Summary Plan Description

JOHN DEERE

John Deere Summary Plan Description for Pre-Flex Salaried Employees

Effective 1 January 2016

DKD 1477 (2016-05)

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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The sections of this document titled, "Overview", "Who Is This Document For", "Savings And Investment Plan – Traditional Option" and "My Resources: Contact List, Administrative Information, Plan Administration, Rights & Privacy Notice – Your Rights Under Erisa" constitutes part of a plan prospectus covering securities that have been registered under the securities act of 1933 as amended.

Overview

Introduction

This document constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933 for the John Deere Savings and Investment Plan.

This document highlights and summarizes Deere & Company's benefit plans. It covers health care, disability income, survivor protection, and retirement benefits. It is your Summary Plan Description and not the official Plan Document for the ERISA Plans listed in Additional Administrative Facts. Complete plan details are contained in the official Plan Documents. If any information described in this document is different from the Plan Document, the language in the official Plan Document governs.

One or more of the benefits described in this summary may apply to you. As a retiree you could have:

- health care, disability, life insurance, and a pension;
- health care, disability, life insurance, and no pension;
- health care, life insurance, and a pension; or
- health care and life insurance only.

As a surviving spouse you could have:

- health care, monthly survivor benefits, and a pension;
- health care, monthly survivor benefits, and no pension;
- health care and a pension;
- monthly survivor benefits only; or
- only a pension.

Deere Direct

During 1997, Deere Direct began servicing many of our human resource processes. This has enabled the company to focus this expertise in one location to better service your needs. 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 Deere Direct. This service is available to you at (800) 213-3373 | Email: DeereDirect@JohnDeere.com | Fax: (309) 748-0625 .

Situations that can Affect your Benefits

The intent of these benefits is providing you with a certain level of financial security.. However, there are situations that could affect your benefits under these plans.

- 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 payments and any related Plan information. Make sure you contact Deere Direct if your address changes.
- If you (or your surviving spouse), are unable to care for your 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.
- Life insurance benefits are designed to provide financial security for your loved ones. Make sure these benefits will go to the person(s) of your choosing. To review your Beneficiary designation on file with the company, call Deere Direct.

Who Is This Document For?

You may be covered by or eligible for the benefits described in this document if you are a former Pre-Flex salaried employee of Deere & Company.

Section A: Survivor Protection Benefits

These benefits provide financial protection and security for your survivors, including:

– Life Insurance – money for your designated Beneficiary in the event you die; and

– Monthly Survivor Benefit – monthly payments to your surviving spouse, children or parents in certain instances.

A-1. Benefit Information

At the time of your retirement, the in-force amount of your life insurance was indicated on the pension election forms. Additionally, the figures provided the minimum amount that would always be in force. If you require any information regarding the amount of life insurance in force, please contact Deere Direct at (800) 213-3373 | Email: DeereDirect@JohnDeere.com | Fax: (309) 748-0625.

A-2. Your Beneficiary

In the past, you identified someone to receive your life insurance amount when you die. This "Beneficiary Designation" is currently on file with your wishes. To verify or change your Beneficiary designation, please contact Deere Direct at (800) 213-3373 | Email: DeereDirect@JohnDeere.com | Fax: (309) 748-0625.

Section B: Health Care

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. Some of your options are designed to encourage you to receive quality, cost-effective care.

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 section. Your medical plan options will be communicated in your annual enrollment materials or you can contact Deere Direct at (800) 213-3373 | Email: DeereDirect@JohnDeere.com | Fax: (309) 748-0625.
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.
Maximum Benefits	There is currently no lifetime maximum benefit from the Plan. However, specific coverage limits do apply for some services, such as vision and hearing care, the treatment of Mental or Nervous Disorders and Substance Abuse. Effective 1 January 2010, the coverage limits for mental health, nervous disorders and Substance Abuse no longer apply.
Hospital Services	To receive your maximum Plan benefits under the Managed Care Option (MCO) option, you will need to use a MCO network participating hospital. Plan benefits also will be paid for emergency treatment at hospitals or other facilities that are outside the MCO network.
Emergency Room Care	If you have a Medical Emergency, you should seek care immediately. Generally, a Medical Emergency means the sudden and unexpected onset of conditions that could reasonably be expected by a prudent layperson to result in serious jeopardy to the mental or physical health of the individual and for which the member seeks medical care immediately after the onset or as soon as the healthcare can be made available. Visits to the emergency room should not be used as a substitute for care you could receive from your primary care Physician during office hours. If you have an emergency, you should seek treatment immediately from an emergency facility and notify your primary care Physician as soon as possible.
Paying for Coverage	Deere pays the cost of coverage for eligible and allowable expenses after any applicable Deductible, Coinsurance, Copayment has been satisfied. Please see the Healthcare Benefit Summaries included in this Summary Plan Description for additional information on any applicable Deductible, Coinsurance, or Copayment.
Filing a Claim	When you use a Participating Provider, no claim form is needed. In general, you will need to submit a claim from Non- Participating Providers. These usually are required for the Traditional medical plan and dental benefit claims.
Participating Providers	As provided in the Glossary of this Summary Plan Description, Participating Providers are Physicians, hospitals, pharmacies, and other health care Providers who participate in the TPA/MCO's network(s). You may request a listing of Participating Providers in your area to be provided automatically to you, free of charge, by contacting the phone number on the back of your benefit card. In addition, a listing of Participating Providers is available on the medical option's website.

B-2. Eligibility and Enrollment

B-2.1. Eligibility – For You

If you were a salaried employee of Deere & Company retired prior to 1 July 1993, 1 January 1994 for John Deere Credit and John Deere Health Care, or 1 January 1995 for John Deere Insurance Group, and retired from one of the U.S. operations, you are eligible to enroll for health care benefits.

B-2.2. Eligibility – For Your Dependents

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

– Your Spouse

1. if he or she is a Preflex salaried retiree or
2. if he or she is a Flex employee or retiree who is not enrolled and receiving benefits from another company sponsored medical or dental plan or
3. if he or she is not subject to the provisions of a company bargained agreement unless provided for under the bargained agreement

– Your unmarried children who are under age 19 and who are younger than you. Your "unmarried children" is limited to natural born and legally adopted children, stepchildren, and children for whom legal adoption proceedings have been initiated. Unmarried children shall also include 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.

– Also these dependents must qualify, during the period in which they are enrolled, for dependency tax status under the Internal Revenue Code in the current year or have been reported as a dependent on your most recent federal tax return. Coverage for full-time students can be extended four months beyond the date they stop attending school, as long as they otherwise continue to meet the eligibility and dependency requirements.

– Your unmarried children, ages 19 through 24 who are younger than you, who are dependent on you for more than one-half of their support (as defined by the Internal Revenue Code), who are full time students, as defined by the accredited education institutions attended or if they 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 under the Internal Revenue Code in the current year or have been reported on your most recent federal tax return.

  • "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.

– If your unmarried child is covered under the Plan as a "full-time student" and he takes a medically necessary leave of absence from a postsecondary educational institution or changes his enrollment at such an institution (such as a change to part-time student status), then such a child's coverage under the Plan shall not terminate due to the loss of "full-time student" status due to such medically necessary leave of absence. Coverage under the Plan shall continue until the earlier of: (1) the date that is one year after the first day of the medically necessary leave of absence; or (2) the date that coverage would otherwise end under the Plan's terms. During the medically necessary leave of absence, a dependent child, whose Plan coverage and benefits are continued, will be entitled to the same Plan benefits as if such child was still considered a "full-time student" at a postsecondary educational institution and was not on a medically necessary leave of absence. In order to continue Plan coverage as described above, the child's treating Physician must provide written certification to the Plan that (a) the child is suffering from a serious illness or injury; and (b) the leave of absence or change in enrollment is medically necessary.

– For purposes of this Summary Plan Description section, a "medically necessary leave of absence" includes a leave of absence from a postsecondary educational institution or any other change in enrollment (such as to part-time student status), at such an institution that: (a) begins while the child is suffering from a serious illness or injury; (b) is medically necessary; and (c) causes the child to lose "full-time student" status for purposes of Plan coverage.

Your children are not eligible dependents if they are eligible for coverage as employees of Deere & Company or its subsidiaries, or if they are covered by and are receiving benefits through a Flex salaried employee or a Flex salaried retiree (after the dates shown above), of the company. Proof of your child's eligibility may be requested from time to time.

B-2.2.1. 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. Also, these dependents must qualify for dependency status in the current year or have been reported on your most recent federal tax return. 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 **Deere Direct**.

B-2.3. Enrolling

To enroll in health care benefits, contact Deere Direct.

HIPAA Special Enrollment for New Dependents

If you are a retiree enrolled in coverage under the plan, 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. The special enrollment request must be permitted for at least 31 days starting with the date of the event giving rise to the new dependent. 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. To request special enrollment or obtain more information, contact Deere Direct.

B-2.4. When Coverage Begins

Here's when health care coverage begins for you and your dependents:

– For annual enrollments – every January 1.

Special notes

Special notes: Hospitalization 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).

B-2.5. When There is Another Medical or Dental Plan

You or a covered dependent may be covered by more than one group medical or dental plan; for example, under your Spouse's employer's plan. Deere's Medical Plan has a coordination of benefits (COB) feature to prevent duplication of payments in these cases. See **Section G: "Administrative Information"** for details.

B-2.6. When Coverage Ends

Your coverage under Deere benefits stops when you no longer meet the eligibility requirements described in **Section B-2.1**. Your dependents' coverage ends when they no longer meet the definition of a dependent, as described in **Section B-2.2**.

Important information about how benefits can be continued in special cases is found in **Section G: "Administrative Information."**

B-3. Expenses Covered by All Medical Options

The Medical Plan pays benefits for a wide variety of medical services and supplies. The expenses listed below are covered (with some exclusions as noted), 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-3.1. Hospital Charges

The Medical Plan pays benefits for Allowed Charges you incur as an inpatient and as an outpatient in a hospital or other covered health care facility. A hospital is a licensed facility that charges for its services and:Primarily provides medical care and treatment of the sick and injured;

– 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;

– Provides 24-hour nursing service by registered nurses (R.N.s); and

– Is an institution that qualifies as a hospital, a psychiatric hospital, or a tuberculosis hospital, and a Provider of services under Medicare.

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 Plan covers room and board charges up to the hospital's semi-private room rate. If semi-private rooms are not available, the Plan pays benefits on the hospital's most frequent semi-private 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. Successive hospital stays for the same or a related cause will be considered one period of disability.

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 a 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 and her newborn child 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 to prescribe a length of stay not in excess of 48 hours (or 96 hours).

