of its officers or agents.
- Lawsuits against the Plan provider, any participating law firm or attorney, or the Plan.
- Matters for which you are or have been receiving legal services before you received an authorization number, and matters handled outside the Plan.
- Any employment-related matters. This includes proceedings against the Union, a Local Union, the Company, any employee benefit plan, or any agents, officers, or employees of the Company or the Union. Claims for Workers' Compensation or unemployment compensation also are excluded.
- Any matter for which you or your eligible dependents are eligible to receive legal services through another plan, group arrangement, or insurance policy.
- Legal services to a spouse or dependent who is not an employee against the interests of a Company employee.
- Any bankruptcy or debt proceeding that would result in the discharge or collection delay of a debt owed to the Company, its subsidiaries or affiliates, the Union or any benefit plan established, maintained, or administered by Deere & Company, its affiliates or subsidiaries.
- Any services for which benefits already have been claimed.
- Any matter for which you are or have been receiving legal services before you received an authorization number, and matters handled outside the Plan.

G-6. Ethical Rules and Liability

All attorney's services provided under the Plan are subject to ethical rules established by the courts for lawyers. Attorneys will abide by the rules of the Plan, but they will not receive any further instructions, direction, or interference from anyone connected with the Plan.

The attorney's obligations are exclusively to you and his or her relationship is exclusively with you. The Plan provider or the law firm providing services under the Plan is responsible for all services provided by their attorneys. The Plan has no liability for the conduct of any attorney referred to you by the Plan.

If you have a complaint about the legal services you receive or the conduct of an attorney, call Hyatt Legal Plans at 1-800-821-6400. Your complaint will be reviewed and you will receive a response within two business days of your call.

G-7. If a Claim or Eligibility is Denied

MetLife Legal Plans verifies eligibility and coverage under the Plan. If you are found to be ineligible and you disagree with this determination, contact the Plan Administrator (see section H-3.2) within 30 days of your denial. You have a right to a full review, as described in Chapter H: "Administrative Information."

If you are denied coverage, you may appeal by sending a letter to: Director of Administration

MetLife Legal Plans, Inc.
1111 Superior Ave
Ste. 800
Cleveland, OH 44114

The director will send you a response within 30 days of receiving your letter. This response will include the reasons for the denial with reference to the specific Plan provisions on which the denial is based and a description of any additional information that might cause Hyatt to reconsider its decision. You should also receive an explanation of the review procedure.

- If you are still not satisfied, follow the appeals process described in Chapter H: "Administrative Information."

Chapter H: Paid Parental Leave

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H-2. How to Apply for the Parental Leave Benefit ____ 110

H-1. Paid Parental Leave Highlights

Benefit Description	Up to two weeks of parental leave will be paid at 100% of the eligible employee's average straight-time hourly rate on the last day worked exclusive of shift and overtime premium. The leave can be taken at one time or in full week increments for up to one year beginning on the date of birth or when adoptive parents gain custody of a child. Parental leave is considered part of family leave under the Family and Medical Leave (FMLA) and will run concurrently with FMLA. Full week increments are defined as 5 consecutive business days.
Eligibility	(1) Effective 1 October 2021, all employees who, while actively working and meeting eligibility requirements, have a child that was born or adopted on or after the effective date are eligible for paid parental leave under this article. If both parents are qualifying employees at the time of birth or adoption of the child, each parent is eligible for a two-week parental leave benefit, subject to submission and approval of the parental leave request. (2) The adopted child may not be the child of the employee's blood relative, spouse, domestic partner or a blood relative of the employee's spouse or domestic partner. The adopted child must be under the age of 18 at the time the adoption becomes final. Eligibility for adoptive parents starts at the time of custody even if the adoption is not legally completed but the adoptive process has begun. (3) Supplemental employees are not eligible for this parental leave.
Qualifying Event	Parental leave can be taken for up to one year (12 months) from date of birth or the date when the adoptive parents gain custody of the child. The birth or adoption of multiple children (example-twins, triplets, etc.) will be counted as one occurrence. The birth or adoption of multiple children within the same calendar year does not allow for an additional two weeks of parental leave benefit for each child in that calendar year.
Payment Calculation	The benefit is calculated using 100% of the eligible employee's average straight-time hourly rate on the last day worked exclusive of shift and overtime premium. Employees on parental leave will be paid through the normal payroll process.
Holidays	When a Company recognized holiday falls during an employee's parental leave, the employee is entitled to an equal number of additional days of parental leave.

H-2. How to Apply for the Parental Leave Benefit

- You must first notify their supervisor no later than 30 days prior or as soon as reasonably possible of intention to take time off work. No action for supervisor.
- You will then need to contact John Deere Disability and Leave Services, managed by Sedgwick, no later than 30 days prior or as soon as reasonably possible of intention to take time off work.
- Key points needed to qualify for parental leave:
    - Provide John Deere Disability and Leave Services with proof of birth or adoption placement (i.e. hospital certificate, crib card, birth certificate, adoption paperwork). The phone number is 855-232-0815.
    - Notify John Deere Disability and Leave Services of Parental Leave taken by first missed day. Must be done for each week taken.
    - Payments will not be made until you complete all steps.

  Note: It is acceptable for planned dates vs actual dates taken to vary depending on your personal experience.
- May not take time off until baby is born or gain custody of child through adoption process. Exception may occur if travel time is required for adoption.

Chapter I: Employee Purchase Plan and Discounts

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I-2. Employee Purchase and Supplier Discount Programs ____ 112

I-1. If You Want to Purchase John Deere Consumer Equipment

You may buy certain John Deere consumer equipment and receive a rebate on a portion of your purchase price.

Eligibility

Active employees, retirees, and surviving spouses of any U.S. or Canadian unit of Deere & Company (as well as any subsidiary or affiliate of the Company that has adopted the Plan), are eligible participants for this benefit.

What Products Are Eligible for a Rebate

You may receive a rebate on any John Deere consumer equipment listed on the John Deere Employee Purchase Plan Rebate Claim Form. These rules apply:

- Only new products purchased are eligible for rebates.
- Only products/model years listed on rebate form are eligible for rebates.
- The products must be purchased new from a John Deere dealer.
- Products must be for the purchaser's personal household use.
- Products must not be traded or resold within six months of purchase.

Purchases of these products are limited to two total products each calendar year:

- John Deere Residential Walk-Behind Mowers
- John Deere Riding Lawn Equipment (includes Compact Utility Tractors and Commercial Mowing Equipment)
- John Deere Gator Utility Vehicle

Products must be for the participant's personal household use. Purchases for commercial applications or for resale are excluded. Equipment purchased under this Plan cannot be purchased for or given to family, friends, neighbors, siblings, or any other individual who is not an authorized purchaser.

If any equipment is returned to the John Deere retailer/dealer or sold, for any reason, prior to the six months from date of purchase, the employee must return the rebate that was paid on that product.

