Summary Plan Description

JOHN DEERE

Effective 1 January 2024

DKD1474 (2024-02)

IMS #275484

John Deere Summary Plan Description for Salaried Employees

QUICK LINKS

The sections of this document titled, “Overview”, “Who Is This Document For?“, “My Retirement – Savings and Investment Plan – Contemporary Option”, “My Retirement – 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

Your Deere & Company "Salaried Employee Benefits" document was produced to inform you and your family about your benefits. In this section, you will find a general description of each of your benefits and where to get more information on each plan.

Introduction

This benefits document provides highlights and summaries of benefit plans and personnel policies as of January 1, 2024, for John Deere salaried employees of Deere & Company [hereafter referred to as employee], as defined in Who This Document Is For. It is your summary plan description and not the official Plan Document for the ERISA plans listed in Additional Administrative Facts.

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 Documents, the language in the official Plan Documents governs. In addition, not all administrative procedures or policies of the various plans are explained here.

Your Human Resources Department or the John Deere Benefits Center can help you through these procedures if you have questions. None of the plans and/or policies described in this document creates a contract of employment between Deere & Company or its affiliates and subsidiaries, and any employee. 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.

John Deere Benefits Center

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

About This Document

As a salaried employee of Deere & Company (see "Who This Document Is For" for more information), you are covered by a comprehensive package of benefits that, along with your pay, make up your total compensation.

Certain benefits are designed to provide you with financial security today. These benefits include the medical and dental plans, life insurance for you and your family, accidental death and dismemberment (AD&D) insurance, and disability benefits.

Other benefits help you prepare for tomorrow's needs. The John Deere Pension Plan for Salaried Employees and the Savings and Investment Plan are designed to help you build long-term savings to supplement your retirement income from Social Security and other personal savings. The Stock Purchase Plan gives you both the opportunity to invest in your company and a stake in its future.

Finally, some of your benefits help you balance the needs of your work and family life. These benefits include the: Health Savings Account; Limited Purpose Health Care Flexible Spending Account; and Dependent Care Flexible Reimbursement Account. These benefits also include: vacation, holidays, the Tuition Assistance Plan, and the John Deere Employee Purchase Plan.

Value

That's what benefits represent to Deere & Company employees and families. They're an important part of the value of your job. It is important for you to understand your benefits and decide how to make the most of the plans and programs available to you and your family.

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Who Is This Document For?

You may be covered by or eligible for the benefits and personnel policies described in this document if you are a salaried employee on the U.S. payroll or the U.S. pension of Deere & Company and you are (or were), actively employed by a business unit listed below on or after July 1, 1993 (Exceptions: John Deere Financial (79 or 9A), or John Deere Healthcare (9F), on or after January 1, 1994; John Deere Insurance (81), John Deere Life (82), or John Deere Transportation (9E), on or after January 1, 1995).

Units With Active U.S. Employees	
1000-A&T Sales Marketing	LV00-Augusta - C&CE
1700-Const Eq - Marketing Admin	M 00-Horicon
1800-JD Power Systems - Waterloo	MI00-Southeast Engineering Center
2V01-Waratah Forest Attch - Atlanta	N 00-Des Moines
3L00-JD Mexico Trading Co	NA00-JD ISG - Torrance
4B00-JD Global Trading Co	PC00-JD ISG - Urbandale
7900-JD Financial - Johnston	PH00-John Deere Electronic Solutions-Fargo
9000-World Headquarters	R 00-Waterloo Works
9A00-JD Financial - Madison	RE00-Product Engineering
A800-JD Seeding Valley City	RF00-Waterloo Foundry
AN00-A&I Products U.S.	RG00-Waterloo Engine
DW00-Davenport	SB00-Sunbelt
DY00-Parts Dist Center	SE00-JD Reman - Springfield
E 00-Ottumwa	T 00-Dubuque
FF00-Kernersville	T800-JD Thibodaux
GX00 - Greeneville	TC00-Turf Care
H 00-Harvester East Moline	YZ00-JD Coffeyville
H 02-Harvester Seeding Group	YK00-John Deere Performance Upgrade
JL00-JD Paton	

Units With Retired U.S. Employees	
0500-Raleigh	KV00-Knoxville
1000-A&T Sales Marketing	LV-00-Augusta - C&CE
1700-Const Eq - Marketing Admin	M 00-Horicon
1800-JD Power Systems - Waterloo	MI00-Southeast Engineering Center
2800-Construction Equipment OVS	N 00-Des Moines
2V01-Waratah Forest Attch - Atlanta	NA00-JD ISG - Torrance
3G00-Timberjack Corp - Atlanta	PC00-JD ISG - Urbandale
3L00-JD Mexico Trading Co	PH00-John Deere Electronic Solutions - Fargo
4B00-JD Global Trading Co	PS00-John Deere Electronic Solutions - Springfield
7900-JD Financial - Johnston	R 00-Waterloo Works
8100-JD Insurance	RE00-Product Engineering Center
8200-JD Life Insurance	RF00-Waterloo Foundry
9000-World Headquarters	RG00-Waterloo Engine
9A00-JD Financial - Madison	T 00-Dubuque
9E00-JD Transp - Brookfield	T800-JD Thibodaux
9F00-JD Health	TC00-Turf Care
9Q00-JD Water U.S.	TR00-Special Technologies Group
A800-JD Seeding Valley City	V300-JD Cons Prod - Charlotte
AI00-JD Agri Svcs - Atlanta Legacy	VC00-Global Vehicle Communication
CS00-JD Foundry	VE00-JD Cons Prod - Clover
DW00-Davenport	VG00-Vehicle Group
DY00-Parts Dist Center	VJ00-JD Cons Prod - Columbia
E 00-Ottumwa	VM00-JD Cons Prod - Gastonia
EV00-Equipment Savers - Colorado	VP00-JD Cons Prod - Greer
GX00-Greeneville	VW00-JD Cons Prod - Sacramento
H 00-Harvester - East Moline	YZ00-JD Coffeyville
H 02-Harvester Seeding Group	YK00-John Deere Performance Upgrade
JL00-JD Paton	

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My Benefits at a Glance

Benefit	Description	Participation
Flexible Benefits	Through John Deere flexible benefits, you have choices. Flexible benefits are a method of providing these benefits to eligible employees, using before tax dollars.	
Medical	You may have a variety of medical options; each pays benefits for Covered Health Services in case you or a covered family member suffers an illness or injury. Most options also pay benefits for certain preventive care such as annual physicals.	You can join the Plan as of the first day of the month after you start work and each year during the flex enrollment period.
Dental	The Dental Plan pays benefits for a broad range of covered dental services—from preventive care to oral surgery and orthodontia.	Participation is voluntary; you can join the Plan as of the first day of the month after you start work. Active employees can elect new coverage effective in each year during the flex enrollment period.
Health Savings Account (HSA)	This account allows you to use pre-tax dollars to pay for qualified medical expenses not otherwise reimbursed.	If eligible, an annual company contribution is made to your HSA. Personal contributions are voluntary.
Limited Purpose Health Care Flexible Spending Account (Active only)	This account uses pre-tax dollars to pay for out-of-pocket dental and vision expenses.	Participation is voluntary; you can join the Plan as of the first day of the month after you start work, and each year during the flex enrollment period.
Dependent Care Flexible Reimbursement Account (Active only)	This account uses pre-tax dollars to pay for Dependent Care expenses.	Participation is voluntary; you can join the Plan as of the first day of the month after you start work, and each year during the flex enrollment period.
Group Life/AD&D Insurance (Active only)	If hired, rehired, or transfered to participating status under the SPD prior to 1/1/2018 or an employee of John Deere Reman Electronic Solutions (f/k/a Ciona), John Deere provides you with group life insurance and AD&D coverage of up to two times your annual salary (minimum $25,000). Otherwise, your coverage is one times your annual salary (minimum $25,000).	Coverage is automatic as of the day you start work.
Optional Life Insurance (Active only)	You can choose optional life insurance up to eight times your annual salary (maximum $1,500,000). Coverage also is available for your spouse and dependent children.	Participation is voluntary. Proof of insurability may be required.
Voluntary Benefits (Active only)	You have the option to enroll in three voluntary benefits that will provide income protection - Critical Illness, Accident, and Hospital Indemnity.	Participation is voluntary.