University of Iowa Health Care and Mayo Clinic's Campus in Minnesota Benefits

Special benefits may apply if you are referred to the University of Iowa Hospitals and clinics or the Mayo Clinic at Rochester, Minnesota on an outpatient basis. The Plan pays benefits for certain procedures and tests performed at these hospitals and for associated room and meal expenses (up to defined limits).

- Benefits for meal expenses up to four (4) meals a day (considering one (1) light snack), for the patient (maximum reimbursement of $40 per day).
- Total room and board charges are limited to the most frequent single room and board rate charged by Rochester or Iowa City area hospitals (maximum reimbursement of $150 per day).

Managed Care Plan Option – To receive reimbursement for meals and lodging, third party administrator (TPA)/MCO's Care Coordination must have approved the service/procedure at Rochester or Iowa City. If the service/procedure was not approved by TPA/MCO's Care Coordination, you will not receive reimbursement for meals and lodging.

Traditional Plan Option – To receive reimbursement for meals and lodging, your Physician must authorize the services at Rochester or Iowa City. A letter from your Physician authorizing the services must accompany your reimbursement request.

B-3.2. 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.

- Hospital care and treatment such as blood transfusions, blood plasma and serums, and X-rays.
- 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. Benefits will not be paid for preadmission tests if you or your dependent cancels the hospital admission.

B-3.3. Hospital Pre-certification

All of the medical options have features designed to help you manage the cost of your care. When you receive services from Participating Providers, cost management procedures happen automatically. If you're in the Traditional option or you're using the point of service feature, non-emergency hospital admissions require pre-certification for you and your covered dependents. With the Traditional option or out-of-area care, you should call the phone number on your 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 pre-certify a hospital stay, you, a family member, your doctor, or the hospital must call the toll-free number on your benefit card and talk to one of the trained pre-certification specialists.

Concurrent Review

Once you're in the hospital, your stay will be monitored to make sure the length of your confinement is appropriate based on your medical condition. If your hospital stay extends beyond the approved number of days, the medical need for additional days will be evaluated by your Provider and Health Plan carrier (and approved, if appropriate).

Individual Case Management Program
If you or a covered dependent becomes ill with an extended or complex illness, the TPA/MCO's Case Management may present alternatives to long-term hospital stays (such as home health care, confined in an extended care facility or treatment plans for pain management), that will be beneficial to you.

In an effort to ensure the quality of health care you receive, your Health Plan carrier has various medical review committees to evaluate and assess the quality of health care delivered by Providers under all medical options.

As a result, claims data may be audited and reviewed to identify the appropriateness of care or services provided, explore potentially harmful patterns of health care utilization, or, as the case may be, over utilization of health care services.

Examples of potential quality of care problems may be suggested by:

– Excessive doctor visits or multiple Physicians directing your care.

– Frequent emergency room visits.

– Over utilization of prescription drugs or use of multiple contradicting drugs.

In the event the care you receive is reviewed, you may be contacted to provide further information.

Potential outcomes may also include:

– A determination that the care given you is appropriate and medically necessary.

– A Provider(s) may be contacted to demonstrate or assure care or services provided to you are appropriate and medically necessary.

– In an extreme case, you may have Restricted Access to medical Providers, pharmacies and other Providers of health services on a temporary basis, pending an on-going review of your utilization pattern.

B-3.4. Organ/Tissue Transplant Services

The Medical Plan requires the use of a network of facilities for all transplant services covered by the plan. "Centers of Excellence" are networks of facilities available for transplant services.

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.

B-3.4.1. Transplant Donors

The Medical Plan provides coverage for services in conjunction with organ donation. Allowed Charges include hospital, surgical, and Physician services required. Coverage is provided for all Plan members who donate, regardless of whether or not the recipient is a member of a Deere medical plan or an employee, former employee, or retiree of the company. In many instances the recipient's health insurance coverage will cover the donor's expenses. The Medical Plan will coordinate payment with the recipient's carrier.

B-3.5. Extended Care Services

Skilled care in a qualified extended care facility, such as a nursing home, may be covered by the Plan. Allowed Charges include semi-private 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);

– Is not (other than incidentally), a place of rest; a home for the aged, the blind or deaf; or a home for alcoholics, drug addicts, the mentally ill, or tuberculosis patients; 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.

B-3.5.1. 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 Plan, or if:

– The stay is primarily for Custodial Care;

– The stay is due to pregnancy, childbirth, or miscarriage (unless the confinement is for you or your Spouse);

– Recovery from a Mental or Nervous Disorder is not considered likely; or

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

B-3.6. Home Health Care

All home health requests must be initiated by a Physician and pre-authorized by your Health Plan carrier.

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-3.6.1. 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 Plan

– Private-duty or shift coverage

– Custodial Care

– Charges for help by family members or residents of the home

– Charges for social work

B-3.7. Surgery Charges

Charges for covered surgical procedures performed either in or out of the hospital are covered by the Plan. 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.

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.

B-3.8. Maternity Charges

Maternity expenses and expenses for obstetrical procedures incurred by retirees or their covered Spouses are covered by the Plan. Maternity benefits are not provided for dependents or sponsored dependents. 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.

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 a 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 and her newborn child 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 to prescribe a length of stay not in excess of 48 hours (or 96 hours).

B-3.9. 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
- Surgical procedures – to include post-operative hospital and office visits – or to assist in surgery (when medically necessary).
- Emergency treatment – services provided during a Medical Emergency or immediately following an accident.
- Allergy tests – needed to identify allergic reactions, also charges for injections.
- A second or third opinion – after a surgeon has recommended major elective (non-emergency), surgery. **(A consulting Physician must be Board qualified or a Board Certified member of the surgical specialty required.) Major elective surgeries include procedures such as:**

  - Adenoidectomy and/or tonsillectomy
  - Hysterectomy
  - Cholecystectomy
  - Inguinal hernia repair
  - Laminectomy
  - Coronary artery bypass surgery
  - Hemorrhoidectomy
  - Bunionectomy
  - Knee surgery
  - Mastectomy
  - Varicose vein ligation and/or stripping
  - Myringotomy with insertion of drainage tubes
  - Submucous resection
  - Thyroidectomy
  - Cataract removal
  - Colonoscopy
  - 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.

QUESTIONS FOR YOUR DOCTOR

Becoming a well-informed health care consumer is important in today's environment of high medical costs and highly sophisticated methods of treatment. Here are some questions you can ask to feel more comfortable about treatment:

- Why is hospitalization being recommended?
- Is surgery my only option? Do I have other treatment options?
- What are the advantages and disadvantages to the treatment you're recommending?
- What are the risks?
- How long will I be in the hospital?
- How long will it take me to recover?
- How much are the Physician fees?
- How much will the Hospital cost?

B-3.10. 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:

– Examinations to determine pregnancy under the Traditional option.

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

– Tests covered by other Plan provisions.

B-3.11. Physical/Speech/Occupational Therapy

Benefits are payable for physical, occupational, and 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 your Health Plan. (The company will not cover or approve therapy in a facility owned by the treating or referring Physician where there is an opportunity for conflict of interest.)

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).

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 Therapy

Benefits are payable for cardiac rehabilitation therapy for up to 36 combined outpatient treatment days per calendar year.

Cardiac rehabilitation is a customized program of exercise and education. The goals of cardiac rehabilitation are to help the patient regain strength, to prevent his condition from worsening and to reduce his risk of future heart problems.

Cardiac rehabilitation must be prescribed by a Physician and performed by a licensed therapist. Treatment must be given in the outpatient facility of a hospital or qualified extended care facility, or in another facility approved by your Health Plan. The company will not cover or approve therapy in a facility owned by the treating or referring Physician where there is an opportunity for conflict of interest.

B-3.12. Radiation Therapy and Chemotherapy

Radiation therapy and chemotherapy expenses, including Physician charges, include:

– Treatment by X-Ray, radon, radium or radioactive isotopes (like cobalt), is covered when performed by a Physician in the outpatient department of a hospital; and

– Chemotherapy treatment.

B-3.13. 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 approved by the TPA/MCO.

Prosthetic devices are covered only to the extent that the device restores the basic function lost as a result of disease or accidental injury. Any enhancements above what are medically necessary to restore basic function will not be covered.

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.

At the TPA/MCO's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the covered person's medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

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

B-3.14. Durable Medical Equipment Rental

Rental of durable medical equipment, prescribed by a Physician for medical treatment or physical mobility and approved by the TPA/MCO, 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, and be appropriate for treatment at home. 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.

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.

– Augmentative communication devices.

– Orthotic appliances and devices, except when all of the following are met:

  • Prescribed by a Physician for a medical purpose; and

  • Custom manufactured or custom fitted to an individual covered person

– Other devices that do not serve a meaningful and necessary therapeutic purpose.

– Personal comfort and convenience items, unless medically necessary.

At the TPA/MCO's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the covered person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at anytime and are not subject to the three year timeline for replacement.

Durable medical equipment is not covered while confined to a hospital or qualified extended care facility. Not all durable medical equipment is covered, even if ordered by a Physician and/or Medically Necessary.

B-3.15. 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 and approved by the Health Plan.

B-3.16. 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. Effective 1 January 2010, the coverage limits (for example, day or visit limits per calendar year), for mental health, nervous disorders and Substance Abuse no longer apply.

Q: What is "Triage" and why is it important?

A: Triage is a process (similar to hospital pre- certification), you follow to access mental health and Substance Abuse care. You work with a professional consultant to identify the right source for the health care services you or a family member needs. You must call a triage clinician to receive benefits.

B-3.16.1 Inpatient Care

Inpatient mental health care for a hospital stay or for an approved stay in a residential Substance Abuse facility is covered for up to 45 days per calendar year. Separate 45-day limits apply to mental health services and to Substance Abuse services. Effective 1 January 2010, the coverage limits for mental health, nervous disorders and Substance Abuse no longer apply.

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-3.16.2. Mental Health Outpatient Care

The Plan pays benefits to a psychiatrist, psychologist or other approved Providers identified through the triage process for up to 20 outpatient visits per calendar year. Psychological testing is covered when conducted by a psychologist. Effective 1 January 2010, the coverage limits for mental health, nervous disorders and Substance Abuse no longer apply.

A psychiatrist is a Physician who is qualified and licensed to practice medicine and surgery and who is certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology; or who has completed an approved residency training program in psychiatry.

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-3.16.3. Outpatient Substance Abuse Care

The Plan pays benefits for up to 35 outpatient visits per calendar year to an outpatient Substance Abuse facility, approved by the Health Plan, that provides detoxification and rehabilitation services. Benefits are limited to 140 visits per lifetime under the MCO option; 105 visits per lifetime under the Traditional option. Effective 1 January 2010, the coverage limits for mental health, nervous disorders and Substance Abuse no longer apply.