How To Get the Rebate

To receive a rebate, you should make your best deal with a John Deere dealer, just as any other customer would do. Then, follow these steps to apply for your rebate:

- Obtain a John Deere Employee Purchase Plan Rebate Claim Form from Deere Direct or from the John Deere Online Employee Purchases and Supplier Discounts site. The dealer will not have claim forms.
- Complete the form and send it with the original invoice to the address on the form (within 90 days of the purchase or delivery date, whichever is later).
- Submit the qualified purchaser's original, paid-in-full receipt or bill of sale. It must include the name, city, and state of the selling dealer; the sale date; the purchaser's name and address; price paid; and a description of the product (including serial number).
- The eligible participant (employee, retiree, or surviving spouse), must submit each rebate request. Payment will be mailed to the eligible participant, included in the employees paycheck, or mailed to the retiree or surviving spouse.
- Plan questions should be directed to the following phone number: 1-888-432-3373

I-2. Employee Purchase and Supplier Discount Programs

- Vehicle Purchase Programs
  - General Motors, Ford, BMW
- Cell Phone Discounts
  - Verizon and AT&T
- Stihl Equipment Rebate Program
- Hotel Discount Programs
  - Doubletree, Hilton, IHG, Radisson
- Computers and Equipment Purchase Programs
  - Hewlitt Packard, Dell, and Microsoft Office
- Hertz Employee Discount Program
- Office Depot / Office Max Office Products
- Liberty Safe Rebate Program
- Mi-T-M Rebate Program

Chapter J: Administrative Information

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J-1. Administrative Information Highlights

Special Cases	Certain life events, such as retirement or disability, affect your Deere benefits.
Your Legal Rights	Although the Company is not required by law to provide any of the plans described in this book, federal law does regulate certain kinds of plans when they are offered. This section describes your legal rights under a federal law called the Employee Retirement Income Security Act of 1974 (ERISA).
An Important Note	This book summarizes the key features of benefit plans provided to certain wage employees of Deere & Company, who are represented by the International Union United Automobile, Aerospace and Agricultural Implement Workers of America ("U.A.W."). It is intended to provide easy- to-understand descriptions of important provisions, and to serve as Summary Plan Descriptions for these plans. This book is not the official Plan document for any of the plans.

J-2. Terms You Should Know

- Disability rate for COBRA – 150% of the full COBRA continuation rate.
- COBRA continuation rate – The full price of medical and dental coverage plus a 2% administrative fee.
- Total and permanent disability – A physical or mental condition caused by an illness or injury that leaves you unable to work for the Company. The condition can be work-related or not, as long as you have medical evidence satisfactory to the Company to support it.

J-3. Plan Administration

J-3.1. Employer Identification Number

The employer identification number assigned to Deere & Company by the Internal Revenue Service is 36-2382580.

J-3.2. Plan Administrator

The Plan Administrator has authority to control and manage the operation and administration of each of the plans and is the agent for service of legal process. If you have a claim, you may send it to the Plan Administrator. In the event legal actions commence, the Plan Administrator has been designated as the agent for service of legal process.

The Plan Administrator for TDSP is the 401(k) Benefits Committee:
Deere & Company
401(k) Benefits Committee
One John Deere Place
Moline, Illinois 61265
(309) 765-8000

The Plan Administrator for the John Deere Pension Plan for Wage Employees is the Pension Benefits Committee:
Deere & Company
Pension Benefits Committee
One John Deere Place
Moline, Illinois 61265
(309) 765-8000

The Plan Administrator for the remaining plans is:
Deere & Company
One John Deere Place
Moline, Illinois 61265
(309) 765-8000

UnitedHealthcare is the third-party administrator and claims administrator for the medical and dental plan options described in this summary plan description.
UnitedHealthcare
PO Box 740800
Atlanta, GA 30374-0800
1-888-JDEERE1 (1-888-533-3731)

Legal process may also be served on plan trustees, where applicable.

J-3.3. Plan Sponsor

The Plan Sponsor is Deere & Company.

J-3.4. Plan Documents

The Summary Plan Description summarizes the important features of your Deere & Company benefit program. In regard to ERISA plans (identified in the "Additional Administrative Facts" chart in section J-7.), complete details of each of the plans can be found in the official Plan Documents (and trust agreements or insurance contracts, where applicable), which govern the operation of the plans. All information contained in this book is subject to the provisions and terms of those documents.

In the event of a conflict between the language of the official Plan Documents, trust agreements, and/or insurance contracts, and the descriptions in this book, the language of official Plan Documents, trust agreements, and/or insurance contracts will control.

Copies of the official Plan Documents, as well as the latest annual reports of the plan's operations, are available for your review at any time during normal working hours. If you disagree with any of the Plan Administrator's interpretations regarding any benefit, you are urged to carefully review the official Plan Documents. Contact Deere Direct or Deere & Company Employee Benefits, One John Deere Place, Moline, Illinois 61265.

This benefits book is your Summary Plan Description of the plans.

J-3.5. Other Plan Information

Information regarding plans governed by ERISA, plan numbers, plan types, trustees, insurers, etc., can be found in the "Additional Administrative Facts" chart in section J-7. In the event of changes to this information, you will be notified within a reasonable period of time.

J-3.6 Claims Appeal Process

The Plan Administrator, or its delegate has the right to construe, interpret and apply all terms and provisions of the Plans and decide all questions arising under the Plans or in connection with the administration of the Plans. The Plan Administrator's decisions on such matters are final and conclusive.

If your request for benefits under an ERISA plan (plans identified in the Additional Administrative Facts chart) is denied in whole or in part, you are entitled to file a claim for benefits with the Plan Administrator or with the entity designated by the Plan Administrator. Your claim must be received within a certain time period, depending on the type of claim, after you receive notice of denial. Any ERISA plan claim you submit will be evaluated based on your circumstances as of the date your claim arose.

You must exhaust the appeal(s) process prior to bringing a civil action under ERISA Section

502(a). The Plan Administrator or its delegate has the sole and exclusive discretionary authority to interpret, construe, to finally determine appeals, and apply all terms and provisions of the Plan. All decisions by the Plan Administrator or its delegate are final and binding on all parties.

The steps in the claim process depend on the type of claim and are described below:

Group Health Plan Claims

If any claim for coverage or benefits under the Plan is wholly or partially denied, you will be given notice in writing of such denial within certain timeframes.

If you wish to appeal a denied pre-service request for benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination.

You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card
- the provider's name
- the date of medical service
- the reason you disagree with the denial
- any documentation or other written information to support your request

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare – Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for benefits that have been denied, you or your provider can call the Claims Administrator at the toll-free number on your ID card to request an appeal.