My Benefits at a Glance (continued)

Benefit	Description	Participation
Salary Continuance (Active only)	Employees hired prior to November 1, 2014: If you are ill or disabled, all or part of your monthly salary is continued for up to 12 months (depending on your length of service). Employees hired, rehired or transferred to participation status under this SPD on or after November 1, 2014: Each year of service earns a month of SAC at 100% of pay, up to six months, if you are ill or disabled. Salaried employees at Seeding Valley City have 6 months of SAC eligibility.	Coverage is automatic as of the day you start work.
Short-Term Disability (Active only)	As a salary intern, you salary will be continued at 65% for up to 26 weeks if you are ill or disabled.	Coverage is automatic as of the day you start work.
Long-Term Disability (Active only)	If you are disabled, the Plan provides up to 60% of your monthly salary.	Coverage is automatic as of the day you start work.
Pension Plan (for employees of units that have a defined benefit pension plan.)	The Plan provides you with income when you retire.	Coverage is automatic as of the day you start work.
Savings and Investment Plan (Active only)	You can contribute up to 75% of your salary on a pre-tax basis and/or Roth after-tax basis. Based on company profitability, John Deere may match a portion of your contributions on a pre-tax basis. If you are age 50 or older as of December 31 of the calendar year, you are eligible to make catch-up contributions. The catch-up amount will be based upon your election as described above, and will begin once you have reached the current year's IRS maximum.	To enroll call the John Deere Savings & Retirement Service Center at Fidelity Investments at 1-800-354-3427 [hereafter referred to as the Service Center] or visit their website at www.netbenefits.com. Participation is voluntary . New hires are auto-enrolled 30 days following date of hire.
Stock Purchase Plan (Active Only)	You can contribute 1% to 15% of your salary, on an after-tax basis, to purchase Deere & Company common stock.	Participation is voluntary. Contact Deere Direct to enroll.
Vacation/Paid Time Off and Holidays (Active only)	You earn time off each year based on your continuous employment; you may have options to buy, or defer vacation. John Deere also provides time off with pay for certain holidays	You earn additional time off the longer you work for John Deere. To buy, defer or retrieve vacation, you need to complete a form.
Tuition Assistance Plan (Active only)	You are eligible for classes with a start date on or after date of hire.	Contact the John Deere Benefits Center at 844-689-7833 or log on to benefit portal at www.yourbenefitsresources.com/deere for more information.
John Deere Employee Purchase Plan for John Deere Consumer Equipment	You can receive a discount on covered purchases of new John Deere Consumer Equipment when they are purchased from a John Deere Dealer.	Go to www.Deere.com/EPP to apply for an EPP voucher via John Deere Rewards before visiting a John Deere dealer.
Supplier Discount and Discounted Voluntary Benefits	Supplier discounts are available on products and for Identity Theft Protection and Pet Insurance.	Participation is voluntary.

My Life Quick Links

The following sections provide an overview of your benefits when certain events occur. If you have questions about the impact of a Life Event, please contact a Service Representative at the John Deere Benefits Center by calling 1-844-689-7833 or go to the benefit portal at www.yourbenefitsresources.com/deere.

What Happens When ...

What Happens When ... You Take a Leave of Absence?

Your Deere & Company benefits are affected when you take a leave of absence (see Family Leave if this applies). This is a summary of what happens.

Medical Benefit Plan and Dental Benefit Plan

For leaves less than six weeks—pre-tax premium eligibility continues with employee premiums placed in arrears and collected upon your return from leave.

For leaves beyond six weeks—pre-tax premium eligibility ends. You may continue paying premiums on an after-tax basis at the employee subsidized rate for the first 6 weeks and 50% of the full benefit continuation rate beginning at the 7th week and for up to six months. Premiums are paid through direct billing. Coverage is available through COBRA after six months.

For company HSA contributions, if you are enrolled in a CarePlus or CarePlusMAX plan you will not continue to be eligible for the company HSA contribution for leaves greater than six weeks.

For all leaves—you may elect to discontinue coverage during your leave.

When you return from leave where coverage was not continued during the leave:

- In the same calendar year, coverage resumes in the options selected prior to the leave, unless you have a corresponding family or employment status change.
- In a different calendar year, You will be given an enrollment event to select your coverage options. You will have 31 days to elect your coverage.
- Dual Eligibility—you can discontinue and have coverage under your spouse. If your spouse is a salaried employee, he/she must change dependent coverage to include you during your period of leave.

Limited Purpose Health Care Flexible Spending Account

For leaves less than six weeks, pre-tax eligibility ends and contributions are stopped. Upon return from leave, you will be reinstated and your pre-tax deductions will be adjusted to meet your prior goal amount.

For leaves beyond six weeks, pre-tax eligibility ends. You may continue contributions on an after-tax basis through the direct billing process. When you return from leave in the same year, pre-tax contributions will begin through the payroll process. If your leave crosses plan years, your eligibility ends on the last day of the year.

If contributions are continued, you can claim expenses incurred during the leave period.

If you choose not to continue contributions, you may not claim expenses incurred during the period of leave.

You may always claim expenses incurred during periods you contributed to your account.

For all leaves, you may elect to discontinue coverage during your leave. When you return from leave, re-enrollment for coverage is necessary if you discontinued coverage. You will have 31 days from your return to make your election.

Dependent Care Flexible Reimbursement Account

- Coverage ends the pay period following the start of your leave.
- You have until March 31st of the following year to obtain reimbursement for claims incurred prior to your leave.

Health Savings Account (HSA)

- If enrolled in a CarePlus or CarePlusMAX medical plan option, Company HSA contribution eligibility will no longer continue for leaves greater than six weeks.
- Company will continue to pay for HSA account management fees while enrolled.
- Payroll deferrals to HSA cease until you return to work.
- You may make additional personal contributions through Fidelity.

Group Life/AD&D Insurance

- Coverage ends at the end of the pay period your leave begins.
- Coverage can continue if you pay for coverage through direct billing.
- When you return from leave—coverage continues/resumes.

Optional Life Insurance

- Coverage ends at the end of the pay period your leave begins.
- Coverage can continue if group life is continued and if you pay for coverage through direct billing.
- When you return from leave:
  - For a family leave or if coverage continued during your leave, coverage continues or resumes without reenrollment.
  - Otherwise, coverage resumes upon reenrollment and proof of insurability.

Salary Continuance or Short-Term Disability

- Coverage ends on the day your leave begins.
- When you return to active employment from leave—coverage resumes.

Long-Term Disability Coverage

- Coverage ends on the day your leave begins.
- When you return to active employment from leave—coverage resumes.

Pension Plan

- You continue to participate in the Plan.
- You continue to earn service credit, as long as you are credited with at least 500 hours worked during the anniversary year in which leave occurs.
- When you return from leave—participation continues with service credit adjusted if necessary.
- Pay Credits are suspended during an unpaid leave of absence for Cash Balance Benefit participants until you return. Interest Credits continue during your leave.

Savings and Investment Plan

- Contributions suspended; you can continue to make transactions.
- New loans are permitted; loan payments are suspended through payroll deduction, payments are continued through Automated Clearing House (ACH). Loans must be paid in full within original loan term in order to avoid loan default and a taxable event.
- When you return to active employment from leave—contributions resume automatically.

Stock Purchase Plan

- Contributions suspended.
- When you return to active employment from leave—contributions resume automatically.

Time Off/Holidays

- Time off earned for next anniversary year are prorated, based on length of leave.
- Employees on military leave generally receive pay instead of time off for days earned as of their anniversary date. During the military leave, time off continues to be earned.
- When you return to active employment from leave—eligibility and time off accrual resume.
- Unused days remaining when your leave begins may be sold or deferred under provisions of the Plan.
- However, any unused days remaining on your next anniversary date will be lost.

John Deere Employee Purchase Plan

- Eligibility continues.

Tuition Assistance Plan

- Not eligible to begin new degree or course when on leave of absence.
- When you return to active employment from leave—eligibility resumes.

Voluntary Benefits

- Coverage continues until you terminate your coverage at Paylogix.

What Happens When ... You Are Disabled?

If you become disabled—on salary continuance or short-term disability—your John Deere benefits may be affected. The following summarizes what happens.