To qualify for benefits, a Physician must examine the patient and diagnose the condition as Substance Abuse (alcoholism or drug dependency), as defined in the glossary. Also, treatment must be coordinated and supervised by a Physician.

B-3.16.4. Mental Health Expenses Not Covered

The Plan does not pay mental health benefits for services not authorized by your Health Plan. Examples of mental health expenses that are not covered include, but are not limited to:

– Expenses for services not recommended by a Physician.

– Expenses for services provided by someone who is not a psychiatrist or a psychologist, unless approved under a specific medical plan option.

– Expenses for services that are not diagnostic in nature.

– Expenses for services that consist of practices not generally accepted by the health care profession.

– Expenses for services related primarily to treatment of a disorder for diseases that do not constitute a Mental or Nervous Disorder under the plan.

B-3.16.5. Substance Abuse Care Not Covered

The Plan does not cover Substance Abuse expenses not authorized by your Health Plan. Examples of Substance Abuse expenses that are not covered include, but are not limited to:

– Expenses for diversional activities, such as sports, hobbies, or crafts.

– Expenses for dispensing of methadone and the taking of urine samples without having the patient undergo psychological testing, counseling, or therapy.

– Expenses for services related primarily to the treatment of disorders or diseases that do not constitute Substance Abuse under the plan.

B-3.17. Prescription Drug Benefits

The Plan pays prescription drug benefits according to this schedule:

– In most cases, you pay $2 per prescription for up to a 34-day supply, when you use a participating pharmacy.

– You pay $5 per prescription for up to a 34-day supply when you use a participating pharmacy, if the drug is available from multiple sources and a brand name drug is dispensed, when a generic is available.

– Under the Traditional option, you pay $2 or $5 per prescription **plus 25%** of the amount over $2 or $5 (for up to a 34-day supply), if you use a non- participating pharmacy when a participating pharmacy is available. **No benefit is paid under the MCO option if you use a non-participating pharmacy**.

– You can fill up to a 100-day supply for listed drugs, as described below, and defined in the Glossary.

– You can fill prescriptions through the mail order program; your benefits are the same as indicated above.

B-3.17.1. Participating and Nonparticipating Pharmacies

Participating pharmacies have agreed to provide their services at a contracted rate. Because this agreement saves the company money, to receive maximum benefits use a participating, or network pharmacy. For a list of participating pharmacies call the number on the back of your benefit card.

B-3.17.2. 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.

– "Listed drugs" – certain prescribed medications which you take on a continuing basis over a long period, available in 90 to 100 day supply.

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

Tip: Generics Cost Less
Generic Drugs are made from the same basic formulation as brand names, but they cost less than brand names. Ask your doctor or pharmacist if a generic can be substituted for its brand name equivalent.

B-3.17.3. Prescription Expenses Not Covered

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

- Drugs available over the counter, unless prescription, specifically approved for inclusion by the third party administrator (TPA)/MCO Formulary committee.
- Drugs that are entirely consumed at the time and place of prescribing.
- Replacement of lost, stolen, damaged or discarded drugs.
- Drugs prescribed for cosmetic purposes.
- Charges for the administration of prescription drugs.
- Contraceptive medication, even if it is a prescription drug and is used for purposes other than birth control.
- 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 (90 or 100-day supply for approved listed 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, drugs labeled "Limited by Federal Law to Investigational Use", and drugs used for any treatment that hasn't been approved by the U.S. Food and Drug Administration.
- FDA-approved drugs in experimental or non-FDA approved dosage forms, or for non-approved or experimental indications, unless use is a commonly accepted standard of care as indicated by the following official compendia: United Pharmacopeia Dispensing Information or American Hospital Formulary Service Drug Information.
- 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 dispensed by a facility other than a licensed pharmacy.
- Drugs that are fraudulently obtained or demonstrate abuse.

B-3.17.4. Using Your Prescription Drug Benefit

For most prescriptions you fill, you can receive up to a 34-day supply per prescription. For approved listed drugs, you can receive up to a 90 or 100-day supply. Here's how you get prescription drug benefits:

- At participating pharmacies – When you fill a prescription, present your benefit card, and you will be charged the $2 or $5 per prescription. No claim forms are needed. This includes a national network of pharmacies. For a list of participating pharmacies call the number on the back of your benefit card.
- At nonparticipating pharmacies in participating areas (Traditional option only) – You must pay the full cost of your prescription, then submit a completed claim form to the Health Plan. You will be reimbursed up to the benefit level paid by the Plan.
- Mail order program – You receive the same benefits payable at participating pharmacies, with the added convenience of mail order service.

B-3.18. Vision Care

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 managed vision plan.

When you receive vision services and supplies from managed vision network Providers, your out-of-pocket costs may be less.

B-3.18.1. If You Don't Use The Managed Vision Provider

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.

– Charges to prepare corrective lenses – up to two lenses per prescription.

– Charges for frames – if corrective lenses are prescribed.

– Regardless of age, one frame in any period of 24-consecutive months.

B-3.18.2. If You Use The Managed Vision Provider

To be eligible, vision services and supplies must be received from a participating managed vision network Provider. Here's how the plan works:

– Call the phone number on the back of your benefit card for a list of Participating Providers in your area.

– Schedule an appointment for an exam with a Participating Provider.

– 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 managed vision network Provider when you receive services. No claim forms are needed.

B-3.18.3. 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.

Other Vision Benefits

Vision care provided by an ophthalmologist (other than routine exams and the prescription of corrective glasses or lenses), is considered a covered medical expense and is not subject to the limitations for vision care described under each Plan option.

B-3.19. Hearing Care

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 advance 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.

– Hearing Aid Specialist/Dispenser – A person with state certification to test and fit hearing aids.

B-3.19.1. 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 one 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-3.19.2. 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.

– Services that are not necessary, according to professionally accepted standards, that are not recommended or approved by the ear doctor.

– Services where 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).

– Services that are payable by any health care program supported by 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-3.20. 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-3.20.1. 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.

B-3.20.2. Basic Expenses

Covered basic services for each person include:

– Fillings – amalgams of silver or gold, composites or resins: to restore tooth structure and prevent further decay..

– Extractions.

– Gum and mouth treatments – including surgery for the treatment of gum and mouth diseases. Also includes scaling and maintenance – one time per quadrant per consecutive 12 months following definitive periodontal treatment. Thereafter, benefits for periodontal maintenance or cleaning will be paid four times the first consecutive 12 months and then two times annually thereafter.

– Onlays, Crowns or veneers – porcelain, metal, or gold; used to restore the structure of teeth and prevent further decay. Except, that payments for benefits on porcelain Crowns and repairs of such Crowns on tooth numbers 1, 2, 15, 16, 17, 18, 19, 30, 31, and 32 will be based on the non-porcelain benefit structure.

– 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-3.20.3. Major Services

Covered major services for each covered person include:

– Fixed Bridgework – to install Fixed Bridgework, including inlays and Crowns to form abutments. Crown and bridgework replacement is payable after 60 consecutive months.

– 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-3.20.4. How Dental Benefits Are Paid – A Quick Glance

Dental Service	Benefit Description The Plan Pays*:	Up to These Maximums	Some Examples
Preventive	100%		Exams, Cleanings
Basic	100%	$1,200 per person annually**	Fillings, X-rays, Crowns, Extractions, Oral Surgery
Major	50%		Dentures, Bridgework
Orthodontia	50%	$1,300 per person lifetime maximum	Orthodontia

*For allowed charges only **Oral Surgery, and some other codes, not subject to annual maximum.

B-3.20.5. 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 $200 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 TPA/MCO Customer Support Department. 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**.

Q: How do I predetermine my dental treatments?

A: 1. Ask your Dentist to complete a dental claim form, mark that it's a predetermination, and send it to the TPA/MCO Customer Support Department..

2. The claims administrator will review the information and let you and your Dentist know how much the Plan will pay, and whether there are less costly alternatives.

3. You and your Dentist then discuss the alternatives and decide on treatment.

Any dental expenses not paid by the Plan are your responsibility.

Q: What is an "allowed dental charge"?

A: Allowed dental charges are determined in the following ways:

1. If TPA/MCO and the Provider have agreed to a contracted rate, the Plan pays benefits on that amount.
2. The Plan pays benefits up to the Reasonable and Customary level (see glossary for a definition).
3. Sometimes a Reasonable and Customary level is not available. In these cases, the Plan pays benefits on the billed charges – the total amount (of covered expenses), billed by the Provider.

For more information on Allowed Charges, see the definition in glossary.

B-3.20.6. 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.

Most claims can be submitted electronically. Your Dentist can contact the TPA/MCO for more information.

All dental claims must be submitted within one year of the date of service. Otherwise, they are not eligible for reimbursement under the Plan.

B-3.20.7. 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 **Section G: "Administrative Information"**.

B-4. Health Care Expenses Not Covered

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

B-4.1. Medical Expenses Not Covered

– Claims submitted more than one year after the date of service.

– Expenses above the Allowed Charge.

– 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 services including 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 as well as mandated coverage for breast reconstruction under the Women's Health & Cancer Rights Act of 1998.

– Charges for drugs, medicines, or other devices used in conjunction with birth control, regardless of intended use.

– Charges for services, treatment, technology, prescription drugs, or supplies that are not medically necessary (see medically necessary in the Glossary).

– 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 Medical Plan option).

– Charges that you (or Deere & Company) 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, special diets and drugs used to treat obesity.

– Biofeedback treatment and relaxation therapy.

– Nonprescription vitamins, nutritional supplements, special formula for infants, children or adults, and special diets.

– Any treatment or procedures related to the performance of gender transformation, complications from such treatment or to gender identity disorders.

– Exercise equipment or devices.

– Special shoes unless attached to a brace, corset, other article of clothing, or cosmetic device.

– Court ordered services unless the court order qualifies as a qualified medical child-support order and the ordered services are covered by the Plan.

– Infertility services or treatment (and complications from these treatments), including but not limited to artificial insemination, in vitro fertilization, GIFT, or other artificial fertilization techniques.

– Reversal of voluntary sterilizations (and complications from this procedure).

– Charges for the treatment of temporomandibular joint dysfunction (TMJ).

– Charges for surgery to the cornea to improve vision by changing the refraction (e.g., radial keratotomy, LASIK), and complications arising from these treatments.

– Services for mental retardation or non-treatable mental deficiency and for mental disorders that are not likely to improve through accepted psychiatric practice.

– Services for learning problems, family or marital counseling, and antisocial behaviors or aggressive or nonaggressive conduct disorders (unless there is an associated psychiatric 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.

– Charge incurred for drugs, counseling or behavior modification guidance related to smoking cessation.

– Charges for any dental service provided by a Dentist or services provided by an oral surgeon, unless due to emergency or accident.