Timing of Appeals Determinations
Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for benefits: a request for benefits provided in connection with
- Urgent Care services, as defined in Definitions
- Pre-Service request for benefits: a request for benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided
- Post-Service: a claim for reimbursement of the cost of non-Urgent Care that has already been provided

Urgent Care Claims
You will be notified of the claim decision no later than 72 hours after receipt of the claim, if you provide sufficient information to determine whether and to what extent benefits are payable under the Plan. If additional information is needed to evaluate the claim, you will be notified within 24 hours after receipt of the claim regarding what information is needed to decide the claim. You will have a reasonable amount of time, but not less than 48 hours, to provide the specified information. After you provide the additional information, you will be notified of the claim decision within the earlier of (1) 48 hours of receipt of this additional information or (2) the end of the period to provide the specified information.

An "urgent care" claim is a claim for medical care or treatment that, if the longer time frames for non-urgent care determinations were applied, the delay could: (a) seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or (b) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.

Concurrent Care Claims
In the event that coverage is denied for a concurrent care claim (e.g., a denial of coverage involving a course of treatment before the end of such period of time or number of treatments), you will be notified of the denial in advance of the reduction or termination of coverage for ongoing treatment to allow you to appeal and obtain a response to that appeal before the benefit is reduced or terminated.

A "concurrent care" claim is a claim for ongoing treatment over a period of time or a number of treatments.

If a concurrent care claim is a claim involving urgent care, you will be notified of the claim decision as soon as possible taking into account the medical circumstances. You will be notified of the claim determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of treatment. If the claim is made less than 24 hours prior to the expiration of treatment, then the claim will be handled according to the urgent care claims procedures described above.

Pre-Service Claims
You will be notified of the claim decision within 15 calendar days after receipt of the claim.

If you or your authorized representative do not follow the Plan's procedures for filing a pre- service claim, you will be notified of the failure and the proper procedure(s) within 5 days following the failure.

In certain circumstances, the time period for making a claim decision may be extended. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the reasons for the extension. You will be notified of the additional information needed to decide the claim within 15 days. You will have 45 calendar days from receipt of the notice to provide the additional information. You will be notified of the decision within 15 calendar days after the earlier of (1) receipt of the additional information, or (2) the end of the 45 day period.

The time period for making a claim decision may also be extended one time for 15 calendar days due to circumstances beyond the control of the Plan Administrator or its delegate. You will be notified of the reasons for the extension.

A "pre-service" claim is a claim for a benefit for which prior authorization or approval is required by the Plan.

Post-Service Claims
You will be notified of the claim denial within 30 calendar days after receipt of the claim. In certain circumstances, the time period for making a claim decision may be extended. If additional information is needed to make a claim decision, you will be advised of the specific information within 30 calendar days of receipt of a post-service claim. You will have 45 calendar days from receipt of the written notice to provide the additional information. You will be notified of the decision within 30 calendar days after the earlier of (1) receipt of the additional information, or (2) the end of the 45 day period.

The time period for making a claim decision may also be extended one time for 15 calendar days due to circumstances beyond the control of the Plan Administrator or its delegate. You will be notified of the reasons for the extension.

A "post-service claim" is a claim for payment or reimbursement of health care services that have already been provided.

If a Claim is Denied
If a disability claim is denied, the Plan Administrator or its delegate will notify you of the claim denial no later than 45 days after receiving the claim. The 45-day period may be extended for up to 30 days if the Plan Administrator or its delegate (1) determines the extension is necessary because of matters beyond the Plan's control, and (2) notifies you, before the end of the 45-day period, why the extension is needed and the expected decision date.

If the Plan Administrator or its delegate determines, before the end of the 30-day extension, that due to matters beyond the Plan's control a decision cannot be made within the extension period, the Plan Administrator or its delegate may extend the determination period for up to an additional 30 days. However, the Plan Administrator or its delegate must notify you why the extension is necessary and what the expected decision date is before the end of the first 30-day extension period.

The extension notice will explain (1) the standards on which benefit entitlement is based; (2) the unresolved issues that prevent a claim decision; and (3) any additional information needed. You will have at least 45 days to provide any additional information needed.

If your claim is denied in whole or in part, you will be notified of the claim decision. This notification will be provided in a culturally and linguistically appropriate manner (including oral language services and upon request a notice in any applicable non-English language, and will include:

- The specific reason(s) for denial
- Reference to the specific Plan provisions on which the denial is based
- A description of any additional material and/or information necessary for you to perfect the claim and an explanation of why that information is necessary
- A description of the Plan's review procedures, the applicable time limits for such procedures, and your rights to bring a civil action under ERISA Section 502(a) following an appeal denial
- If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request; and
- Either the specific internal rules, guidelines, protocol standards or other similar criteria of the Plan relied upon in making the adverse determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
- A discussion of the decision including an explanation of the basis for disagreeing with or not following:
  - The views that you presented to the Plan presented by health care professionals treating you and vocational professionals who evaluated you,
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
  - A disability determination made on your behalf by the Social Security Administration, presented by you to the Plan.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals
You or your authorized representative may appeal a denied claim within 180 days after receipt of a claim denial notice.

During the 180-day period, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim, and you may request copies free of charge. You may submit written comments, documents, records, and other information relating to the claim to the Plan Administrator or its delegate.

Review of your appeal shall take into account all comments, documents, records, and other information, without regard to whether such information was submitted or considered in the initial claim decision. The review of your claim denial will not defer to the initial determination made by the Plan Administrator or its delegate. The individual who will review your appeal will be independent from the individual who reviewed your claim.

If your appeal involves a medical judgment, the Plan Administrator or its delegate will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be an individual who was neither consulted in connection with the claim decision nor the subordinate of any such individual.

Before an adverse determination on appeal is issued, the Plan Administrator or its delegate will provide you free of charge with any new or additional evidence considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you.

Before an adverse determination on appeal is issued based on a new or additional rationale, the Plan Administrator or its delegate will provide you free of charge with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you. If your appeal is denied, the Plan Administrator or its delegate will provide written notification of its decision to you. The Plan Administrator or its delegate will notify you within 45 days after the appeal is received by the Plan Administrator or its delegate (or within 90 days if the Plan Administrator or its delegate determines special circumstances require an extension of time for considering the appeal, and if written notice of such extension and circumstances is given to you within the initial 45 day period).

If your appeal is denied, you will receive a notification in a culturally and linguistically appropriate manner (including oral language services and upon request a notice in any applicable non-English language) that includes:

– The specific reason(s) for the decision

– Reference to the specific Plan provision(s) on which the decision i s based

– A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim

– A statement describing the Plan's voluntary appeal procedures, your right to obtain information about such procedures, and your right to bring a civil action under ERISA Section 502(a) and a description of any contractual limitations period applicable to your right to bring such action, including the calendar date on which such contractual limitations period expires for the claim

– If the adverse benefit determination was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms on the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request ; and

– Either the specific internal rules, guidelines, protocol standards or other similar criteria of the Plan relied upon in making the adverse determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

– A discussion of the decision including an explanation of the basis for disagreeing with or not following:

  • The views that you presented to the Plan presented by health care professionals treating you and vocational professionals who evaluated you,

  • The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and

  • A disability determination made on your behalf by the Social Security Administration, presented by you to the Plan.