Salary Continuance/Short-Term Disability

What Happens When ... You Are Unable to Work Due to Illness or Injury? If you are on Salary Continuance/Short-Term Disability:

Medical Benefit Plan and Dental Benefit Plan

- Your coverage continues at pre-tax, company subsidized flex rates.

Health Savings Account (HSA)

- If enrolled in a CarePlus or CarePlusMAX medical plan option, Company HSA contribution eligibility will continue.
- Company will continue to pay for HSA account management fees while enrolled.
- Payroll deferrals to HSA are allowed.

Limited Purpose Health Care Flexible Spending Account

Pre-tax eligibility continues.

- You can continue to file claims against your account.

Dependent Care Flexible Reimbursement Account

Pre-tax eligibility continues.

- You can continue to file claims against your account.

Group Life/AD&D Insurance

- Coverage continues.

Optional Life Insurance

- Coverage continues.
- Contributions deducted from salary continuance or short-term disability benefit payments.

Long-Term Disability Coverage

- Coverage continues.

Pension Plan

- You continue to earn service credit.
- When you return from salary continuance or short-term disability—participation continues and service credit continues unbroken.
- For Cash Balance Benefit participants, Pay Credits and Interest Credits continue.

Savings and Investment Plan

- Contributions continue.

Stock Purchase Plan

- Contributions continue.

Time Off/Holidays

- You continue to earn time off.
- Where eligible, an employee may be able to defer time off.
- If your period of salary continuance or short-term disability extends into your next anniversary year, unused vacation from the current year will be lost unless deferred (if eligible). If you are in a PTO plan unused paid time off will still be available to use. New paid time off hours will accrue until the cap is reached. Paid time off maximum cap hours vary by unit.

John Deere Employee Purchase Plan

- Eligibility continues.

Tuition Assistance Plan

- Not eligible to begin new degree or course when on salary continuance or short-term disability.
- When you return from disability—eligibility resumes.

Voluntary Benefits

- Coverage continues until you terminate your coverage at Paylogix.

Long-Term Disability (LTD)

What Happens When ... You Are Disabled? If you are on LTD:

Medical Benefit Plan and Dental Benefit Plan

- Coverage continues at company subsidized premium rates on an after-tax basis .Your premiums are deducted from LTD benefit payments.
- If you were hired, rehired or transferred to participation status under this SPD on or after November 1, 2014, or are a salaried employee at Seeding Valley City; company subsidized medical and dental coverage will continue for up to 24 months. COBRA coverage is available after the 24 months.
- Your premiums are deducted from LTD benefit payments.
- If you return from LTD—coverage premiums are reinstated on a pre-tax basis.

Health Savings Account (HSA)

- If enrolled in a CarePlus or CarePlusMAX medical plan option, Company HSA contribution eligibility will continue.
- You may not defer HSA contributions from your Long-Term Disability payment. Any personal HSA contributions will need to be made directly to Fidelity.
- Company contributions continue.

Limited Purpose Health Care Flexible Spending Account

Pre-tax eligibility ends.

- You can file claims for expenses incurred prior to going on LTD.
- You can continue contributions on an after tax basis (COBRA) for up to 29 months. Contributions are made through direct billing.
- If you return from disability—coverage is reinstated. You may re-enroll within 31 days if in a new calendar year.

Dependent Care Flexible Reimbursement Account

Eligibility ends; you can continue to submit claims incurred prior to LTD against your remaining account balance.

- If you return from disability—coverage is reinstated. You may re-enroll within 31 days if in a new calendar year.

Group Life/AD&D Insurance

- Coverage continues while receiving LTD benefits .
- If you were hired, rehired or transferred to participation status under this SPD on or after November 1, 2014, or are a salaried employee at Seeding Valley City; subsidized group life/AD&D coverage will continue for up to 24 months.

Optional Life Insurance

- Coverage continues while receiving LTD benefits .
- If you were hired, rehired or transferred to participation status under this SPD on or after November 1, 2014, or salaried employee at Seeding Valley City; Optional Life coverage will continue for up to 24 months.
- Contributions deducted from LTD benefit payments.

Long-Term Disability Coverage

- 60% of monthly salary continues, starting after salary continuance; and continuing until eligibility ends.
- If you return from disability—eligibility resumes.

Pension Plan

- If you have less than five years (three years for Cash Balance Benefit), of service and are on LTD, you will not be eligible for pension benefits.
- If you have five or more years (three or more years for Cash Balance Benefit), of active service when LTD begins, service credit is awarded for time on LTD when you become eligible for early or normal retirement.

Savings and Investment Plan

- Contributions end.
- You can continue to make transactions.
- New loans are not allowed; loan payments are suspended through payroll deduction.
- Payments are continued through ACH.
- Loans must be paid in full within original loan term in order to avoid loan default and a taxable event.
- If you return to active employment you must re-enroll in the Plan.

Stock Purchase Plan

- Contributions end.
- You can keep shares in the Plan, transfer them, or take the account (in part or in full), as shares or in cash.
- If you return from disability—eligibility resumes; re-enrollment required.

Time Off/Holidays

- You stop earning paid time off when LTD starts.
- If you return from disability—paid time off eligibility and accrual resume. The amount of vacation earned on your next anniversary year will be pro-rated.
- Any remaining unused and accrued time off will be paid.

John Deere Employee Purchase Plan

- Eligibility continues.

Tuition Assistance Plan

- Not eligible to begin new degree or course when on disability.
- If you return from disability—eligibility resumes.

Voluntary Benefits

- Coverage continues until you terminate your coverage at Paylogix.

What Happens When ... You Leave the Company?

If you leave the company because of involuntary separation or voluntary separation, your Deere & Company benefits are affected. The following summarizes what happens.

Medical Benefit Plan

- Coverage ends at the end of the payroll period in which you leave.
- Coverage available on an after-tax basis (at the full continuation rate for COBRA) for up to 18 months. Contributions are made through direct billing.
- Conversion to individual policy available after 18-month period ends.

Dental Benefit Plan

- Coverage ends at the end of the payroll period in which you leave.
- Coverage available on an after-tax basis (at the full continuation rate for COBRA) for up to 18 months. Contributions are made through direct billing.

Health Savings Account (HSA)

- Payroll deferrals stop.
- Company HSA contributions stop.
- Company does NOT pay for HSA fees.
- Terminated employee will be responsible for any HSA fees.

Limited Purpose Health Care Flexible Spending Account

- Pre-tax eligibility ends at the end of the payroll period in which you leave. You can claim expenses incurred prior to leaving the company.
- Continued participation through COBRA is available on an after-tax basis through the end of the enrollment year. Contributions are made through direct billing and allows you to continue participating in the Limited Purpose Health Care Flexible Spending Account.
- If contributions are continued, you can claim expenses incurred while you participate through COBRA.
- If you choose not to continue contributions through COBRA, you may not claim expenses incurred after you leave the company. Any expenses incurred prior to leaving the company must be filed by March 31st of the following year. Election to continue contributions must be made within 31 days of termination.

Dependent Care Flexible Spending Account

Pre-tax eligibility ends.

- You can claim expenses incurred prior to leaving the company against any remaining account balance.
- Any expenses incurred prior to leaving the company must be filed by March 31st of the following year.

Group Life/AD&D Insurance

- Coverage ends on the last day of employment.
- Conversion to individual policy available.

Optional Life Insurance

- Coverage ends at the end of the pay period you last worked.
- Conversion to individual policy available.

Salary Continuance/Short-Term Disability

- Coverage ends on the day you terminate.

Long-Term Disability Coverage

- Coverage ends on the day you terminate.

Pension Plan

- Participation ends.
- If you have at least five years of active service credit and participate in either the Traditional or Contemporary Option, you are eligible for a deferred vested pension benefit.
- If you have at least three years of active service credit and participate in the Cash Balance Benefit, you have a vested pension benefit. Participants may elect to receive payment at the time of permanent separation or defer until a later date. If you elect to defer, Interest Credits will continue.
- If your benefit under the Pension Plan (including your cash balance account and the present value of your benefit under the Contemporary or Traditional Option, if applicable), does not exceed $1,000 at the time of distribution, it will be distributed to you in cash with 20% federal income tax withholding applied.
- If your benefit under the Pension Plan (including your cash balance account and the present value of your benefit under the Contemporary or Traditional Option, if applicable), does not exceed $5,000 but is greater than $1,000 at the time of distribution, you may elect a lump sum distribution in cash or a rollover to an IRA or another employer's eligible retirement plan that will accept the rollover. If you do not make an election in this latter case regarding whether to receive the distribution in cash or as a rollover, an IRA will be established in your name by the Plan Administrator and your distribution will be rolled over to the IRA.
- If your benefit under the Pension Plan (including your cash balance account and the present value of your benefit under the Contemporary or Traditional Option, if applicable), exceeds $5,000 at the time of distribution, you may elect to receive in all the forms offered by the Plan.