– Charges for transportation other than covered ambulance services and as specified under organ transplant.

– Charges associated with autologous blood transfusions.

– Custodial Care.

– Experimental/investigational care.

– Excluded Providers.

– Charges for vocational, educational, or recreational therapy and vocational rehabilitation.

– Charges for acupuncture.

– Charges for services or supplies that any school system is legally required to provide.

– Charges for services that are provided without charge under any Federal, state or local law.

– Charges for services that are reimbursed as a result of legal action or settlement.

– Charges incurred prior to coverage under the Plan.

– Charges incurred after termination from the Plan.

– Charges for therapy, supplies or counseling for sexual dysfunction.

– Charges for education, special education or job training.

– Charges for shift care, 24-hour nursing, and private duty nursing.

– Charges for the purchase, rental or operation of personal computers.

– Charges for missed appointments.

– Charges for services, treatment, technology, prescription drugs, or supplies that are not Reasonable and Customary as determined by the Plan.

– Charges or any complications arising from any procedure or services not specifically covered under the Plan.

– Inpatient, intermediate or outpatient care services that were not pre-authorized by the Mental Health/Substance Use Disorder (MH/SUD) Administrator.

– Services performed in connection with conditions not classified in the current edition of the **Diagnostic and Statistical Manual of the American Psychiatric Association**.

– Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.

– Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that , in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: (1) not consistent with generally accepted standards of medical practice for the treatment of such conditions; (2) not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; (3) typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; (4) not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or (5) not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

– The Mental Health/Substance Use Disorder Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

– Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal), and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the MH/SUD Administrator.

– Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

– Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.

– Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders.

– Routine use of psychological testing without specific authorization; and

– Pastoral counseling.

B-4.2. Dental Expenses Not Covered

Some services and supplies are not covered by the Dental Plan. Excluded expenses are:

– Services in excess of Allowed Charges.

– Services or treatments that are not deemed professionally necessary to correct the dental condition.

– 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, and charges for cosmetic treatment of stains resulting from coffee or cigarette stains, or of stains after orthodontic treatment of mal-shaped or mal-positioned teeth.

– 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 it 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 you or your dependent's immediate family.

– Charges for which benefits are paid by the Medical Plan.

– Replacement of a lost, missing, or stolen prosthetic device or orthodontic appliance.

– 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.

– Porcelain on posterior teeth.

– Analgesia/anesthesia which does not render the patient unconscious in connection with covered oral surgery.

– Surgical augmentation for orthodontics of the maxilla (upper jaw) or mandible (lower jaw).

– Orthognathic surgery, which refers to any surgical procedure performed to correct skeletal malposition on misalignment of the maxilla and/or mandible, including ostetomy or condylotomy.

– Charges for any services that are not specified as covered under this Plan.

B-4.3. 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 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-4.4. Experimental/Investigational Care

Charges in connection with certain experimental or investigational drugs, devices, medical treatment, or procedures, and for complications arising from these procedures are not covered by the Plan.

A drug, device, medical treatment, or procedure is experimental or investigational 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 or investigational); 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.

B-4.5. Excluded Providers

Deere Health Plan carriers may, at their 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.

Plan #0223 | UHC Choice Plus 100/80% PreFlex | 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 copayments, prescription drugs, vision, hearing, and charges in excess of reasonable & customary*	None	$1,000 per individual and $2,000 per family per calendar year
Physician Services - General		
Office Visits	*100% of allowed covered charge*	*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*	*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		
Allergy Testing	*100% of allowed covered charge*	*80% of allowed covered charge**
Allergy Injections	*100% of allowed covered charge*	*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*
Hospital Services		
Inpatient Care	*100% of allowed covered charge*	*80% of allowed covered charge**
Outpatient Care	*100% of allowed covered charge* *(Pre-notification required)*	*80% of allowed covered charge** *(Pre-notification required)*
Emergency Room	*100% of allowed covered charge for initial medical care*	
Emergency Ambulance	*100% of allowed covered charge to nearest facility*	
Skilled Care	*100% of allowed covered charge* *(Pre-notification required)*	*80% of allowed covered charge** *(Pre-notification required)*
Home Health Care	*100% of allowed covered charge* *(Pre-notification required)*	*Not covered*
Hospice	*100% of allowed covered charge* *(Pre-notification required)*	*Not covered*
Durable Medical Equipment	*100% of allowed covered charge*	*Not covered*
Prosthetic Devices	*100% of allowed covered charge*	*Not covered*
Physical/Occupational/Speech 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)*
Cardiac/Pulmonary Therapy	*100% of allowed covered charge* *(Maximum 60 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*

*Deductible applies. Allowed charge means, in order, contracted rates, reasonable and customary charges and billed charges.

Plan #0223 | UHC Choice Plus 100/80% PreFlex | 1-888-JDEERE1 (continued)

Benefit	In-Network	Out-of-Network
Mental Health Services *Office Visit* *Inpatient Care* *Outpatient Care*	*100% of allowed covered charge* *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** *(Must triage through United Behavioral Health)*
Substance Abuse Services *Office Visit* *Inpatient Care* *Outpatient Care*	*100% of allowed covered charge* *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** *(Must triage through United Behavioral Health)*
Chiropractic Services	*100% of allowed covered charge for x-ray and laboratory* *80% after $100 deductible for office visit and manipulation* *Modalities are not covered* *(Out-of-Network deductible does not apply)*	
Prescription Drugs *34-day supply/100-day supply for listed maintenance drugs*	*Variable copayment based on whether the prescription drug is generic or brand-name, with a maximum of $5.00. Outside the area, a national network of pharmacies is available.*	*Not applicable*
Hearing (Benefit payable once every 36 months) *Exam* *Hearing Aids*	*100% of allowed covered charge - $70 benefit maximum* *100% of allowed covered charge - $640 ($320 per ear) benefit maximum*	
Hearing Aid Mgmt Svcs (HAMS) Network (where available) *Exam* *Hearing Aids* *(Contact UHC for a list of providers)*	*100% of allowed covered charge* *100% of allowed covered charge for pre-determined hearing aids*	
Vision Care *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* *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* *Exam, lenses and frame – one per 24 months – combined in- and out-of-network*	Non-Participating UHC Vision Provider *$43.70 maximum reimbursement* *$35.00 maximum reimbursement per pair* *$52.50 maximum reimbursement per pair* *$70.00 maximum reimbursement per pair* *$87.40 maximum reimbursement per pair* *$52.50 maximum reimbursement per pair* *$24.80 maximum reimbursement* *Exam, lenses and frame – once per 24 months – combined in- and out-of-network*
Dental Services	*Services provided through UnitedHealthcare*	
Coordination of Benefits	*Standard Coordination (Come Out Whole)*	

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*Deductible applies. Allowed charge means, in order, contracted rates, reasonable and customary charges and billed charges.

Plan #0224 | UHC Traditional (Preflex) | 1-888-JDEERE1

Benefit	
Annual Deductible	$100 per individual and $300 per family per calendar year under Major Medical portion of plan*
Maximum Out-of-Pocket Expense	None
Physician Services - General *Office Visits* *Hospital Visits* *Surgical Procedures* • *Office* • *Outpatient* • *Inpatient* *Maternity Care* *Allergy Testing* *Allergy Injections*	 *80% 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* *(For employee and spouse only) (Dependents are not eligible)* *100% of allowed covered charge* *100% of allowed covered charge*
Physician Services - Preventative *Routine Physicals* *Mammograms* *Pap Tests* *Well-Child Care* *Immunizations*	 *Not covered* *100% of allowed covered charge* *100% of allowed covered charge* *Not covered* *Not covered*
Hospital Services *Inpatient Care* *Outpatient Care*	 *100% of allowed covered charge* *100% of allowed covered charge* *(Pre-notification required)*
Emergency Room	*100% of allowed covered charge for initial medical care*
Emergency Ambulance	*100% of allowed covered charge to nearest facility*
Skilled Care	*100% of allowed covered charge* *(Pre-notification required)*
Home Health Care	*100% of allowed covered charge* *(Pre-notification required)*
Hospice	*100% of allowed covered charge* *(Pre-notification 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 treatment days per calendar year – combined Physical/Occupational Therapy)*
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)*

*Deductible applies. Allowed charge means, in order, contracted rates, reasonable and customary charges and billed charges.

Plan #0224 | UHC Traditional (Preflex) | 1-888-JDEERE1 (continued)

Benefit		
Mental Health Services *Office Visit* *Inpatient Care* *Outpatient Care*	 *80% of allowed covered charge** *100% of allowed covered charge* *100% of allowed covered charge* *(Must triage through United Behavioral Health)*	
Substance Abuse Services *Office Visit* *Inpatient Care* *Outpatient Care*	 *80% of allowed covered charge* *100% of allowed covered charge** *100% of allowed covered charge** *(Must triage through United Behavioral Health)*	
Chiropractic Services *Imaging and Lab* *Office Visit and Manipulation*	 *100% of allowed covered charge for x-ray and laboratory* *80% of allowed covered charge** *(Modalities are not covered)*	
Prescription Drugs *34-day supply/100-day supply for listed maintenance drugs*	*Variable copayment based on whether the prescription drug is generic or brand-name, with a maximum of $5.00. Outside the area, a national network of pharmacies is available.*	
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 Services *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* *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* *Exam, lenses and frame – one per 24 months – combined in- and out-of-network*	**Non-Participating UHC Vision Provider** *$43.70 maximum reimbursement* *$35.00 maximum reimbursement per pair* *$52.50 maximum reimbursement per pair* *$70.00 maximum reimbursement per pair* *$87.40 maximum reimbursement per pair* *$52.50 maximum reimbursement per pair* *$24.80 maximum reimbursement* *Exam, lenses and frame – once per 24 months – combined in- and out-of-network*
Dental Services	*Benefits provided through UnitedHealthcare*	
Coordination of Benefits	*Standard Coordination (Come Out Whole)*	

Deere & Company reserves the right to suspend, amend, modify, or terminate the Plan(s) in any manner at any time, including the right to modify or eliminate any cost-sharing between the company and participants. Changes, which can be made at any time, are made by action of the company's board of directors, or to the extent authorized by resolution of its board of directors, or by the Deere & Company Compensation Committee. In the event of a conflict between the language of the official Plan Documents and this document, the language of the official Plan Documents will control.

*Deductible applies. Allowed charge means, in order, contracted rates, reasonable and customary charges and billed charges.