Contractual Limitations Period

You must exhaust the Plan's administrative claims and appeals procedures before bringing suit in either state or federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination. Any claim or suit must be filed within 24 months after, the earliest of (1) the date the first benefit payment was made or due; (2) the date the Plan Administrator or its delegate first denied your request; or (3) the first date you knew or should have known the principal facts on which your claim or action is based; provided, however, that, if you commence the Plan's claims and appeals procedure before the expiration of the 24 month period, the period for commencing the claim or action in court expires on the later of the end of the 24 month period and the date that is three months after you have exhausted the Plan's claims and appeals procedures. If you raise a claim or commence on action after expiration of the 24 month period (or, if applicable, expiration of the three period following exhaustion of the Plan's claims and appeals procedures), the claim or action will be time-barred.

Expedited Appeal Procedure for Urgent Care Claims

In case of urgent care claims, you may make a written or oral request for expedited consideration of a formal appeal. You or your authorized representative will be notified, via telephone or facsimile, of the appeal decision within 72 hours after receipt of your appeal which includes all necessary information. You or your authorized representative will also receive written confirmation of the urgent care appeal decision within 3 calendar days after the decision is provided via telephone or facsimile. If additional information is needed to evaluate the appeal, you or your authorized representative will be notified within 24 hours of the expedited appeal request regarding what information is needed to decide the appeal. After the additional information is received, you will be notified of the appeal decision within the earlier of (1) forty-eight (48) hours of receipt of the specified information or (2) the end of the period to provide the specified information.

Appeal Procedure for Concurrent Care Claims

For concurrent care claims, you will be notified before the reduction or termination in benefits.

Appeal Procedures for Pre-Service and Post-Service Claims

For pre-service claims, you will be notified of the appeal decision within 15 calendar days after receipt of your appeal. In case of post-service claims, you will be notified of the appeal decision within 30 calendar days after receipt of your appeal.

In the event that you are not satisfied with the appeal decision for a pre-service or post- service medical or dental claim, you shall have the right to request a second level appeal within 60 days from receipt of the first level appeal decision. For pre-service claims, you will be notified of the appeal decision within 15 calendar days after receipt of your appeal. For post-service claims, you will be notified of the appeal decision within 30 calendar days after receipt of your appeal.

In the event that you have exhausted the two levels of appeal that apply for purposes of pre- service and post-service medical or dental claims and you are not satisfied with the final appeal determination, you have right to participate in a voluntary external review program. This program shall only apply if a claim denial is based on (a) clinical reasons or (b) the exclusions under the Plan and Plan documentation for experimental and investigation services or unproven services. The voluntary external review program shall not be available if a claim denial is based on explicit benefit exclusions or defined benefit limits.

Notice of Benefit Determination on Appeal

If your appeal is denied, you will receive a written or electronic notification that includes:

- The specific reason(s) for the adverse determination;
- The specific Plan provisions on which the determination is based;
- A statement regarding the documents to which you are entitled;
- An explanation of the Plan's voluntary appeal procedures, your right to obtain information about such procedures, and your right to bring a civil action under ERISA section 502(a);
- The specific internal rule, guideline, protocol or other similar criterion that was used in making the adverse determination regarding your appeal, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon and will be provided free of charge upon request; and
- If the appeal denial was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request;

Disability Claims

If a Disability Claim Is Denied

If a disability claim is denied, the Plan Administrator or its delegate will notify you of the claim denial no later than 45 days after receiving the claim. The 45-day period may be extended for up to 30 days if the Plan Administrator or its delegate (1) determines the extension is necessary because of matters beyond the Plan's control, and (2) notifies you, before the end of the 45-day period, why the extension is needed and the expected decision date.

If the Plan Administrator or its delegate determines, before the end of the 30-day extension, that due to matters beyond the Plan's control a decision cannot be made within the extension period, the Plan Administrator or its delegate may extend the determination period for up to an additional 30 days. However, the Plan Administrator or its delegate must notify you why the extension is necessary and what the expected decision date is before the end of the first 30-day extension period.

The extension notice will explain (1) the standards on which benefit entitlement is based; (2) the unresolved issues that prevent a claim decision; and (3) any additional information needed. You will have at least 45 days to provide any additional information needed.

If your claim is denied in whole or in part, you will be notified of the claim decision. This notification will be provided in a culturally and linguistically appropriate manner (including oral language services and upon request a notice in any applicable non-English language, and will include:

- The specific reason(s) for denial
- Reference to the specific Plan provisions on which the denial is based
- A description of any additional material and/or information necessary for you to perfect the claim and an explanation of why that information is necessary
- A description of the Plan's review procedures, the applicable time limits for such procedures, and your rights to bring a civil action under ERISA Section 502(a) following an appeal denial
- If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request; and
- Either the specific internal rules, guidelines, protocol standards or other similar criteria of the Plan relied upon in making the adverse determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
- A discussion of the decision including an explanation of the basis for disagreeing with or not following:
  - The views that you presented to the Plan presented by health care professionals treating you and vocational professionals who evaluated you,
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
  - A disability determination made on your behalf by the Social Security Administration, presented by you to the Plan.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals
You or your authorized representative may appeal a denied claim within 180 days after receipt of a claim denial notice.

During the 180-day period, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim, and you may request copies free of charge. You may submit written comments, documents, records, and other information relating to the claim to the Plan Administrator or its delegate.

Review of your appeal shall take into account all comments, documents, records, and other information, without regard to whether such information was submitted or considered in the initial claim decision. The review of your claim denial will not defer to the initial determination made by the Plan Administrator or its delegate. The individual who will review your appeal will be independent from the individual who reviewed your claim.

If your appeal involves a medical judgment, the Plan Administrator or its delegate will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be an individual who was neither consulted in connection with the claim decision nor the subordinate of any such individual.

Before an adverse determination on appeal is issued, the Plan Administrator or its delegate will provide you free of charge with any new or additional evidence considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you.

Before an adverse determination on appeal is issued based on a new or additional rationale, the Plan Administrator or its delegate will provide you free of charge with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you.

If your appeal is denied, the Plan Administrator or its delegate will provide written notification of its decision to you. The Plan Administrator or its delegate will notify you within 45 days after the appeal is received by the Plan Administrator or its delegate (or within 90 days if the Plan Administrator or its delegate determines special circumstances require an extension of time for considering the appeal, and if written notice of such extension and circumstances is given to you within the initial 45 day period).