Savings and Investment Plan

- Contributions end.
- You can continue to make transactions.
- New loans are allowed but only for those with a retired status.
- Loan payments are suspended through payroll deduction, payments are continued through ACH.
- Loans must be paid in full within original loan term in order to avoid loan default and a taxable event.

Stock Purchase Plan

- Contributions end.
- You decide what to do with shares you own. You can keep shares in the Plan, transfer them, or take the account as shares or cash (in part or in full).

What Happens When ... You Leave the Company? (continued)

If you leave the company because of involuntary separation or voluntary separation, your Deere & Company benefits are affected. The following summarizes what happens.

Time Off/Holidays

- Remaining and deferred time off is paid to you as taxable cash.
- Prorated payment for vacation provided based on the period between your last anniversary date and your termination date.

John Deere Employee Purchase Plan

- Eligibility ends.

Tuition Assistance Plan

- Eligibility ends.

Voluntary Benefits

- Coverage continues until you terminate your coverage at Paylogix.

What Happens When ... You Take Early or Normal Retirement

When you retire from Deere & Company, your benefits are affected. The following summarizes what happens.

Medical Benefit Plan and Dental Benefit Plan

- If your service date in your last period of employment is prior to April 1, 2000, you may be eligible for subsidized retiree medical and dental coverage if you meet the retirement conditions of the pension plan and worked at an eligible unit. If eligible for retiree healthcare, you will transition automatically from active to retiree coverage on your first day of retirement.
- Your enrollment will be for both medical and dental coverage. You may change your elections annually during open enrollment.
- If retired, at age 65 or when eligible for Medicare, whichever occurs first, Medicare becomes primary and Deere Plan is secondary. You must apply for Medicare Part B coverage. Special exceptions may apply for End Stage Renal Disease or Early Medicare.
- Payments will be deducted from your pension benefit at the retiree continuation rate, on an after-tax basis.
- You may change your coverage category at the time of retirement.
- You may opt out of coverage in retirement, but if you do, you may only opt into coverage during the annual open enrollment or if you lose other coverage. Special provisions and dates apply.
- If eligible for company subsidized retiree medical, upon eligibility for Medicare, your company provided benefit will be in the form of Retiree Medical Credits and you will no longer be eligible for a CarePlus or CarePlusMAX plan. Special transition year rules may apply.
- If not eligible for subsidized retiree medical coverage, your subsidized coverage from the company will end on your last day worked. You will be eligible for COBRA continuation coverage for up to 36 months.

Health Savings Account (HSA)

- If you are enrolled in a CarePlus or CarePlusMAX medical plan option:
  - Company HSA contribution eligibility will continue.
  - You may not defer HSA contributions from your pension. Any personal account contributions will need to be made directly to Fidelity.

Limited Purpose Health Care Flexible Spending Account

- Pre-tax participation ends.
- You can continue participating by making contributions on an after-tax basis (COBRA) for up to 36 months. Contributions are made by personal check. Election to continue contributions must be made within 31 days of your retirement.
- You can claim expenses incurred while you participate.
- If not participating, you can claim expenses only incurred prior to retirement. If you choose not to continue contributions, you may not claim expenses incurred after you retire. Any expenses incurred prior to leaving the company must be filed by March 31 of the following year.

Dependent Care Flexible Spending Account

- Pre-tax eligibility ends.
- You can claim expenses incurred while you participate (making contributions).
- If not participating (making contributions), you can claim expenses only incurred prior to your retirement. If you choose not to continue contributions, you may not claim expenses incurred after you retire. Any expenses incurred prior to leaving the company must be filed by March 31st of the following year.

Group Life/AD&D Insurance

- Employees hired before July 1, 1993—group life insurance equal to annual salary in effect on June 30, 1993 (as of December 31, 1993 for John Deere Health and as of December 31, 1999 for John Deere Financial), (or $25,000, whichever is more); AD&D coverage ends.
- Employees hired on or after July 1, 1993 but prior to November 1, 2014—group life insurance of $25,000; AD&D coverage ends.
- Employees hired, rehired or transferred to participation status under this SPD on or after November1,2014 have no group life insurance in retirement. Employees hired into JD Seeding Valley City, Sunbelt and A&I Products have no group life insurance in retirement.
- Your group life coverage provided by the company will end on your last day worked.

Optional Life Insurance

- Coverage ends at the end of the pay period you last worked.
- Conversion to individual policy available.

Salary Continuance/Short-Term Disability

- Coverage ends on the day you retire.

Long-Term Disability Coverage

- Coverage ends on the day you retire.

Pension Plan

- You may apply for pension benefits; your monthly pension payment or your lump sum for Cash Balance Benefit participants will be directly deposited in your bank account the first working day of the month.

What Happens When ... You Take Early or Normal Retirement (continued)

When you retire from Deere & Company, your benefits are affected. The following summarizes what happens.

Savings and Investment Plan

- Contributions end; you can continue to make transactions.
- New loans are allowed for those with a status of retired; loan payments are suspended through payroll deduction, payments are continued through ACH.
- Loans must be paid in full within the original loan term in order to avoid loan default and a taxable event.

Stock Purchase Plan

- Contributions end.
- You decide what to do with shares you own. You can keep shares in the Plan, transfer them, or take the account as shares or cash (in part or in full).

Time Off/Holidays

- Deferred vacation days can be taken as cash or as paid time off before retirement.
- Any unused time off, as of your retirement date, are paid for the current year.
- Prorated vacation payment provided based on the period between your last anniversary date and your retirement date.

John Deere Employee Purchase Plan

- Eligibility continues.

Tuition Assistance Plan

- Eligibility ends.

Voluntary Benefits

- Coverage continues until you terminate your coverage at Paylogix.

What Happens When ... You Die

If you die, your Deere & Company benefits are affected and may continue to your survivors. The following summarizes your survivors' benefits.

Medical Benefit Plan and Dental Benefit Plan

- If you are eligible to retire with company subsidized benefits within 12 months of your death, your surviving spouse can continue coverage at the company subsidized retiree rate.
- Your surviving spouse can continue COBRA coverage at the company subsidized, flex rate for 12 months; then for 24 additional months at COBRA rates.
- If there is no surviving spouse, your other eligible dependents can continue COBRA coverage for up to 36 months at the full COBRA rate.
- Survivors may change medical option and coverage category at time of your death.

Health Savings Account (HSA)

- If surviving spouse is enrolled in a CarePlus or CarePlusMAX medical plan option at company subsidized rates, they will be eligible for the company HSA contribution.
- Any personal HSA contributions will need to be made directly to Fidelity.

Limited Purpose Health Care Flexible Spending Account

Survivors can claim expenses incurred prior to your death. You may not claim expenses incurred after the employee's death. Any expenses incurred prior to the employee's death must be filed by March 31st of the following year.

Dependent Care Flexible Spending Account

Survivors can claim expenses incurred prior to your death against any remaining account balance. You may not claim expenses incurred after the employee's death. Any expenses incurred prior to the employee's death must be filed by March 31st of the following year.

Group Life/AD&D Insurance

- Benefits paid to your beneficiary (If you have not named a beneficiary at the time of your death, completion of a Preference Beneficiary Affidavit will be required to determine surviving relatives-spouse, children, parents, siblings. If there are no surviving relatives at the time of your death, benefits will be paid to your estate).

Optional Life Insurance

- If you have this coverage, benefits are paid to your beneficiary (If you have not named a beneficiary at the time of your death, completion of a Preference Beneficiary Affidavit will be required to determine surviving relatives-spouse, children, parents, siblings. If there are no surviving relatives at the time of your death, benefits will be paid to your estate).

Salary Continuance/Short-Term Disability

- Coverage ends.
- No survivor benefits payable under the Plan.