JOHN DEERE EMPLOYEE BENEFITS – 2016 HEALTHCARE BENEFIT SUMMARY

Plan #2185 | UHC Dental - LowMax | 1-888-JDEERE1

Benefit	
Annual Deductible	*Not applicable*
Calendar Year Maximum	*$1,200 per individual*
Orthodontic Lifetime Maximum	*$1,300 per individual*
Preventive and Diagnostic	
Examination & routine cleanings	*100% of allowed covered charge. Two per calendar year.*
X-rays	*100% of allowed covered charge. Bitewings twice per calendar year. Panoramic/full mouth every 36 months.*
Sealants	*Not covered*
Fluoride treatment	*100% of allowed covered charge.*
	All subject to 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	*100% of allowed covered charge*
• *four times first year*	
• *two times annually, thereafter if needed in place of prophylaxis*	
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*
	All subject to calendar year maximum.
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*
	All subject to calendar year maximum.

Plan #2185 | UHC Dental - LowMax | 1-888-JDEERE1 (continued)

Benefit	
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*
	All subject to orthodontics lifetime maximum.
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*

Exclusions (Partial List)

Consultations (other than for orthodontics)

Implants

Bleaching

Replacement in less than 5 years of prosthetic devices including bridgework, partials, full dentures, etc.

Charges for infection control

Temporary partials

Porcelain on posterior teeth

TMJ splinting or appliances

Oral hygiene instruction

Drugs and medicines

Cosmetic procedures

Charges made by a dental laboratory

Replacement of lost or broken prosthetic or orthodontic device

Emergency exams except as the result of an accident

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B-5. Medicare

B-5.1. A Word About Medicare

Once you or your Spouse turns age 65, you will be eligible for Medicare in addition to benefits from our Medical Plan. (You or your Spouse also may be eligible for Medicare before age 65 as a result of a disability.) Benefits will be paid under Deere's Plan for charges that are not payable by Medicare but would have been payable under the Plan in the absence of Medicare. In addition, Deere pays your Medicare Deductibles and Coinsurance.

As a retiree eligible for Medicare, Deere 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. You will be required to enroll in Medicare Part A and Part B. In these plans, you will receive a single integrated Explanation of Benefit (EOB) for medical benefits and a separate EOB for prescription drug.

If you fail to enroll in Medicare, or you enroll in either a non-Deere sponsored Part C Plan (including a Medicare Cost Plan), or Part D plan, you will be excluded from the Deere sponsored Part C and/or Part D Plan and the company will coordinate benefits with Medicare. Here's how:

- Your Benefits under Deere's Medical plan become secondary to Medicare, even if you do not enroll in Medicare coverage. Generally, for each claim you submit, the TPA/MCO calculates the amount our plan would pay alone. Next, the amount Medicare pays is subtracted from Deere's benefit payment.
- Deere's Medical Plan pays the difference between Deere's benefit and the Medicare benefit.
- For more specific information, see the coordination of benefits rules in Plan
- Administration, Coordination of Benefits.
- If you are Medicare eligible and eligible for benefits under a John Deere Plan, for example End Stage Renal Disease or disability, but not enrolled in, Medicare; Deere's Medical Plan is secondary to Medicare and benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

If you elect to be removed from the Deere sponsored Part C or Part D plan and do not meet the conditions above for coordination with Medicare, you will be dis-enrolled from Deere's healthcare, vision, hearing and dental coverage. You can resume your healthcare coverage with Deere by calling Deere Direct.

There may be situations where you're eligible for Medicare coverage, but your Spouse or dependents are not. In these cases, Deere's Plan would be primary for your Spouse or dependents until they also become eligible for Medicare. For example, if you reach age 65 but your covered Spouse is 63, you would receive benefits through the Part C and Part D plan while the company would continue to pay your Spouse's non-Medicare benefits primary .

B-5.5.1. 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).

You will want to be sure to enroll in Medicare Part B to have this coverage. The Deere Medical Plan does not pay for benefits that would have been covered under Medicare Part B if you fail to enroll. Also, if you fail to enroll when first eligible at 65 or earlier or when you are disabled, you will pay more for Medicare Part B coverage when you enroll later.

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-5.1.2. Claiming Medicare Benefits

In most cases, your Physician will submit Medicare claims on your behalf. However, in some instances, you may be required to submit claims directly to Medicare. When calculating your medical benefits, the TPA/MCO assumes you receive payment from Medicare.

B-6. Other Information

B-6.1. What Happens if...You Die?

If you die – Spouse and dependent coverage continues if your Spouse and dependents were covered under the Medical Plan.

B-6.2. Filing a Claim

If you enroll in the MCO option and you use a Participating Provider, you do not need to submit a claim for benefits. If you enroll in the Traditional option (or use the point of service feature of a managed care option), you will need to submit your claims as follows:

– Non-Medicare Health Care Claim Procedures

– Medicare Health Care Claim Procedures

B-6.2.1. Non-Medicare Health Care Claims Procedures

When you receive medical care, you must submit a claim for benefits to be paid. Here's what you should do:

1. Show your benefit card and ask your Provider to bill the Customer Support Department indicated on your benefit card.
2. If the Provider will not submit your claim, you may need to pay your bill and then submit a claim reimbursement, as follows:
   - Ask your Provider to complete a HCFA-1500 (dated 12/90) Medical Form or a UB92 Hospital Form. If the Provider of service will not complete one of these forms, ask your Provider for a bill that must include the following:
     - The diagnosis.
     - The date services and/or supplies were provided.
     - A description of the services provided, including the appropriate CPT/HCPC code(s).
     - The amount of the charges(s).
     - Any accident details (if applicable).
     - The Provider's name, address, phone number, and tax ID number.
   - Contact the TPA/MCO to obtain a Healthcare Claim Transmittal form. You will need to supply your name, Social Security number, home address and telephone number and a brief explanation of the situation.
   - Send the bill with the attached information to the TPA/MCO's Customer Support Department indicated on your benefit card.

B-6.2.2. Medicare Health Care Claims Procedures

When you obtain healthcare services under the Deere sponsored Medicare Advantage Part C plan, the service provider normally submits a claim on your behalf. If the service provider is unwilling to do so, you can request reimbursement from the TPA/MCO. To receive reimbursement, please take the following steps:

1. Obtain a copy of your itemized receipt(s) from the provider.
2. Make sure the itemized receipt includes the following:
   - The service provider's name, address and phone number
   - Your name
   - The date the service was completed
   - The amount you paid (or "paid in full" if the total amount has been paid)
3. Mail the itemized receipt(s) to: UnitedHealthcare Claims Department P.O. Box 30968 Salt Lake City, UT 84130-0968

The TPA/MCO should receive an itemized receipt from you or the provider within ninety (90) days after the date of service, or as soon thereafter as reasonably possible. The TPA/MCO will process your reimbursement based on your benefits. Upon completion of the reimbursement process, an Explanation of Benefits (EOB) will be sent to your mailing address.

The TPA/MCO will not reduce or deny a claim for failure to furnish such proof within the time required, provided a claim is furnished as soon as reasonably possible. Except in the absence of legal capacity, the TPA/MCO will not accept a claim more than one (1) year from the date of service.

Section C: Pension Information

Section C: Pension Information

C-1. The Pension Plan

The John Deere Pension Plan for Salaried Employees is one way the company has recognized your years of service with Deere & Company. It provides monthly benefits for eligible retirees and surviving Spouses.

Your monthly pension is tailored especially for you – to help meet your retirement income needs. It is based on pay nearest retirement and on the service credit built up during your John Deere career.

C-1.1. The Pension Plan Highlights

Company-Funded	The Pension Plan is 100% funded by the company. You do not need to contribute to the Plan. Its goal is to provide you or your Spouse steady retirement income once you have ended your career with the company. Your monthly pension benefit is paid in advance, which means the pension trust pays your benefit on the first of each month for that month.
Classification	The Plan is classified as a "defined benefit" Pension Plan allowing for payment of monthly benefits to retired participants and their surviving spouses. This means your monthly pension benefit was calculated according to a formula, then adjusted depending on when you took your retirement.
Surviving Spouse Protection	The Plan offers surviving spouse protection after your death. Survivor benefits are based on the terms of the Plan in effect at the time you retired. In some cases you needed to elect this surviving spouse protection and take a reduced pension benefit amount to provide this benefit following your death.
Medicare Part B Premium Reimbursement	At age 65 or when eligible for Medicare, whichever occurs first, Medicare becomes primary and Deere Plan is secondary. You must enroll for Medicare Part B coverage. A monthly premium for Part B is deducted from your Social Security check. During 2016 the company is reimbursing you and your Medicare covered Spouse $104.90 per person per month on your pension payment, so long as you or your Spouse are not receiving a Medicare Part B reimbursement from another employer.
Direct Deposit	Your monthly pension payment is deposited in your bank or credit union account and is available on the bank's or credit union's first working day each month. Direct deposit has proven to be fast, safe, reliable, and saves the Pension Plan money.
Earnings Statement	Earning statements are sent to retirees on a quarterly basis. You will receive an earnings statement on the first of January, April, July and October each year. Additional statements will be sent to any pensioner whose pension payment or deduction amounts change for any reason.

C-1.2. Eligibility and Cost

If you were a salaried employee of Deere & Company, retired prior to 1 July 1993, or John Deere Health Care, John Deere Insurance Group, retired prior to 1 January 1995, and John Deere Credit, retired prior to 1 January 1994, you are covered by the Plan.

Plan Cost

The company pays the full cost of your pension benefits by making contributions to a trust, the John Deere Pension Trust Fund for Salaried Employees.

C-1.3. Benefits Payable To Your Surviving Spouse

Surviving Spouse Benefit

You may have elected to have a percentage of your retirement benefit paid to your Spouse in the event of your death. Your Spouse, who must be alive at your death to qualify, would receive monthly payments for life.

You can elect this feature if you were not married at retirement but married later. You must notify the company within one year of your marriage to elect surviving spouse protection otherwise you or your Spouse will be required to retroactively pay for this protection for as long as it has been in effect. In no event will a surviving spouse benefit be payable for any Spouse who has been married to the retiree for less than one calendar year.

Election of this feature is restricted if all or part of your survivor benefit has been assigned to a former Spouse recognized as an alternate payee under a Qualified Domestic Relations Order. (See Assignment of Benefits.)

Application for Surviving Spouse Protection and When Effective

To elect the surviving Spouse benefit, you must file a written application with the company. You can contact Deere Direct for the survivor application form or more information.

The surviving spouse benefit protection becomes effective the first of the month after the month the company receives your written application. However, protection can start no sooner than the first of the month after the month you celebrate one year of marriage to your designated surviving spouse you want protected. Surviving spouse benefits will be based on the terms of the Plan in effect at the time you retired. You must have elected the surviving Spouse option to have coverage for your Spouse after your death. The Pension Plan will pay surviving Spouse benefits only to your designated surviving Spouse. Benefit payments are not provided to a Beneficiary other than your surviving Spouse.

When Benefits Are Paid
Benefits to your surviving Spouse will start on the first day of the month following your death, once the company is notified of your death.