If your appeal is denied, you will receive a notification in a culturally and linguistically appropriate manner (including oral language services and upon request a notice in any applicable non-English language) that includes:

- The specific reason(s) for the decision

- Reference to the specific Plan provision(s) on which the decision i s based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim
- A statement describing the Plan's voluntary appeal procedures, your right to obtain information about such procedures, and your right to bring a civil action under ERISA Section 502(a) and a description of any contractual limitations period applicable to your right to bring such action, including the calendar date on which such contractual limitations period expires for the claim
- If the adverse benefit determination was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms on the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request ; and
- Either the specific internal rules, guidelines, protocol standards or other similar criteria of the Plan relied upon in making the adverse determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
- A discussion of the decision including an explanation of the basis for disagreeing with or not following:
  - The views that you presented to the Plan presented by health care professionals treating you and vocational professionals who evaluated you,
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determi nation, and
  - A disability determination made on your behalf by the Social Security Administration, presented by you to the Plan.

External Review Process

Certain benefits are subject to an external review process by an Independent Review Organization. Any external review process is available to only to benefits options under the Plan that are not grandfathered. You will be notified in your appeal denial letter if your benefit is eligible for an external review and what the process is to apply for an external review. If you have questions about this process you can contact the claims administrator listed in section 1-7.

Contractual Limitations Period

You must exhaust the Plan's administrative claims and appeals procedures before bringing suit in either state or federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination. Any claim or suit must be filed within 24 months after, the earliest of (1) the date the first benefit payment was made or due; (2) the date the Plan Administrator or its delegate first denied your request; or (3) the first date you knew or should have known the principal facts on which your claim or action is based; provided, however, that, if you commence the Plan's claims and appeals procedure before the expiration of the 24 month period, the period for commencing the claim or action in court expires on the later of the end of the 24 month period and the date that is three months after you have exhausted the Plan's claims and appeals procedures. If you raise a claim or commence on action after expiration of the 24 month period (or, if applicable, expiration of the three period following exhaustion of the Plan's claims and appeals procedures), the claim or action will be time-barred.

Claims that are not group health or disability claims

Send your written claim for benefits, including the reason(s) you believe you are entitled to benefits, and any supporting documents to the Plan Administrator identified in this document at Deere & Company, One John Deere Place, Moline, Illinois 61265 (or at the address of any entity designated by the Plan Administrator).

The Plan Administrator may delegate authority to decide questions about eligibility and/or benefits to another entity. If any authority is delegated to another entity, you will be told whom it is.

You will receive written notification of the decision within 90 days after receipt of your claim.

The notice will explain:

- The reason(s) why your claim was granted or denied;
- The specific plan provisions on which the decision was based;
- Any additional material or information that is needed before a decision can be made and the reason(s) why the material or information is necessary; and
- The procedures for appealing the decision, including the time limits applicable to such procedures, and your right to bring a civil action under ERISA Section 502(a) following an appeal denial.

If the Plan Administrator or its delegate determine that special circumstances require more than 90 days for processing your claim, you will be notified of that fact in writing within the 90- day period. The notice you receive will explain the special circumstances that have made an extension necessary and will indicate a date by which the final decision is expected to be made. The extension may be for no more than an additional 90 days from the end of the initial 90-day period. If you receive no response of any kind within 90 days after filing a claim, you can assume your claim has been denied. You may then proceed as if you had received a notice denying your claim.

After receiving a notice denying your claim, you or your authorized representative may:

– Submit a written request to the Plan Administrator for a full and fair review of the denial of your claim. Review of your claim will take into account all comments, documents, records, and other information that you submit relating to your claim, without regard to whether this information was submitted or considered during your initial claim decision; and

– Request an opportunity to review all relevant documents relating to your claim; and

– Submit any issues, written comments, documents, or additional information as may be appropriate to your claim.

– Your request for an appeal of your claim denial must be received within 60 days after you receive notice of denial.

– Within 60 days after receipt of your request for a review, a decision on your appeal request will be made.

You will receive a written or electronic notification of the decision that includes: (1) the specific reason(s) for the decision and references to the plan provisions on which the decision was based; (2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and (3) a statement describing the Plan's voluntary appeal procedures, your right to obtain information about such procedures, and your right to bring an action under ERISA Section 502(a).

If the Plan Administrator or its delegate determine that special circumstances require a review period of longer than 60 days, the time for making a final decision may be extended. In this case, you will receive a written notice of extension prior to the end of the initial 60-day period; this notice will provide the special circumstances that require an extension and the date that the plan expects to render a decision. However, the total review period cannot be more than 120 days.

If you are not satisfied with the decision on rendered under H.3.6 and you elect to appeal the decision, follow the Appeal Board Procedure, described in section H-3.6.1.

J-3.6.1 – Appeal Board Procedure

If you are not satisfied with an adverse benefit determination under H.3.6 then you can consult your Union representative who can file an appeal in accordance with Appendix "1", Article VII, Section 2 of the Collective Bargaining Agreement.

J-3.7. Plan Amendment, Modification, Suspension, or Termination

Deere & Company reserves the right to suspend, amend, modify, or terminate the Plan(s) in any manner at any time and for any reason, including the right to modify or eliminate any cost-sharing between the company and participants, a former participant or other beneficiary.

Changes are made by action of the company's board of directors, or to the extent authorized by resolution of its board of directors, by the Deere & Company Compensation Committee.

The procedure for amendment or modification of the Plan, programs, or policies shall consist of the lawful adoption of a written amendment or modification to the Plan, programs, or policies by majority vote at a validly held meeting or by unanimous, written consent, followed by the filing of such duly adopted amendment or modification by the Secretary with the official records of the company. Participants will be notified in due course concerning substantial changes.

Benefits for claims occurring after the effective date of plan modification or termination are payable in accordance with the revised Plan Documents.

All statements in this book, the official Plan documents, and all representations by the company or its personnel are subject to this right of amendment, modification, suspension, or termination. These rights apply without limitation, even after an individual's circumstances have changed by retirement or otherwise.

Plan benefits do not become Vested except as provided under the Pension Plan and the Savings and Investment Plan, and then only to the extent specifically provided in the Plan documents for the Pension Plan and Tax Deferred Savings Plan.

In the event a Deere & Company plan is terminated, any assets held in trust for the plan will be used to provide benefits for employees of Deere & Company or a successor, or they may be used in other ways not prohibited by Internal Revenue Service regulations.

J-3.8. Coordination of Benefits

If you or a covered dependent is covered by more than one group medical or dental plan (your spouse's employer's plan, for example), Deere's Medical and Dental Plans have a coordination of benefits (COB) feature to prevent duplication of payments in these cases. This does not include coordination of benefits on drug expenses. The maximum the Deere plan pays for medical or dental benefits is the difference between the benefits paid by the other plan and the benefits that would have been paid under Deere's plan.

COB applies to you if you are covered by more than one health benefit plan, including any one of the following:

– another employer sponsored health benefits plan;

– a medical component of a group long-term care plan, such as skilled nursing care;

– no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;

– medical payment benefits under any premises liability or other types of liability coverage; or

– Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

– this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;

– when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;

– a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;

– if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay benefits first;

– your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:

  • the parents are married and not legally separated; or

  • a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

– if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:

  • the parent with custody of the child; then

  • the spouse of the parent with custody of the child; then

  • the parent not having custody of the child; then

  • the spouse of the parent not having custody of the child.