Long-Term Disability Coverage

- Coverage ends.
- No survivor benefits payable under the Plan.

Pension Plan

Contemporary and Traditional Option Participants

- If you're eligible to retire when you die—your spouse will receive a survivor pension benefit equal to 55% of your pension benefit as long as you were married at least one year prior to death. Benefit payments begin on the first working day of the month following your death; or
- If you have five or more years of service when you die—your spouse will receive a survivor pension benefit equal to 55% of your pension benefit figured as of the earliest date on which you could have retired. Benefit payments begin on the first working day of the month following the earliest date you could have retired; or
- If you have less than five years of service or if you are not married—no survivor benefits are payable.
- Pension payments are automatically deposited into your bank account.
- Surviving spouse pension benefits may be subject to a Qualified Domestic Relations Order (QDRO).

Cash Balance Benefit Participants

- If you have three or more years of service, are an active employee and are married when you die, your spouse will receive a survivor pension benefit equal to 100% of your account. Benefit payments may begin on the first working day of the month following your death. Your spouse may elect to receive the benefit as a single lump sum payment. Your surviving spouse may also elect to defer payment until a later date, but no later than the date you would have attained normal retirement age under the Plan, had you lived.
- You may also designate one or more beneficiaries to receive a portion of your account with a spousal waiver if you are married, and each beneficiary will receive a single lump sum payment based upon their proportionate share. The benefit will be paid as soon as reasonably possible; or
- If you have three or more years of service, are an active employee and unmarried when you die, your designated beneficiary or beneficiaries will receive a survivor pension benefit equal to 100% of your account value as a single lump sum payment. The benefit will be paid as soon as reasonably possible following your date of death.
- If you have less than three years of service or are unmarried and have not designated a beneficiary, no survivor benefits are payable.
- If you have separated from the Company and all of its subsidiaries and affiliates when you die and you were vested when you left, you and your spouse have the same options as an active employee described in the first two bullets. However, your beneficiary or beneficiaries will receive a total of 55% of your account value.

What Happens When ... You Die (continued)

If you die, your Deere & Company benefits are affected and may continue to your survivors. The following summarizes your survivors' benefits.

- Pension payments may be automatically deposited into your bank account.
- Surviving spouse pension benefits may be subject to a Qualified Domestic Relations Order (QDRO).

Savings and Investment Plan

- Assets are transferred to your beneficiary (ies).
- Your beneficiary must contact the Plan record keeper to request a distribution.
- Distribution of all or part of your vested account may be elected; however, 100% of the vested account balance must be distributed no later than five years from your death date. Spousal beneficiary may elect to roll over the balance to an IRA.

Stock Purchase Plan

- If held in joint tenancy, account paid to your survivor.
- In all other cases, account paid to your estate.

Time Off/Holidays

- Remaining and deferred time off paid to your survivors.
- Any purchased days not used paid as taxable cash to your survivors.
- Prorated vacation payment provided to your survivors based on the period between your last anniversary date and your death. These payments will be paid to your estate in the event of no survivors.

John Deere Employee Purchase Plan

- Eligibility continues for a surviving spouse, if he/she is eligible for medical and/or pension benefits.

Tuition Assistance Plan

- Eligibility ends.

Voluntary Benefits

- Coverage ends if enrolled.

What Happens When ... You Get Married

Your Deere & Company benefits are affected when you get married. When this event occurs, you must notify the John Deere Benefits Center to add dependents or change your flexible spending account election. The following summarizes what happens.

Medical Benefit Plan and Dental Benefit Plan

- You may not change your medical and dental option but coverage may be elected for spouse and eligible children of spouse only.
- Coverage is effective:
  - No earlier than the date of marriage;
  - On the date of marriage, if notice is provided within 31 days after date of marriage (notice requires copies of birth certificates for spouse and any eligible dependents as well as a copy of your marriage certificate); or
  - On the date notification is provided if later than 31 days after the date of marriage (notice requires copies of birth certificates for spouse and any eligible dependents as well as a copy of your marriage certificate).
  - Payroll deductions begin as of the first payroll period following date of coverage.

Health Savings Account (HSA)

- If employee is enrolled in a CarePlus or CarePlusMAX medical plan option, Company HSA contribution eligibility will continue (and pending a change in coverage tier, company HSA contribution may increase or decrease).
- Payroll HSA deferrals are allowed.
- If employee opts out of company provided health coverage and is no longer enrolled in a CarePlus or CarePlusMAX medical plan option, Company HSA contribution eligibility will stop. Payroll deferrals to HSA stop.

Limited Purpose Health Care Flexible Spending Account

Coverage continues.

- You may stop, start, increase or decrease coverage.
- Coverage is effective:
  - No earlier than the date of marriage;
  - On the first day of the pay period after marriage is reported.
  - Payroll deductions begin as of the first payroll period following date of coverage.

Dependent Care Flexible Spending Account

Coverage continues.

- You may stop, increase, decrease, or start coverage.
- Coverage is effective:
  - No earlier than the date of marriage; or on the first day of the pay period after marriage is reported.
  - Payroll deductions begin with the payroll period in which coverage becomes effective.

Group Life/AD&D Insurance

- Coverage continues (spouse is not eligible).
- You should review your beneficiary designation.

Optional Life Insurance

- Coverage continues if you are enrolled.
- Spouse and eligible children can be enrolled if you are covered.
- No Evidence of Insurability required if spouse enrolls within 31 days of marriage.
- You should review your beneficiary designation.

Salary Continuance/Short-Term Disability

- Coverage continues.

Long-Term Disability Coverage

- Coverage continues.

Pension Plan

- You continue to participate in the Plan, if eligible.
- If you participate in the Cash Balance Benefit, you should review your beneficiaries on file to make sure they are appropriate.
- If you have designated a non-spouse beneficiary for any death benefits payable from the Plan, that beneficiary designation will no longer apply. Your spouse will be designated as the beneficiary to receive 100% of any death benefits payable unless you designate a new beneficiary and obtain spousal consent to your designation of an alternate beneficiary.

Savings and Investment Plan

- Eligibility continues.
- Your spouse becomes your sole beneficiary unless spousal consent is given to name someone other than or in addition to your spouse by contacting Fidelity Investments.

Stock Purchase Plan

- Eligibility continues.

Time Off/Holidays

- You continue to earn time off.

John Deere Employee Purchase Plan

- Eligibility continues.

Tuition Assistance Plan

- Eligibility continues.
- Voluntary Benefits
- Coverage ends if enrolled.

Voluntary Benefits

- You may change your voluntary benefit elections from the Life Changes page of the benefit portal.

What Happens When ... You Get Divorced

Your Deere & Company benefits are affected when you get divorced. When this event occurs, you must notify the John Deere Benefits Center immediately to determine how your benefits will be affected. The following summarizes what happens.

Medical Benefit Plan and Dental Benefit Plan

- You are required to report your divorce to the John Deere Benefits Center by calling 1-844-689-7833 or by accessing benefit portal at www.yourbenefitsresources.com/deere within 31 days of the date of divorce. A copy of the first and last pages of the divorce decree is required.
- Payroll deductions for spouse's coverage stop as of the first payroll period following date of notification; deductions are refunded for current coverage period if the John Deere Benefits Center is notified within 31 days of the divorce.
- Coverage for children will continue if elected or required under a Qualified Medical Child Support Order (QMCSO).
- In order for your ex-spouse and/or children to elect continuation coverage under COBRA, you or they must notify the John Deere Benefits Center within 60 days of the event.
- You may not change your medical and dental option but coverage must be dropped for spouse and step-children only.

Health Savings Account (HSA)

- If employee is enrolled in a CarePlus or CarePlusMAX medical plan option, Company HSA contribution eligibility will continue (and pending a change in coverage tier, company contribution may increase or decrease).
- Payroll HSA deferrals are allowed.

Limited Purpose Health Care Flexible Spending Account

Coverage continues.

- You may stop, start, increase or decrease coverage.
- Change is effective on the first day of the pay period after divorce is reported.
- Payroll deductions start or stop as of the first payroll period following date of notification.
- If you stop contributions, deductions are refunded for current coverage period if the John Deere Benefits Center is notified within 31 days of the divorce.

Dependent Care Flexible Spending Account

Coverage continues as long as you remain eligible to participate.