C-1.4. Assignment of Benefits

Qualified Domestic Relations Order
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 that may affect your Pension Plan benefits, contact the John Deere Pension Benefits Center Attention: Qualified Order Center by phone 1-866-630-2256 or www.qocenter.com.

C-1.5. A Few Words About Taxes

Federal and State 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 is important that you consult a qualified tax expert.

C-2. Situations That Affect Your Pension Plan

C-2.1. Plan Maximums

There are laws that limit the amount of benefits individuals can receive from this Plan in combination with other plans. If you are affected by these limits, you may be eligible for a benefit under the John Deere ERISA Supplementary Benefit Plan or the John Deere Senior Supplementary Benefit Plan. These Plans are unfunded, nonqualified plans with the payment of benefits made from the general assets of the company. You were notified on your date of retirement if these limits affect you.

C-2.2. Top Heavy Provisions

As required by law, alternate Plan provisions go into effect if a plan becomes “top heavy”. A plan is top heavy if more than 60% of accumulated benefits 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 the plan becomes top heavy and of the corresponding consequences.

C-2.3. The Pension Benefit Guaranty Corporation (PBGC)

A Pension Plan is a “defined benefit” plan (meaning that benefits are determined by a formula). Therefore, some of the Pension Plan benefits are guaranteed by the PBGC, under certain circumstances, if the Plan is terminated. The PBGC is a federal government agency. Generally, the PBGC guarantees a portion of Vested normal retirement benefits, early retirement benefits, and certain survivor and disability pension benefits. However, the PBGC does not guarantee all types of pensions, and the amount of protection is subject to certain limitations.

Section D: Disability Benefits

When you were an active employee, you may have qualified for benefits from the company's Long Term Disability Plan. To qualify for benefits, you would have been totally disabled, as defined under the Long Term Disability Plan, and provided evidence satisfactory to the company.

Benefits from long term disability provide necessary income you are unable to earn on your own. The benefits in place pay up to certain limits and may continue until you recover or reach age 65 (or beyond age 65 if disability commences on or after age 60), or you die.

Section E: Savings and Investment – Traditional Option

Section E: Savings and Investment – Traditional Option

The Company sponsors the Savings and Investment Plan (SIP). The SIP allows you to build additional retirement income through the Company match and pre-tax employee contributions to the SIP.

E-1. The Savings and Investment Plan — Traditional Option

The Savings and Investment Plan (SIP) — Traditional Option is an easy way to supplement the retirement income you may receive from the Company's pension plan and Social Security.

- Highlights
- Investment Choices
- Loans
- Distributions
- Taxes
- If You Die
- Beneficiary Information
- Situations Affecting Your Retirement Plan
- Denied Claim

E-2. Highlights — Traditional Option

Tax Advantages

The money you contributed to the Plan and the matching contributions from the Company was deposited in your account on a pre tax basis. Taxes are delayed on pre tax dollars until distributed from the Plan.

You Choose the Funds

You choose how to invest your account among the funds offered by the Plan.

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.

When You Retire or Leave the Company

When you retire or terminate employment with the Company and all of its subsidiaries and affiliates, your SIP account is payable to you or, if you die before payment, your beneficiary through several distribution options. Pre-tax distributions paid directly to you or your beneficiary may be subject to withholding. Distributions directly paid to you or your beneficiary may be rolled over to an IRA or other qualified plan.

Naming a Beneficiary

Your beneficiary is the person you name to receive your unpaid Plan account balance, if any, when 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 by signing the Beneficiary Designation Form in the presence of a notary public. If you ever want to change your beneficiary, your Spouse must again approve the change in writing.

E-3. Investment Choices — Traditional Option

You decide how your SIP account balance is invested. The Plan provides a 3 choice investment structure that offers a variety of investment options. The funds offered can change from time to time so be sure to contact Fidelity for the most current fund listing. Call the Service Center at (800) 354-3427 or log on to NetBenefits® (401k.com), for more information.

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® Retirement L
– BTC LifePath® 2020 L
– BTC LifePath® 2025 L
– BTC LifePath® 2030 L
– BTC LifePath® 2035 L
– BTC LifePath® 2040 L
– BTC LifePath® 2045 L
– BTC LifePath® 2050 L
– BTC LifePath® 2055 L
– BTC LifePath® 2060 L

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 Fund
– Boston Partners Large Cap Value Fund
– Loomis Sayles Small/Mid Cap Fund
– TS&W International Large Cap Equity Trust
– Wells Fargo Emerging Markets Equity Fund Class R6
– Wells Fargo Core Plus Bond Fund

In addition, CHOICE 3 includes the Deere & Company Common Stock Fund, Blended Interest Fund, Fidelity Institutional Money Market Fund Class I (effective March 18, 2016, this fund was replaced by the Short-Term Investment Fund W), and Fidelity BrokerageLink® that offers both passively managed and actively managed mutual funds not available directly through the Plan.

If you currently are allocating more than 20% of your contributions to the Deere & Company Stock Fund you must decrease your election to no more than 20%. If you do not proactively decrease your election to 20% or less by January 27, 2014, Fidelity will redirect your contributions in excess of 20% to the LifePath® Index Target Date Fund based on your target retirement range.

Additionally, beginning January 28, 2014 you will not be 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%. If you do not make a change to decrease your elections to 20% or less, beginning on January 28, 2014, you will be restricted to make any changes to your investment elections for up to two business days.

Any other account activity will not be affected or restricted. Your balances will not be adjusted and you can make changes to your asset allocation or deferral amounts at any time after the Company stock restrictions are complete.

Making Your Investment Choices

– Transfer current investments. You can move your existing savings from fund to fund, except you cannot move directly from the Blended Interest Fund to the Fidelity Institutional Money Market Fund or the replacement fund Short-Term Investment Fund W. These funds compete with the Blended Interest Fund and is subject to a 3 month equity wash. Call the Service Center for more information

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

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. You'll receive a personalized statement after each calendar quarter, showing your account balances as of the end of the most recent calendar quarter. On line statements are also available through the Service Center.

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 SIP 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.

E-4. Loans — Traditional Option

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. As soon as practicable, a loan origination fee of $5 and a loan maintenance fee of $2.50 will be deducted from your account. The origination fee is charged for each new loan and the loan maintenance fee is charged each quarter during which you have a loan outstanding. You may only have one loan outstanding at a time. Call the service center to obtain the current loan origination and loan maintenance fee charges.

Who's Eligible?

Employees with a status code of retired are also eligible to take a loan.

Applying for a Loan

To apply for a loan, call the Service Center ((800) 354-3427) at Fidelity or log on to www.401k.com and access the withdrawal link. A Fidelity representative will answer your questions and assist you with your loan. Fidelity Investments will send your loan check and amortization schedule directly to you.

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.

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). Effective 10 November 2008, if you are retired, you may request a loan and make all payments through ACH. You must make a minimum of one payment each quarter equal to all payments due for the quarter in order to avoid loan default and possible tax consequences.

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 a published national index.

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

Prepaying the Loan
You may make partial loan repayments. Call the Service Center at (800) 354-3427 and speak to a Fidelity Representative if you are interested in prepaying your loan in full or making a partial payment.

Missed Payments and Defaulting
You repay your loan over a period of up to 54 months for a regular loan or 10 years for a mortgage loan.

You are required to keep your loan current so call the Service Center (800) 354-3427 to make up any missed payments. Failure to keep your loan current will result in loan default and a taxable event.

If your loan is not repaid within the original terms it will be defaulted and taxes and/or penalties will be due.

E-5. Distributions — Traditional Option

You're always 100% vested in your contributions to the SIP. Your company matching contributions are also 100% vested. This means you have full ownership rights to your whole account. Your account may be distributed at your request by contacting Fidelity, if you die, or if the Plan is terminated.

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 Distribution document which will explain your distribution options — and the corresponding tax implications — in greater detail.

Distribution Options
Once you terminate employment with the Company and its subsidiaries and affiliates, you must contact the Service Center at Fidelity Investments to request one of the following distribution options, or to obtain more information.

Lump Sum Distribution
100% of your account balance can be paid directly to you with the mandatory 20% withheld for Federal taxes for pre tax distributions. Or, you may elect to rollover all or part of your account to another qualified plan or IRA. Taxes are not withheld from distributions payable to another qualified plan or to an IRA, which is referred to as a direct rollover.

Scheduled Distributions
You may choose...

– A specific dollar amount paid out every month until your account balance reaches zero; or

– 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; or

– A Minimum Required Distribution (MRD) This type of distribution is required by the Internal Revenue Code and is based on actuarial calculations. After your employment with the Company and its affiliates and subsidiaries is terminated, when you reach 70½, an annual MRD is required, unless you already elected a lump sum distribution. 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.

Assignment of Benefits
Your benefits from the SIP 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 SIP benefits, contact the Service Center (800) 354-3427.

Participants and beneficiaries may obtain, at no cost, a copy of the SIP's procedures for QDROs. Participant accounts are charged the following fees for QDROs:

– Web review of one defined contribution plan order generated on the Fidelity QDRO Web site and not materially altered - $300 each.

– Manual review of one defined contribution plan mentioned in an order that was not generated on the QDRO Web site or was generated on the Web site, 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.

Taxes
Tax laws are complicated, and they affect people in different ways. Before you receive your distribution from the SIP, 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. Also, these guidelines don't reflect every possible situation or interpretation.

General Tax Treatments
Since your account balance can be 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. Your pre-tax distribution will have a mandatory 20% withheld for federal taxes, unless you elect a direct rollover. See Distributions.

– 10% early payment penalty. The IRS places a 10% penalty tax on any payment you receive from the SIP before you are 59 ½ 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 terminate employment with the company, during or after the calendar year in which you reach age 55.

The tax laws are very complex—and they change often. You should contact your tax advisor for more information, particularly if you have Roth after tax dollars as part of your account balance.

Paying Your Taxes
As mentioned earlier, when you receive a pre-tax distribution of your account, the IRS requires the Record keeper to withhold 20%, unless you elect a "direct rollover." If you have Roth after-tax dollars, be sure and check with your tax advisor before requesting a distribution. If you are in a 20% or higher tax bracket, you may owe more taxes on the pre-tax payment when you file that year's tax return. If you are in a tax bracket that is lower than 20%, part or the entire amount withheld may be refunded or used as an offset to your federal income tax return for that year.

The 10% early payment 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.

If You Die
If you die before receiving your SIP benefits, the full value of your account is paid to your beneficiary. If you haven't named a beneficiary, or if your beneficiary dies before you do, the full value of your account is distributed in accordance with the SIP's hierarchy. Contact Deere Direct for more information.