– plans for active employees pay before plans covering laid-off or retired employees;

– finally, if none of the above rules determines which plan is primary or secondary, the plan that has covered the individual claimant the longest will pay first. Only expenses normally paid by the Plan will be paid under COB.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

1. Let's say you and your spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an employee under this Plan, and as a dependent under your spouse's plan, this Plan will pay benefits for the Physician's office visit first.

2. Again, let's say you and your spouse both have family medical coverage through your respective employers. You take your dependent child to see a Physician. This Plan will look at your birthday and your spouse's birthday to determine which plan pays first. If you were born on June 11 and your spouse was born on May 30, your spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the primary plan's allowable expense.
- If this Plan would have paid less than the primary plan paid, the Plan pays up to the maximum benefits; but not more than your personal liability.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference; but not more than your personal liability.

The maximum combined payment you can receive from all plans may be less than 100% of total allowable expense.

Determining the Allowable Expense When This Plan is Secondary

When this Plan is secondary, the allowable expense is the primary plan's network rate. If the primary plan bases its reimbursement on Reasonable and Customary charges, the allowable expense is the primary plan's Reasonable and Customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plan's Reasonable and Customary charges.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan benefits, will not exceed 100% of the total allowable expenses.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Coverage pursuant to a Qualified Medical Child Support Order

If you become separated or divorced, a qualified medical child support order (QMCSO) may provide that one parent provide health benefit coverage, such as medical coverage, for your children.

Deere & Company follows certain procedures to determine if an medical child support order is "qualified." You may obtain a copy of these QMCSO procedures, free of charge by contacting the John Deere Benefit Center. If you have any questions or would like a copy of the written procedures used to determine whether a medical child support order is a QMCSO, please contact the John Deere Benefit Center.

J-3.9. Continuing Coverage Through COBRA

When benefits coverage ends, in some situations you can continue your medical and dental benefits at your own expense under provisions of a federal law—the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Under COBRA, each qualified Beneficiary who would lose coverage under the Plan due to a COBRA qualifying event may elect, within the applicable election period, to continue participation in the Plan benefits in which he or she participated in immediately before the COBRA qualifying event. You, your spouse, and your eligible dependent children could become qualified beneficiaries under the Plan if Plan coverage is lost due to a qualifying event.

If you or your eligible dependents have experienced a COBRA qualifying event, in order for you or your dependents to qualify for continuation of coverage under COBRA, you and/or your dependents must be covered by the Plan at the time of the qualifying event and notify the John Deere Benefit Center within 60 days after the later of: (1) the date the you would lose coverage due to the qualifying event; or (2) the date on which the Plan or its COBRA administrator provides you with a notice of your COBRA rights to continue Plan coverage.

COBRA Qualified Beneficiaries

For purposes of COBRA, a "qualified Beneficiary" is an individual who is covered under the Plan on the day before a COBRA qualifying event. COBRA qualified beneficiaries include an employee, retiree, spouse, and eligible dependent children. A dependent who is born to or placed for adoption with an employee during a period of COBRA continuation coverage is a qualified Beneficiary if timely notice of the dependent's birth or adoption is provided to the Plan.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their eligible children.

COBRA Qualifying Events and Duration of COBRA Coverage

Retiree

You may be able to continue coverage under COBRA if you lose your coverage under certain limited situations. You will be notified if one of these situations occur. The maximum COBRA continuation coverage period under these situations ends in the event of your death. The maximum COBRA continuation coverage period for a qualified beneficiary who is your Spouse, your surviving Spouse, or your eligible dependent children ends on the earlier of (1) the date of the qualified beneficiary's death; or (2) the date that is 36 months after your death.

Spouse and Eligible Dependents of Retiree.

Coverage for your spouse and eligible dependents can continue for up to 36 months if they lose coverage because of these COBRA qualifying events:

- You and your spouse are divorced or legally separated;
- Your dependent child is no longer eligible for coverage under the plan;
- You become entitled to Medicare; or
- You die.

No COBRA qualifying event can give rise to a maximum coverage period that ends more than 36 months after the date of the first COBRA qualifying event.

Notification Requirements for COBRA Continuation Coverage

The Plan will offer COBRA continuation coverage to a qualified Beneficiary only after the Plan Administrator or its delegate John Deere Benefit Center has been notified that a qualifying event has occurred.

For all qualifying events (such as death, divorce, legal separation, or your dependent child no longer satisfying the eligibility requirements for Plan coverage), you or a family member must contact John Deere Benefit Center as soon as possible and no later than 60 days after the later of: (1) the date of the qualifying event; or (2) the date when coverage would otherwise be lost under the Plan due to the qualifying event. If you or your family member does not notify John Deere Benefit Center of these qualifying events within the applicable 60 day period, then Deere & Company is not required to provide COBRA continuation coverage to a qualified Beneficiary.

Time Period for Electing COBRA Continuation Coverage

You have 60 days from the later of (1) the date that you would lose coverage under the Plan due to the qualifying event or (2) the date that notice is provided to you of your right to elect COBRA continuation coverage, to elect COBRA continuation coverage.

Paying for COBRA Continuation Coverage

COBRA allows you to continue the same medical and dental coverage you had before the qualifying event. However, premiums and continued contributions to the reimbursement account must be made with after-tax dollars.

If you elect to receive continued coverage under COBRA, you are required to pay the full continuation rate (102% of the cost for employees and dependents).

Any company-subsidized continuation offered automatically will count toward the 36-month periods.

The first payment for COBRA continuation coverage is due within 45 days after you elect COBRA continuation coverage. After that, payments are due by the first day of each calendar month of participation, with a 30-day grace period.

When COBRA Continuation Coverage Ends

Continued coverage under COBRA will end on the earliest of the following:

- The last day of the maximum COBRA continuation coverage period described above (for example: 36 months);
- The first day that premiums for continued coverage are not paid on time;

- The first date, after the date of election of COBRA continuation coverage, that the qualified Beneficiary is first covered under any other group Health Plan, provided it does not contain any exclusion or limitation with respect to a pre-existing condition of the qualified Beneficiary;
- The date, after the date of election of COBRA continuation coverage, that the qualified Beneficiary is enrolled in Medicare; or
- The date that Deere stops providing any group medical and dental coverage.

If you have questions regarding your Plan or your COBRA continuation coverage rights, please contact the John Deere Benefit Center.

Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator and the John Deere Benefit Center informed of any changes in the addresses of your family members. Also, for your records, please keep a copy of any notices that you send to the Plan Administrator or the John Deere Benefit Center.

Extension of Coverage Pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you are an employee and you are absent from employment for more than 30 days by reason of service in the uniformed services, you may elect to continue Plan coverage for yourself and your dependents pursuant to USERRA.