- You may stop, start, increase or decrease coverage.
- Change is effective on the first day of the pay period after divorce is reported.
- Payroll deductions start or stop as of the first payroll period following date of notification.
- If you stop contributions, deductions are refunded for current coverage period if the John Deere Benefits Center is notified within 31 days of the divorce.

Group Life/AD&D Insurance

- Coverage continues.
- You should review your Beneficiary designation.

Optional Life Insurance

- Spouse coverage ends the day your divorce is final.
- Ex-spouse may convert coverage to an individual policy at their own expense within 31 days of when coverage ends.
- You should review your Beneficiary designation.

Salary Continuance/Short-Term Disability

- Coverage continues.

Long-Term Disability Coverage

- Coverage continues.

Pension Plan

- You continue to participate in the Plan, if eligible.
- For Contemporary and Traditional pension participants, your spouse is the only individual eligible for death benefits. For Cash Balance pension participants, you have the option to designate non-spousal beneficiaries as well.
- If you participate in the Cash Balance Benefit, you should review your beneficiaries on file to make sure they are appropriate.
- Your pension benefit may be subject to a Qualified Domestic Relations Order (QDRO).

Savings and Investment Plan

- Eligibility continues.
- You should review your beneficiary designation.
- Your benefit may be subject to a Qualified Domestic Relations Order (QDRO).

Stock Purchase Plan

- Eligibility continues.
- You should review your account registration.

Time Off/Holidays

- You continue to earn time off.

John Deere Employee Purchase Plan

- Eligibility continues.

Tuition Assistance Plan

- Eligibility continues.

Voluntary Benefits

- Coverage continues.
- You may change your voluntary benefit elections from the Life Changes page of the benefit portal.

My Health Quick Links

Medical Care

When You Need Medical Care

Non-discrimination

The benefits offered under the Plan are nondiscriminatory. The Plan complies with the nondiscriminatory requirements under Section 1557 of the Affordable Care Act and does not discriminate on the basis of race, color, national origin, age, disability or sex. Benefits offered under the Plan will be offered in a neutral, nondiscriminatory manner.

Joining the Plan

You and your eligible dependents can join the Plan as of the first day of the month after you start work.

Your Medical Options

Deere offers a variety of medical options. Each medical option pays benefits for Covered Health Services, 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 options will vary according to your plan eligibility as outlined in the John Deere Health Benefit Plan for Salaried Employees. Your medical plan options will be communicated in your fall enrollment information or can be obtained by calling the John Deere Benefits Center at 1-844-689-7833 or by accessing the benefit portal at www.yourbenefitsresources.com/deere. With all options, you are able to utilize a point-of-service feature (self-referral process), that allows you to use most providers at a reduced benefit coverage level.

All options help lower costs by offering care through a network of providers who have agreed to provide health care services at contracted rates.

Paying for Coverage

John Deere pays a major share of the cost of coverage; your cost depends on the option you choose and on the dependents you cover.

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.

Maximum Benefits

For most covered in-network medical expenses, there is currently no lifetime maximum benefit from the Plan. However, specific coverage limits do apply for some services, such as vision, hearing care, and prosthetic devices.

Hospital Services

To receive your maximum Plan benefits, you will need to use a Managed Care Organization (MCO) network participating hospital. Plan benefits also will be paid for emergency treatment at hospitals or other facilities that are outside the MCO network (see the following section for proper emergency procedures).

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.

Executive Physicals

Annual executive physicals are available to salaried employees in grades 19 and above.

Urgent Care Facility

If you're outside the MCO service area while you're on vacation or when a dependent is away at college, for example, charges by non-participating providers for emergency room or urgent care facility services are covered. This includes medical emergencies and other sudden onset illnesses or injuries that require medical care.

Care received while traveling overseas or in foreign countries will be treated as in-network for purposes of benefit administration. Please review your benefit summary or contact your MCO for detailed benefit coverages.

Point-of-Service (Self-Referral) Benefits

You can choose to go to non-participating providers, without authorization and receive benefits at reduced levels. This is called the point-of-service (self-referral) feature.

When Covered Health Services are received from an non-Network provider, Eligible Expenses are an amount negotiated by the MCO, a specific amount required by law (when required by law), or an amount the MCO has determined is typically accepted by a healthcare provider for the same or similar service. Please contact the MCO if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

The Plan has contracted with the MCO to provide advocacy services on your behalf with respect to non-Network providers when you have questions about Eligible Expenses and how the MCO determined those amounts. Please call the MCO at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if the MCO, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the MCO, or its designee, determines that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims), the MCO, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

Exclusions and Limitations

The point-of-service feature does not pay self-referral benefits for Durable Medical Equipment (DME), prosthetic devices, or organ transplants.

All point-of-service hospital stays must be pre-certified in advance with the MCO, except for emergency or urgent care. Failure to obtain a pre-certification could result in a benefit reduction of $300. See Health Care Management Services for more information on pre-certification, concurrent review, and case management services and requirements.

Explanation of Benefits/Health Statements

Periodically, you will receive Explanation Of Benefits (EOBs)/health statements from the MCO that identify the health care services you and your family have received from providers outside your network. Actual charges for those services will be included on the EOBs/health statements. If you have any questions or concerns about the charges, you should contact a MCO Customer Services Representative.

Claiming Your Benefits

When you use MCO providers, you do not need to file a claim for benefits. If you use the point-of-service feature or you have an emergency and you're out of the MCO service area, you may need to submit a claim to receive benefits.

You should:

- Show your MCO benefit card and ask your provider to bill the MCO Customer Support Department indicated on your Card.
- If the provider will not submit your claim, you may need to pay your bill and then submit a claim for reimbursement, as follows:
  - Ask your provider to complete a HCFA-1500 Medical form or a UB04 Hospital form. If the provider of service will not complete one of these forms, ask your provider for a bill that includes the diagnosis, the date services were given or supplies provided, a description of the services provided (including the appropriate CPT/HCPC code(s)), the amount of the charge, any accident details (if applicable), and the provider's name, address, phone number, and tax ID number. In addition, you will need to supply your name, member identification number, home address, daytime phone number, and a brief explanation of the situation.
  - Send the bill along with the above information to the MCO Customer Support Department indicated on your MCO benefit card.

Deadline for Submitting Point-of-Service Claims

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

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a network. At your request, UnitedHealthcare will send you a directory of network providers free of charge. Keep in mind, a provider's network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto myuhc.com. Network providers are independent practitioners and are not employees of the employer or UnitedHealthcare.

UnitedHealthcare credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Before obtaining services you should always verify the network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at www.myuhc.com or by calling the telephone number on your ID card to request a copy. If you receive a covered

health service from a non-network provider and were informed incorrectly prior to receipt of the covered health service that the provider was a network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for network benefits.

It is possible that you might not be able to obtain services from a particular network provider. The network of providers is subject to change. Or you might find that a particular network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available to you, you must choose another network provider to get network benefits. However, if you are currently receiving treatment for covered health services from a provider whose network status changes from network to non-network during such treatment due to expiration or non-renewal of the provider's contract, you may be eligible to request continued care from your current provider at the network benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment utilizing a non-network physician or health care facility, you may be eligible to receive transition of care benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care benefits, please contact UnitedHealthcare at the telephone number on your ID card.

Do not assume that a network provider's agreement includes all covered health services. Some network providers contract with UnitedHealthcare to provide only certain covered health services, but not all covered health services. Some Network providers choose to be a network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Eligible Expenses

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits.

- For network benefits for covered health services provided by a network provider, except for your cost sharing obligations, you are not responsible for any difference between eligible expenses and the amount the provider bills.
- For non-network benefits, except as described below, you are responsible for paying, directly to the non-network provider, any difference between the amount the provider bills you and the amount the claims administrator will pay for eligible expenses.
  - For covered health services that are ancillary services received at certain network facilities on a non-emergency basis from non-network physicians, you are not responsible, and the non-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is based on the recognized amount as defined in this document.
  - For covered health services that are non-ancillary services received at certain network facilities on a non-emergency basis from non-network physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-ancillary service is provided for which notice and consent has been satisfied as described below, you are not responsible, and the non-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is based on the recognized amount as defined in this document.
  - For covered health services that are emergency health services provided by a non-network provider, you are not responsible, and the non-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the recognized amount as defined in this document.
  - For covered health services that are air ambulance services provided by a non-network provider, you are not responsible, and the non-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by a network provider. which is based on the recognized amount as defined in this document.