Normally, distribution is made to your beneficiary as soon as possible after your death. Your beneficiary may elect to defer distribution for up to five years following your death date. When your account balance is paid to your beneficiary, it is not subject to the 10% early payment penalty. However, regular income tax will be due on the pre-tax value of your account. Effective 1 January 2008, non-spousal beneficiaries 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 Fidelity Service Center.

E-6. Beneficiary Information — Traditional Option

Naming a Beneficiary
Your beneficiary is the person(s) 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 by signing the Beneficiary Designation Form in the presence of a notary public. To name a beneficiary, contact the Fidelity Service Center at (800) 354-3427 or log on to www.401k.com.

If you ever want to change your beneficiary, your Spouse must again approve the change in writing.

E-7. Situations Affecting Your SIP Benefits – Traditional Option

A Few Words About Taxes
Your 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.

Assignment of Benefits
Your benefits from SIP belong to you and may not be sold, assigned, transferred, pledged, or garnisheed, 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 SIP account, contact the Fidelity Service Center.

Top Heavy Provisions
As required by law, alternate SIP provisions go into effect if the SIP becomes "top heavy." A plan is top heavy if more than 60% of 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 the Plan becomes top heavy and of the corresponding consequences.

The Pension Benefit Guaranty Corporation (PBGC)
The SIP is a "defined contribution" plan, which means the value of your account depends on the amount of contributions made and on gains and losses. Your SIP account is not insured by the PBGC.

E-8. Denied Claim

Review of Denied Claim
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 the Plan Administration section.

Section F: Purchase Plan for John Deere Consumer Equipment

You may buy certain John Deere consumer equipment and receive a rebate on a portion of your purchase price.

F-1. Eligibility

Active employees, retirees, and surviving Spouses of any U.S. or Canadian unit of Deere & Company are eligible participants for this benefit. In addition, the following family members are eligible purchasers:

– Spouse of employee or retiree;

– Parents of employee, retiree, or surviving Spouse;

– Spouse's parents of employee or retiree.

– Nondependent children of an employee, retiree, or surviving

– Spouse, who maintain a separate household.

F-2. What Products Are Eligible for a Rebate

You may receive a rebate on 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.

– The products must be purchased new from a John Deere dealer. Purchases at a mass retailer, like Lowe's or The Home Depot, are not eligible for a rebate.

– Products must be for the purchaser's personal household use.

– Products must not be traded or resold within six (6) months of purchase.

– Purchases of these products are limited to two, total, per two consecutive fiscal years ending 31 October:

  • John Deere Riding Lawn Equipment (includes Compact Utility Tractors and Commercial Mowing Equipment)

  • John Deere Gators

– The limits are for accumulated purchases by Eligible Participant and all Qualified Purchasers. They are not for each Qualified Purchaser and each Eligible Participant.

Product must be for the participant's or a qualified purchaser'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 friends, neighbors, siblings, or any other individual who is not an authorized purchaser.

If any equipment is returned to the John Deere dealer or sold, for any reason prior to the six (6) months from date of purchase, the employee must return the rebate that was paid on that product.

F-3. 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:

1. Obtain a John Deere Employee Purchase Plan Rebate Claim Form from the Employee Purchase Plan website or Deere Direct.
2. Complete the form and send it with the original invoice to the address on the form (within 90 days of the purchase date).
3. 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).

Each rebate request must be submitted by the eligible participant (employee, retiree, or surviving Spouse). Payment will be mailed to the eligible participant.

If you have any questions about how the Plan works or for updated information on new product eligibility and rebates, please call Deere Direct at (800) 213-3373 | Email: DeereDirect@JohnDeere.com | Fax: (309) 748-0625.

Section G: My Resources

Section G: My Resources

Contact List

Deere Direct: (800) 213-3373 | Email: DeereDirect@JohnDeere.com | Fax: (309) 748-0625 | Retired Employees

Fidelity: (800) 354 3427 | www.401k.com

G-1. Administrative Information

Your Legal Rights
The company chooses to provide the plans described here to you even though it is not required by law to do so. However, because they are offered, most of the plans are regulated by federal laws. This could affect a plan's design and/or how you receive the benefit. This section describes your legal rights under a federal law called the Employee Retirement Income Security Act of 1974 (ERISA).

An Important Note
This document summarizes the key features of plans, programs, and certain payroll policies available to Preflex Salaried retirees and surviving spouses. It is intended to provide easy to understand descriptions of important provisions, and to serve as Summary Plan Descriptions for these plans.

This document is not the official Plan Document for any of the plans. This Summary Plan Description does not cover every provision of the Plan Document(s) or a specific plan. Complete details of the plans are contained in the official Plan Documents.

If any information described in this document is different from the Plan Document(s), the language in the official Plan Document(s) will control.

G-2 Plan Administration

G-2.1. Employer Identification Number

The employer identification number assigned to Deere & Company by the Internal Revenue Service is 36-2382580.

Employer
The employer whose retirees are covered by these plans is:
Deere & Company
One John Deere Place
Moline, Illinois 61265-8098
(309) 765-8000

G-2.2. 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, send it to the Plan Administrator. The Plan Administrator or its delegate is authorized to finally determine claims and appeals and interpret the terms of the Plan in its sole discretion. All decisions by the Plan Administrator or its delegate are final and binding on all parties. In the event legal actions commence, the Plan Administrator has been designated as the agent for service of legal process.

The Plan Administrator for SIP 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 Salaried 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 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 ((888) 533-3731)

Legal process may also be served on plan trustees, where applicable.

G-2.3. Plan Sponsor

The Plan Sponsor is Deere & Company.

G-2.4. Plan Documents

This Summary Plan Description highlights and summarizes the important features of your Deere & Company benefit program. In regard to ERISA plans (identified in the Additional Administrative Facts chart), 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 the Plan 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 Summary Plan Description, 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 and contact Deere Direct or Deere & Company Global Benefits, One John Deere Place, Moline, Illinois 61265-8098.

This benefits document is your Summary Plan Description of the plans.

G-2.5. 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 the event of changes to this information, you will be notified within a reasonable period of time.

G-2.6. Leased Workers

1. **Exclusion From Plan**. A person who is considered a "leased worker" shall not be eligible to participate in these Plans as long as such person continues to be a "leased worker".
2. **Nondiscrimination Testing**. A "leased worker" shall be treated as an employee of the company for the exclusive purpose and only to the extent necessary to apply requirements of Code Section 414(n)(3) and to determine the number and identity of highly compensated employees.

G-2.7. Claims 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.

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 any claim for coverage or benefits under the Plan is wholly or partially denied, you will receive notification with the following information:

- The specific reason(s) for the denial;
- Specific reference to the pertinent Plan provisions upon which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why the information is necessary;
- If an internal rule, guideline, protocol, or similar criterion was relied upon to determine a claim, the notification will contain either a copy of the actual rule, guideline, or protocol, or a statement that the rule, guideline, or protocol was relied upon and will be provided free of charge upon request;
- If the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notification will contain either an explanation of the scientific or clinical judgment relied upon in making the decision, or a statement that such explanation will be provided free of charge upon request;
- 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; and
- in case of a claim denial involving urgent care, you will receive an explanation of the expedited review process.

If the Plan Administrator or its delegate fails to provide the written notice described above within the applicable time period, the claim will be deemed to be denied and you will have the right to appeal the decision pursuant to the procedures described below.

Appeals
You or your authorized and designated representative may request a review of your claim denial within 180 days after you receive the notice described above. You must submit your appeal in writing within 180 days of receiving the denial.

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, including determinations to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, 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.

Also, the Plan Administrator or its delegate will identify any medical or vocational experts whose advice was obtained on the Plan's behalf in connection with your claim decision, without regard as to whether the advice was relied upon in making the claim decision.

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 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 an internal rule, guideline, protocol, or similar criterion was relied upon in making the claim decision, the notification will contain either a copy of the actual rule, guideline,
- or protocol, or a statement that such a rule, guideline, checklists, protocol, or other similar criterion was relied upon and will be provided free of charge upon request; and
- If the claim denial was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, the notification will include either an explanation of the scientific or clinical judgment relied upon in making the decision, or a statement that such explanation will be provided free of charge upon request.

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.

Also, the Plan Administrator or its delegate will identify any medical or vocational experts whose advice was obtained on the Plan's behalf in connection with your claim decision, without regard as to whether the advice was relied upon in making the claim decision.

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 that includes:

– The specific reason(s) for the decision;

– Reference to the specific Plan provision(s) on which the decision is 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);

– Any internal rule, guideline, checklists, protocol, or similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, checklists, protocol, or other similar criterion was relied upon and a copy will be provided free of charge upon request; and

– If the decision was based on medical necessity or experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

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.

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 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.

Claims under the Plan's administrative claims and appeals procedures and lawsuits must be commenced within a particular period of time; otherwise, they will be timebarred. You generally must exhaust the Plan's administrative claims and appeals procedure no later than two years following the earliest of (1) in the case of a lump sum payment, the date your lump sum payment was made , (2) in the case of a periodic payment, the date of the first in the series of payments, or (3) the earliest date you knew or should have known the material facts on which your lawsuit is based (the "24-month Claims Period"). Any claim filed under the Plan's administrative claims and appeals procedures after the end of this 24-month Claims Period will be time-barred.

You generally must exhaust the Plan's administrative claims and appeals procedure before filing suit in a federal court. Any suit must be brought within one year of the denial of the claim upon appeal. Lawsuits filed after that date will be time-barred.

G-2.8. If a Plan Is Amended, Modified, Suspended, or Terminated

Deere & Company reserves the right to suspend, amend, modify, or terminate the Plan(s) in any manner at any time, including the right to modify or eliminate any cost- sharing between the company and participants.

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 Savings and Investment 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.

G-2.9. 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.

– individuals enrolled in Deere's Medicare Part C and Part D plan.

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. 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 Deere Direct.

G.2.10. 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 Deere Direct 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 Deere Direct 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 Deere Direct 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 Deere Direct 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.

G.2.11. 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

If you have questions regarding your Plan or your COBRA continuation coverage rights, please contact Deere Direct.

Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator and Deere Direct 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 Deere Direct.

Certification of Prior Health Coverage

Since June 1997, a HIPAA certificate of creditable coverage has been automatically provided to employees and beneficiaries, including dependents, when they have lost coverage under our plan, become eligible for COBRA coverage or lose COBRA coverage. A certificate will be provided if the request is made at any time while an individual is covered under the Health Plan, and within 24 months after a loss of coverage under the Health Plan.

These certificates of creditable coverage certify the period of time of coverage under our Health Plan and may be submitted as documentation to reduce any waiting period for a pre-existing condition exclusion under the Health Plan of an individual's next employer or insurer.

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.

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.

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 Deere Direct.