For purposes of this section of the Summary Plan Description, the terms "uniformed services" or "military service" mean: the Armed Forces; the Army National Guard and the Air National Guard when engaged in active duty for training; inactive duty training; full-time National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President in time of war or national emergency. You may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date that your absence from work begins due to service in the uniformed services or military service; or
- the period beginning on the date that your absence from work begins due to service in the uniformed services or military service and ending on the day after the date on which you fail to apply for, or return to, a position of employment as required by USERRA.

If you are qualified to continue Plan coverage under the provisions of USERRA, you may elect to continue coverage under the Plan by notifying Deere & Company in advance, and providing payment of any required contribution for the health coverage under the Plan.

If your period of military service is less than 31 days, you may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage under the Plan. If your period of military service is 31 days or more, you must pay the entire cost of health coverage under the Plan, not to exceed 102% of the applicable premium amount for such coverage.

If you return to a position of employment, your health coverage and that of your eligible dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on you or your eligible dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Notwithstanding anything herein to the contrary, if an employee dies on or after 1 January 2007, while in the Uniformed Services of the United States and while entitled to reemployment rights under the Uniformed Services Employment & Reemployment Rights Act of 1994 ("USERRA"), his or her beneficiaries are entitled to any additional benefits provided under the Plan as if the participant had resumed employment on the day before the date of death and then terminated employment on account of death.

J-3.10. The Women's Health and Cancer Rights Act of 1998 (WHCRA)

Mandates group health plans cover the following procedures in connection with a mastectomy, and provided in a manner determined in consultation with the attending physician and the insured.

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

J-3.11. Purchasing Individual Coverage

Once coverage under the Medical or Group Life/AD&D insurance Plans ends, you and your eligible dependents may be able to convert these coverages to individual policies. To convert medical coverage, you and/or your dependents must not be eligible for any other group medical plan, Medicare (except Michigan), or any other national health care program. Information about converting coverage is available from the John Deere Benefits Center.

J-3.12. Right of Recovery

If for any reason a benefit is paid that is larger than the amount allowed by any of the Deere benefit plans, or if a benefit is paid by mistake, the plans have a right to recover the mistaken payment received or the excess amount from the person, agency, or participant who received it.

Healthcare Claim Recovery Process for Overpayments

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which the Claims Administrator makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Payment of Benefits

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a non-Network provider without the Claims Administrator's consent. When you assign your Benefits under the Plan to a non-Network provider with the Claims Administrator's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When the Claims Administrator has not consented to an assignment, the Claims Administrator will send the reimbursement directly to you for you to reimburse the non-Network provider upon receipt of their bill. However, the Claims Administrator reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, the Claims Administrator may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will the Claims Administrator pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by the Claims Administrator to an assignment or to waive the consent requirement. When the Claims Administrator in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although the Claims Administrator may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which the Claims Administrator makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

J-3.13. Subrogation

Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for medical care or dental care benefits that the Plan has paid. Subrogation applies when the Plan has paid medical care or dental care benefits for a sickness or injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100% of any services and medical care or dental care benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to fully return to the Plan 100% of any medical care or dental care benefits you received for that sickness or injury.

Third Parties

The following persons and entities are considered third parties:

– a person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages;

– any person or entity who is or may be obligated to provide you with benefits or payments under:

  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a covered person under the Plan, you agree to the following:

– the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.

– the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

– the Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).

– you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:

  - complying with the terms of these provisions;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;
  - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
  - obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

– if you receive payment as part of a settlement or judgment from any third party as a result of a sickness or injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the medical care or dental care benefits the Plan has paid.

– if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.

– you may not accept any settlement that does not fully reimburse the Plan, without its written approval.

– you will assign to the Plan all rights of recovery against third parties to the extent of medical care or dental care benefits the Plan has provided for a sickness or injury caused by a third party.

– the Plan's rights will not be reduced due to your own negligence.

– the Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.

- the provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by a third party.
- in case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your medical or dental care benefits, deny future medical care or dental care benefits, take legal action against you, and/or set off from any future medical care or dental care benefits the value of medical care or dental care benefits the Plan has paid relating to any sickness or injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- if a third party causes you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.

A Subrogation Example
Suppose you are injured in a car accident that is not your fault, and you receive medical care or dental care benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

J-3.14. Confidentiality of Health Benefit Records

Information from necessary medical records and information from Physicians and hospitals incident to the Physician/patient relationship or hospital/patient relationship shall be confidential and not disclosed without the prior written consent of the patient.

However, Deere & Company or its authorized agents may release medical records of employees, retirees, and their dependents for use incident to:

1. The processing of claims for payment;
2. Peer review, utilization review, claims appeal, medical audit, or any other program for quality health care and control of health care costs; or
3. Bona fide medical research and education.

J-3.15. Pension Benefit Statement

You have the right to ask for and receive an annual statement of your pension benefit. This statement must tell you whether or not you have a right to receive a pension benefit at normal retirement age (age 65). If you do have the right to a benefit, the statement must tell you what your benefit would be at age 65 if you stop working under the Plan now.

If you don't have a right to a pension, the statement will tell you how many more years you must work to earn the right to a pension.

Log onto UPoint® at www.yourbenefitsresources.com/deere, or call the John Deere Pension Benefits Center at 1-844-689-7833 to receive your pension benefit statement. The Plan is only required to provide the statement once a year.

J-4. Your Rights Under ERISA

As a participant in most Deere benefit plans described in this book, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). Benefits not listed in the "Additional Administrative Facts" chart, such as the, John Deere Employee Purchase Plan for John Deere and Frontier Consumer Equipment, and Tuition Assistance Program, are not subject to ERISA requirements.

Receive Information About Your Plan and Benefits

Participants of those plans covered by ERISA are entitled to:

- Examine, without charge at the Plan Administrator's office and/or at the Human Resources Department, all official Plan documents (including insurance contracts) and copies of all documents filed for the plan with the U.S. Department of Labor, such as detailed Summary Annual Reports and Summary Plan Descriptions, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all official Plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for the copies.
- Receive a summary of the plans' annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. Your 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.

Your rights also include the reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group Health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group Health Plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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. You also have the right to expect fiduciaries—the people who operate your plan and who are responsible for the management of the plans—to act prudently and to act in the interest of you and other plan participants and beneficiaries.

Another one of your ERISA-guaranteed rights means that no one—including Deere & Company or any other person—may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a ERISA plan 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 example, if you request materials such as a copy of the plan documents or the latest annual report from an ERISA-covered plan and do not receive them within 30 days, you can 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.

Also, you can file suit in a state or federal court if you have a claim for benefits which is denied or ignored, in whole or in part. 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.

You can also seek assistance from the U.S. Department of Labor or file suit in a federal court if a plan fiduciary has misused plan funds or if you are discriminated against for asserting your rights.

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— because, for example, the court finds your claim is frivolous—you may be ordered to pay all these costs and fees on your own, including any court costs and attorney fees.