Eligible expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law, as described in this document.

Network Benefits

Eligible expenses are based on the following:

- When covered health services are received from a network provider, eligible expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When covered health services are received from a non-network provider as arranged by the claims administrator, including when there is no network provider who is reasonably accessible or available to provide covered health services, eligible expenses are an amount negotiated by the claims administrator or an amount permitted by law. Please contact the claims administrator if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible. The plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When covered health services are received from a non-network provider as described below, eligible expenses are determined as follows:

- For non-emergency covered health services received at certain network facilities from non-network physicians when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Health Service Act with respect to a visit as defined by the secretary (including non-ancillary services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the eligible expense is based on one of the following in the order listed

below as applicable:

- The reimbursement rate as determined by a state All Payer Model Agreement.
- The reimbursement rate as determined by state law.
- The initial payment made by the claims administrator, or the amount subsequently agreed to by the non-network provider and the claims administrator.
- The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, "certain network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For ancillary services, non-ancillary services provided without notice and consent, and non-ancillary services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a non-network physician may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the recognized amount as defined in this document.

– For emergency health services provided by a non-network provider, the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claim's administrator, or the amount subsequently agreed to by the non-network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and a non-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the recognized amount as defined in this document.

– For air ambulance transportation provided by a non-network provider, the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claim's administrator, or the amount subsequently agreed to by the non-network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and a non-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by a network provider which is based on the recognized amount as defined in this document.

– For emergency ground ambulance transportation provided by a non-network provider, the eligible expense, which includes mileage, is a rate agreed upon by the non-network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with network providers for the same or similar service.

IMPORTANT NOTICE: Non-network providers may bill you for any difference between the provider's billed charges and the eligible expense described here.

When covered health services are received from a non-network provider, except as described above, eligible expense are determined as follows: (i) an amount negotiated by the claims administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the claims administrator has determined is typically accepted by a healthcare provider for the same or similar service or an amount that is greater than such rate when elected or directed by the plan. The plan will not pay excessive charges. You are responsible for paying, directly to the non-network provider, the applicable coinsurance, copayment or any deductible. Please contact the claims administrator if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your coinsurance, copayment, and deductible) is yours.

Advocacy Service

The Plan has contracted with UnitedHealthcare to provide advocacy services on your behalf with respect to non-network providers that have questions about the eligible expense and how UnitedHealthcare determined these amounts. Please call UnitedHealthcare at the number on your ID card to access these advocacy services if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if UnitedHealthcare, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the eligible expense, and UnitedHealthcare, or its designee, believes that it would serve the best interests of the Plan and its participants (including interests in avoiding costs and expenses of disputes over payment of claims), UnitedHealthcare, or its designee, may use its sole discretion to increase the eligible expense for that particular claim.

Medical Plans Quick Links

Medical Plan Options

Plan options are determined according to your eligibility as outlined in the John Deere Health Benefit Plan for Salaried Employees. Your medical plan options will be communicated in your fall enrollment information or can be obtained by calling the John Deere Benefits Center at 1-844-689-7833 or by accessing the benefit portal at www.yourbenefitsresources.com/deere.

- Plan #0246 | UHC CarePlus
- Plan #0247 | UHC CarePlusMAX
- Plan #0248 | UHC Access CarePlus
- Plan #0249 | UHC Access CarePlusMAX
- Plan #0250 | UHC International 90/50% (Expat)
- Plan #0253 | UHC International 100/50% (Inpat)
- Plan #0263 | UHC Choice Plus PPO 4000
- Plan #0051 | No Coverage (Medical)

*Deductible applies. Allowed charge means, in order, contracted rates, reasonable and customary charges and billed charges. This is a summary only.

**Based upon U.S. Preventative Services Task Force (USPSTF) guidelines.

Plan #0246 | UHC CarePlus

Benefit	In-Network (Choice Plus)	Out-of-Network
Annual Deductible *Deductible cross-accumulates Out-of_Network to In-Network only*	$1,600 for single coverage or $3,200 for family coverage per calendar year	$3,200 for single coverage or $6,400 for family coverage per calendar year
Maximum Out-of-Pocket Expense *Does not include dental, vision, or charges in excess of reasonable and customary.*	$3,700 for single coverage or $7,400 for family coverage per calendar year	Unlimited
Physician Services - General *Office Visits* *Hospital Visits* *Surgical Procedures (Office, Outpatient & Inpatient)* *Maternity Care* *Allergy Testing* *Allergy Injections*	*80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge* (For employee and spouse only. Dependents not eligible.)* *80% of allowed covered charge** *80% of allowed covered charge**	*50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge*(For employee and spouse only. Dependents not eligible.)* *50% of allowed covered charge** *50% of allowed covered charge**
Physician Services - Preventive** *Preventive Exam* *Mammograms* *Pap Tests* *Well-Child Care* *Immunizations* *Screenings (Cholesterol, Osteoporosis, Expanded Women's preventive health)* ***Based upon U.S. Preventive Services Task Force (USPSTF) guidelines and the Affordable Care Act guidelines.*	*100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge*	*50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge**
Hospital Services *Inpatient Care* *Outpatient Care*	*80% of allowed covered charge** *80% of allowed covered charge** *Obesity surgery is only covered in-network through a Center of Excellence. Notify UHC for details*	*50% of allowed covered charge** *50% of allowed covered charge** *(Prior authorization required.)*
Emergency Room	*80% of allowed covered charge**	
Emergency/Non-Emergency Ambulance - Ground or Air (if medically necessary)	*80% of allowed covered charge to nearest facility**	
Skilled Nursing Care	*80% of allowed covered charge**	*50% of allowed covered charge** *(Prior authorization required)*
Home Health Care	*80% of allowed covered charge**	*50% of allowed covered charge** *(Prior authorization required)*
Hospice	*80% of allowed covered charge**	*Covered in-network only*
Durable Medical Equipment	*80% of allowed covered charge**	*Covered in-network only*
Prosthetic Devices	*80% of allowed covered charge**	*Covered in-network only*
Physical/Occupation/Speech Therapy	*80% of allowed covered charge** *Maximum 60 combined treatment days per calendar year in- and out-of-network (visit limit does not apply for therapy related to a Autism Spectrum disorder).*	*50% of allowed covered charge** *Maximum 60 combined treatment days per calendar year in- and out-of-network (visit limit does not apply for therapy related to a Autism Spectrum disorder).*
Cardiac or Pulmonary Therapy	*80% of allowed covered charge** *Maximum 36 days per calendar year in- and out-of-network*	*50% of allowed covered charge** *Maximum 36 days per calendar year in- and out-of-network*
Chiropractic Services	*80% of allowed covered charge** *Maximum 12 visits per calendar year in- and out-of network*	*50% of allowed covered charge** *Maximum 12 visits per calendar year in- and out-of network*

Plan #0246 | UHC CarePlus (continued)

Benefit	In-Network (Choice Plus)	Out-of-Network
Imaging and Laboratory Services	*80% of allowed covered charge**	*50% of allowed covered charge**
Organ Transplants *(Must use a URN provider)*	*80% of allowed covered charge** *(Must be approved by UHC)*	*Covered in-network only*
Mental Health Services *Office Visits* *Inpatient Care* *Outpatient Care*	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge**	 *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge**
Substance Abuse Services *Office Visits* *Inpatient Care* *Outpatient Care*	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge**	 *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge**
Prescription Drugs *31-day supply* *90-day supply for maintenance drugs* *(Mail order program is available)*	Participating Pharmacy *80% of allowed covered for Tier 1 drugs** *80% of allowed covered for Tier 2 drugs** *80% of allowed covered for Tier 3 drugs**	Non-Participating Pharmacy *Covered in-network only*
Hearing (benefit payable once every 36 months) *Exam* *Hearing Aids* *Hearing Aid Management Services (HAMS) Network (where available)* *Exam* *Hearing Aids* *(Contact UHC for a list of providers)*	 *100% of allowed covered charge - $70 benefit maximum** *100% of allowed covered charge - $1,000 ($500 per ear) benefit maximum** *100% of allowed covered charge* *100% of allowed covered charge for pre-determined hearing aids**	
Vision Care *Eye Exam* *Single Vision Lens* *Bifocal Vision Lens* *Trifocal Vision Lens* *Lenticular Vision Lens* *Frame* *Contact Lenses*	Participating UHC Vision Provider *100% of allowed covered charge after $5 copayment for adults age 19 and over. Copay is waived for children under age 19* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $50 copayment* *Frames once per 12 months, combined in and out-of-network.* *Exam and lenses (glasses or contacts) every 12 months, combined in and out-of-network.*	Non-Participating UHC Vision Provider *100% of allowed covered charge for children under age 19. $43.70 maximum reimbursement for adults age 19 and over.* *$35.00 maximum reimbursement per pair* *$52.50 maximum reimbursement per pair* *$70.00 maximum reimbursement per pair* *$87.40 maximum reimbursement per pair* *$24.80 maximum reimbursement* *$52.50 maximum reimbursement per pair* *Frames once per 12 months, combined in and out-of-network.* *Exam and lenses (glasses or contacts) every 12 months, combined in and out-of-network.*
Dental Services	*Services provided through UnitedHealthcare*	
Coordination of Benefits	*Non-Duplication of Benefits*	