G-2.12. 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.

G-3 Rights & Privacy Notice

G-3.1. 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.

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.

G-3.2. 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:

– The processing of claims for payment;
– Peer review, utilization review, claims appeal, medical audit, or any other program for quality health care and control of health care costs; or
– Bona fide medical research and education.

G-3.3. 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.

You must ask for the statement by contacting Retirement Benefits at (800) 213-3373 | Email: DeereDirect@JohnDeere.com | Fax: (309) 748-0625. The Plan is only required to provide the statement once a year.

G-3.4. 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 Stock Purchase Plan for Salaried Employees, John Deere Employee Purchase Plan for John Deere and Frontier Consumer Equipment, and Tuition Payment Plan, 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.

G-3.5. 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 (800) 213-3373 | Email: DeereDirect@JohnDeere.com | Fax: (309) 748-0625, or access it on John Deere Online.

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.

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 at (800) 213-3373 | Email: DeereDirect@JohnDeere.com | Fax: (309) 748-0625. This notice is effective as of 14 April 2003.

G-3.6. 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 Retired Salary and Retired Non- Union Wage Employees	552	Health Care	Mellon Trust of New England N.A. 1 Boston Pl Fl 8 Boston, MA 02108- 4407	The company makes contributions to a trust fund	1 November through 31 October
John Deere Health Benefit Plan for Salaried Employees includes: **Medical Options** **Dental options**	501	Health Care	Deere & Company One John Deere Place Moline, IL 61265	The company and employee. The company pays its portion of the benefits on a self-insured basis.	1 November through 31 October
John Deere Group Life and Disability Insurance Plan for Salaried Employees, known as: **Group Life/ AD&D Insurance**	503	Life Insurance/ AD&D	Minnesota Life Insurance Company A Securian Company 400 Robert Street North St. Paul, MN 55101-2098	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
John Deere Long-Term Disability Plan for Salaried Employees	505	Disability	Sentry Insurance Co. 1800 North Point Drive Stevens Point, WI 54481	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 Salaried Employees	001	Defined Benefit	The Bank of New York Mellon 135 Santilli Highway, Everett, MA 02149	The 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	003	Defined Contribution	Fidelity Management Trust Company 82 Devonshire Street, ZR1 Boston, MA 02109	The company and employee.	1 November through 31 October

– The Plan Administrator for SIP 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 Salaried 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.

Glossary

A

Accrued Benefit — Traditional Option
Your accrued Pension Plan benefit is the benefit you have earned, based on service credit and final average monthly pay at any given time.

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 Health Plan carrier has agreed to pay Providers under a contract, or the Reasonable and Customary charge. Here's how the Allowed Charge is determined:

– First, if the Health Plan carrier and the Provider have agreed to a contracted rate, the Plan pays benefits on that amount.

– If there is no contracted rate, the Plan pays benefits up to the Reasonable and Customary level.

– Finally, sometimes a Reasonable and Customary amount is not available. In these cases, the Plan pays benefits on the billed charge--the total amount (of a covered expense), billed by the Provider.

If the Health Plan carrier determines a charge is above the Allowed Charge and you think the charge or determination is inappropriate, call the number on the back of your member identification card.

Annual Salary — Traditional Option
Your straight-time Salary plus overtime, shift premium, military leave, jury duty, certain commissions, and Salary continuance pay. It also includes any pre-tax contributions you make to any company plans. It does not include any company- matching contributions.

Annuity
A method of paying your benefit that spreads payment out over an extended period of time, as opposed to a single-sum payment.

B

Beneficiary
A person or persons designated to receive life insurance benefits or your Savings and Investment Plan account. You may name more than one person to receive benefits.

C

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985 that requires employers to provide employees and/or their covered dependents with the opportunity to elect to continue health care coverage under certain circumstances when coverage would otherwise end. (See Continuing Coverage Through COBRA.)

Coinsurance
This refers to the way medical expenses are split between Deere & Company and you. It is expressed as a ratio, such as 80/20, which means the company pays 80% and you pay 20%.

Copayment

A fixed dollar amount the patient pays for a specified health care service. The Copayment is usually paid at the time a service is provided.

Coverage Year
The calendar year period for which group benefits and optional life insurance coverage is effective.

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 for personal needs rather than being able to cure. (See Expenses not covered by any medical option, Custodial Care for a list of the types of care considered to be custodial.)

D

Deductible
The amount of money you pay for covered services before the Plan pays medical or dental benefits.

Deere Direct
Contact a Service Representative at Deere Direct if you have any questions or to receive more information on a topic. This service is available to you at (888) 432-3373, if you are in active service; or at (800) 213-3373 | Email: DeereDirect@JohnDeere.com | Fax: (309) 748-0625, if you are a retiree or separated from service.

Dentist
A legally licensed Dentist or dental surgeon practicing within the scope of his or her license.

E

Experimental Care
Certain experimental or investigational drugs, devices, medical treatment, or procedures, and care for complications arising from these procedures. (See Expenses not covered by any medical option, Experimental/Investigational Care for more details.)

F

Final Average Earnings — Traditional Option
The highest five consecutive anniversary years' earnings out of the last 10 anniversary years, or the last 60 months earnings prior to retirement, whichever is higher, divided by 60.

Fixed Bridgework
A non-removable replacement for a natural tooth.

Formulary
A listing of prescription drugs which are selected by the TPA/MCO's pharmacy Formulary committee based upon clinical effectiveness and cost. These drugs may be submitted to quantity limitations and prior authorization as deemed appropriate by the TPA/MCO'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.

G

Generic Drugs
A chemically equivalent form of a brand-name prescription drug for which the patent has expired. A Generic Drug is equally effective, but typically less expensive than the brand name and is sold under the common "generic" name for that drug.

H

Health Plan
The medical and dental options available to you through Deere benefits.

I J K L

Listed Drugs
Certain drugs, which are available in a 3-month supply, and may be prescribed on a continuing basis. Listed Drugs are determined by the TPA/MCO.

M

Medical Emergency
A medical condition showing itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Medically Necessary
Services that are:

– Consistent with generally accepted principles of medical practices for the diagnosis and treatment of the patients 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 (categories 291-302.9, 307.1, 307.5-313.9, and 316).

N

Non-Participating Provider
Physicians, hospitals, pharmacies and other health care Providers who do not participate in TPA/MCO network(s).

O

Occupational Therapist
A person who is a legally licensed graduate of an occupational therapy program approved by the Council on Medical Education of the American Medical Association in connection with the American Occupational Therapy Association (or its equivalent).

Orthodontia
Services performed by a Dentist to correct all dental irregularities from the anomalous growth and development of dentition and its related anatomic structures (or that result from an accidental injury), and that require repositioning of teeth to establish normal occlusion.

Out-Of-Pocket Maximum
The maximum amount you would pay under a benefit option with Copayments and Coinsurance (refer to the benefit summary for your elected benefit option). After the maximum has been met, all other eligible costs in the calendar year are paid at 100%. Charges in excess of the Reasonable and Customary standard are not included in calculating the Out-Of-Pocket Maximum.

P

Participating Provider
Physicians, hospitals, pharmacies, and other health care Providers who participate in the TPA/MCO's network(s).

Periodontics
Treatment of diseases of the bone, gum, and tissues around the teeth.

Physician
A person who is legally licensed to practice medicine or perform surgery within the scope of his or her profession. The term Physician is limited to:

– Doctor of medicine (MD);

– Doctor of osteopathy (DO);

– Doctor of podiatric medicine (DPM); and

– Doctor of chiropractic (DC).

Physical Therapist
A person who is a legally licensed 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).

Plan Administrator
The Plan Administrator for SIP 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 Salaried 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.

The Plan Administrator has authority to control and manage the operation and administration of the plans and is the agent for service of legal process.

Preflex Salary
Group defined as: Core Employee retired or deceased prior to 1 July 1993; John Deere Credit Employee retired or deceased prior to 1 January 1994; John Deere Health Employee retired or deceased prior to 1 January 1994; and John Deere Insurance Employee retired or deceased prior to 1 January 1995.

Point-of-Service
This is a feature of a managed care plan that pays for medical services from a Provider outside the managed care network (Non-Participating Provider). Benefits are reduced so member costs are higher.

Prosthodontics
Replacement of missing teeth and construction or repair of bridges and dentures.

Provider
Any certified or licensed professional who supplies health care services, including Physicians, surgeons, mental health specialists, and registered nurses.

Q R

Reasonable and Customary
The portion of any charge, that is within the amount charged for similar services, and supplies in the geographic 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. Reimbursement is based on the 90th percentile of HIAA profiles.

Amounts in excess of Reasonable and Customary allowances are the responsibility of the covered person. They are not covered items and will not apply to Deductibles or Out-Of-Pocket Maximums.

Residential or Outpatient Substance Abuse Facility
A facility that provides detoxification and rehabilitation services for the treatment of Substance Abuse. To be covered by the Medical Plan, services for inpatient Substance Abuse must be provided at a hospital or an approved residential Substance Abuse facility by referral from your TPA/MCO.

Restricted Access
Means your health care is directed by one Physician and your pharmaceutical needs are provided by one pharmacy, regardless of your health care delivery system.

Retiree Continuation Premium
Net premiums charged for employee medical or dental coverage paid by the retiree, on an after tax basis, through a monthly pension benefit deduction.

S

Salary (Pension — Traditional Option)
For the Pension Plan, Salary includes your straight-time Salary and certain commissions, up to a maximum amount allowed by law. It also includes your straight-time Salary portion of overtime, shift premium, military leave, jury duty, and Salary continuance pay. It does not include bonuses or company-matching contributions under the Savings and Investment Plan, the Stock Purchase Plan, or any other company plan; however, it does include any pre-tax contributions you make to any company plan.

Salary
Your monthly or annual straight-time Salary rate before any deductions to pay-- such as pre-tax contributions you make to any company plan.

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).

Spouse
A person with whom an Employee or Retiree has entered into a marriage in a state or foreign country where the marriage was considered valid under that state's or foreign country's law at the time it occurred, and such marriage has not subsequently been legally dissolved

Substance Abuse
A diagnosis of Substance Abuse-alcoholism or drug dependency- must be made according to the guidelines in the International Classification of Diseases (ninth revision, categories 303.0-305.0), adopted for use in the United States by the U.S. Department of Health and Human Services.

T U V

Vested — Traditional Option
Means you have 100% ownership rights to your accrued pension benefit. You are Vested when you have earned five years of service credit. You may receive your benefit when you are eligible to retire. You're always fully Vested in your Savings and Investment Plan account.

W X Y

Year of Service
For the Pension Plan, a Year of Service is basically the same as a Year of Service credit.

Z

Pre-Flex Salaried Employees

January 2016 – DKD 1477