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.

J-5. Health Care Plan Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The group Health Plan is required by law to maintain the privacy of "protected health information."

"Protected health information" includes any identifiable information that we obtain from you or others that relate to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures the group Health Plan will make of your protected health information.

The group Health Plan reserves the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice by contacting Deere Direct at 888-432-3373.

Permitted Uses And Disclosures

The group Health Plan can use or disclose your protected health information for purposes of treatment, payment, and health care operations.

"Treatment" means the provision, coordination or management of your health care, including referrals for health care from one health care Provider to another. For example, a Provider under the group Health Plan may need to know health care information in plan files that might assist in treatment.

"Payment" means activities to obtain and provide reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, the information on or accompanying health care bills sent to the plan may include information that identifies you, as well as your diagnosis procedures, and supplies used.

As another example, prior to providing health care services, the group health may need information from a Provider about your medical condition to determine whether the proposed course of treatment will be covered. When the plan receives a bill from the Provider, the group health can obtain information regarding your care if necessary to provide payment.

"Health care operations" means the support functions related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, Physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of Providers used in our plan. We may also combine medical information about many patients to decide how to better provide needed benefits under the plan.

The group Health Plan reserves the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice by contacting Deere Direct at 888-432-3373.

Other Uses And Disclosures Of Protected Health Information

The group Health Plan may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

The group Health Plan may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care.

The group Health Plan will only disclose the protected health information directly relevant to their involvement in your care or payment. The group Health Plan may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition, or death. If you are available, the group Health Plan will give you an opportunity to object to these disclosures, and the plan will not make these disclosures if you object. If you are not available, the group Health Plan will determine whether a disclosure to your family or friends is in your best interest, and the plan will disclose only the protected health information that is directly relevant to their involvement in your care. When permitted by law, the group Health Plan may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

Except for the situations set forth below, the group Health Plan will not use or disclose your protected health information for any other purpose unless you provide written authorization.

You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that the group Health Plan already has taken action in reliance on your authorization.

Exceptional Situations

We may use or disclose your protected health information in the following situations without your authorization:

– Health Oversight Activities – We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

- Law Enforcement – We may release medical information in these situations: If asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstance to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime.
- Lawsuits and Disputes – If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Military and Veterans – If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- National Security and Intelligence Activities – We may release medical information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law.
- Public Health Risks – We may disclose medical information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of product, recalls, repairs or replacements; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this decision if you agree or when required or authorized by law.
- Serious Threats – As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- Workers' Compensation – We may release medical information about you for programs that provide benefits for work-related injuries or illness.

YOUR RIGHTS

- You have the right to request restrictions of the group Health Plan's uses and disclosure of protected health information for treatment, payment and health care operations. However, the group Health Plan is not required to agree to your request.
- You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.
- Subject to payment of a reasonable copying charge (if you cannot afford to pay for copies, you will not be denied access), you have the right to inspect and copy the protected health information contained in the plan's records, except for psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed.
- You have the right to receive an accounting of disclosure of protected health information made by the plan to individuals or entities other than you, except for disclosures to carry out treatment, payment and health care operations as provided above; to persons involved in your care or for other notification purposes as provided by law; for national security or intelligence purposes as provided by law; to correctional institutions or law enforcement officials as provided by law; or that occurred prior to 14 April 2003.
- You have the right to request and receive a paper copy of this notice from us.

FILING A COMPLAINT

If you believe that your privacy rights have been violated, you should immediately contact our privacy officer by contacting Deere Direct. The group Health Plan will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact Deere Direct 888-432-3373.

J-6. Situations That Can Affect Your Benefits

Deere & Company's employee benefits are intended to provide you with certain levels of financial security while you are working and after you retire from the company. However, there are situations that could affect your benefits under these plans:

- Benefits are not payable for situations that occur before your coverage begins or after your coverage ends.
- For some benefit plans, you (or your survivor) must apply for benefits or file a claim. Benefits generally cannot be paid until you apply or make a claim for payment.
- You should keep your most current address on file so that the company can locate you (or your survivors) and provide you with all of your benefit payment and any related benefit plan information. If you are actively working or on long-term disability, you should contact Deere Direct to change your address. Retirees and surviving spouses should contact the John Deere Benefit Center to change their address.
- If you (or your surviving spouse) are unable to care for your own financial affairs, any payments due may be paid to someone who is authorized to conduct your financial affairs. This may be a relative, a court-appointed guardian, or some other person.

The information in this chart is for the benefit plans that are governed by ERISA.

The Plan Administrator for the above plans is Deere & Company, One John Deere Place, Moline, IL 61265, (309) 765-8000

J-7. Additional Administrative Facts

The information in this chart is for the benefit plans that are governed by ERISA.

Plan Name	Plan Number	Plan Type	Insurer/Trustee	Source of Contributions	Plan Year
John Deere Health Benefit Plan for Wage Employees	502	Health Care	Deere & Company One John Deere Place Moline, IL 61265	Company pays benefits on a self-insured basis.	1 November through 31 October
John Deere Group Life and Disability Insurance Plan for Wage Employees	504	Life Insurance/ AD&D	Life Insurance Company of North America, 1601 Chestnut Street, Philadelphia, PA 19192	The Company makes payments to a life insurance company; payments are based on the number and ages of people insured and on benefits paid during the latest record-keeping period.	1 November through 31 October
Disability Benefit Plan for Wage Employees	506	Disability	Sentry Select Insurance Company P.O. Box 8024, Steven Point, WI 54481	The Company makes payments to a life insurance company.	1 November through 31 October
John Deere Health Benefit Plan for Retired Union Employees	551	Health Care	The Bank of New York Mellon 135 Santilli Highway, Everett, MA 02149	Company makes contributions to a trust fund; payments are determined by actuaries in amounts judged sufficient to meet expected benefit obligations of the Plan.	1 November through 31 October
John Deere Pension Plan for Wage Employees	002	Defined Benefit	The Bank of New York Mellon 135 Santilli Highway, Everett, MA 02149	Company makes contributions to a trust fund; payments are determined by actuaries in amounts judged sufficient to meet expected benefit obligations of the Plan.	1 November through 31 October
John Deere Tax Deferred Savings Plan	008	Defined Contribution	Fidelity Management Trust Company 82 Devonshire Street, ZR1 Boston, MA 02109	Employee	1 November through 31 October

- The Plan Administrator for TDSP is the 401(k) Benefits Committee, Deere & Company, One John Deere Place, Moline, Illinois 61265, (309) 765-8000
- The Plan Administrator for the John Deere Pension Plan for Wage Employees is the Pension Benefits Committee, Deere & Company, One John Deere Place, Moline, Illinois 61265, (309) 765-8000
- The Plan Administrator for the remaining plans is Deere & Company, One John Deere Place, Moline, IL 61265, (309) 765-8000.

Wage Employees Represented by UAW

October 2021