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

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Plan #0247 | UHC CarePlusMAX

Benefit	In-Network (Choice Plus)	Out-of-Network
Annual Deductible *Deductible cross-accumulates Out-of-Network to In-Network only*	$2,400 for single coverage or $4,800 for family coverage per calendar year	$4,800 for single coverage or $9,600 for family coverage per calendar year
Maximum Out-of-Pocket Expense *Does not include dental, vision, or charges in excess of reasonable and customary.*	$3,900 for single coverage or $7,800 for family coverage per calendar year	Unlimited
Physician Services - General *Office Visits* *Hospital Visits* *Surgical Procedures (Office, Outpatient & Inpatient)* *Maternity Care* *Allergy Testing* *Allergy Injections*	 *90% of allowed covered charge** *90% of allowed covered charge** *90% of allowed covered charge** *90% of allowed covered charge* (For employee and spouse only. Dependents not eligible)* *90% of allowed covered charge** *90% of allowed covered charge**	 *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge*(For employee and spouse only. Dependents not eligible)* *50% of allowed covered charge** *50% of allowed covered charge**
Physician Services - Preventive** *Preventive Exam* *Mammograms* *Pap Tests* *Well-Child Care* *Immunizations* *Screenings (Cholesterol, Osteoporosis, Expanded Women's preventive health)* ***Based upon U.S. Preventive Services Task Force (USPSTF) guidelines and the Affordable Care Act guidelines.*	 *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge*	 *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge**
Hospital Services *Inpatient Care* *Outpatient Care*	 *90% of allowed covered charge** *90% of allowed covered charge** *Obesity surgery is only covered in-network through a Center of Excellence. Notify UHC for details.*	 *50% of allowed covered charge** *50% of allowed covered charge** *(Prior authorization required.)*
Emergency Room	*90% of allowed covered charge**	
Emergency/Non-Emergency Ambulance - Ground or Air (if medically necessary)	*90% of allowed covered charge to nearest facility**	
Skilled Nursing Care	*90% of allowed covered charge**	*50% of allowed covered charge** *(Prior authorization required)*
Home Health Care	*90% of allowed covered charge**	*50% of allowed covered charge** *(Prior authorization required)*
Hospice	*90% of allowed covered charge**	*Covered in-network only*
Durable Medical Equipment	*90% of allowed covered charge**	*Covered in-network only*
Prosthetic Devices	*90% of allowed covered charge**	*Covered in-network only*
Physical/Occupation/Speech Therapy	*90% of allowed covered charge** *Maximum 60 combined treatment days per calendar year in- and out-of-network (visit limit does not apply for therapy related to a Autism Spectrum disorder).*	*50% of allowed covered charge** *Maximum 60 combined treatment days per calendar year in- and out-of-network (visit limit does not apply for therapy related to a Autism Spectrum disorder).*
Cardiac or Pulmonary Therapy	*90% of allowed covered charge** *Maximum 36 days per calendar year in- and out-of-network*	*50% of allowed covered charge** *Maximum 36 days per calendar year in- and out-of-network*
Chiropractic Services	*90% of allowed covered charge** *Maximum 12 visits per calendar year in- and out-of-network*	*50% of allowed covered charge** *Maximum 12 visits per calendar year in- and out-of-network*

Plan #0247 | UHC CarePlusMAX (continued)

Benefit	In-Network (Choice Plus)	Out-of-Network
Imaging and Laboratory Services	*90% of allowed covered charge**	*50% of allowed covered charge**
Organ Transplants *(Must use a URN provider)*	*90% of allowed covered charge** *(Must be approved by UHC)*	*Covered in-network only*
Mental Health Services *Office Visits* *Inpatient Care* *Outpatient Care*	 *90% of allowed covered charge** *90% of allowed covered charge** *90% of allowed covered charge**	 *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge**
Substance Abuse Services *Office Visits* *Inpatient Care* *Outpatient Care*	 *90% of allowed covered charge** *90% of allowed covered charge** *90% of allowed covered charge**	 *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge**
Prescription Drugs *31-day supply* *90-day supply for maintenance drugs* *(Mail order program is available)*	Participating Pharmacy *90% of allowed covered for Tier 1 drugs** *90% of allowed covered for Tier 2 drugs** *90% of allowed covered for Tier 3 drugs**	Non-Participating Pharmacy *Covered in-network only*
Hearing (benefit payable once every 36 months) *Exam* *Hearing Aids* *Hearing Aid Management Services (HAMS) Network (where available)* *Exam* *Hearing Aids* *(Contact UHC for a list of providers)*	 *100% of allowed covered charge - $70 benefit maximum** *100% of allowed covered charge - $1,000 ($500 per ear) benefit maximum** *100% of allowed covered charge* *100% of allowed covered charge for pre-determined hearing aids**	
Vision Care *Eye Exam* *Single Vision Lens* *Bifocal Vision Lens* *Trifocal Vision Lens* *Lenticular Vision Lens* *Frame* *Contact Lenses*	Participating UHC Vision Provider *100% of allowed covered charge after $5 copayment for adults age 19 and over. Copay is waived for children under age 19.* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $50 copayment* *Frames once per 12 months, combined in and out-of-network.* *Exam and lenses (glasses or contacts) every 12 months, combined in and out-of-network.*	Non-Participating UHC Vision Provider *100% of allowed covered charge for children under age 19. $43.70 maximum reimbursement for adults age 19 and over.* *$35.00 maximum reimbursement per pair* *$52.50 maximum reimbursement per pair* *$70.00 maximum reimbursement per pair* *$87.40 maximum reimbursement per pair* *$24.80 maximum reimbursement* *$52.50 maximum reimbursement per pair* *Frames once per 12 months, combined in and out-of-network.* *Exam and lenses (glasses or contacts) every 12 months, combined in and out-of-network.*
Dental Services	*Services provided through UnitedHealthcare*	
Coordination of Benefits	*Non-Duplication of Benefits*	

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

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Plan #0248 | UHC Access CarePlus

Benefit	In-Network (Options PPO)	Out-of-Network
Annual Deductible	$1,600 for single coverage or $3,200 for family coverage per calendar year	
Maximum Out-of-Pocket Expense *Does not include dental, vision, or charges in excess of reasonable and customary.*	$3,700 for single coverage or $7,400 for family coverage per calendar year	
Physician Services - General *Office Visits* *Hospital Visits* *Surgical Procedures (Office, Outpatient & Inpatient)* *Maternity Care* *Allergy Testing* *Allergy Injections*	*80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge** (For employee and spouse only. Dependents not eligible) *80% of allowed covered charge** *80% of allowed covered charge**	*80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge** (For employee and spouse only. Dependents not eligible) *80% of allowed covered charge** *80% of allowed covered charge**
Physician Services - Preventive** *Preventive Exam* *Mammograms* *Pap Tests* *Well-Child Care* *Immunizations* *Screenings (Cholesterol, Osteoporosis, Expanded Women's preventive health)* ***Based upon U.S. Preventive Services Task Force (USPSTF) guidelines and the Affordable Care Act guidelines.*	*100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge*	*100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge*
Hospital Services *Inpatient Care* *Outpatient Care*	*80% of allowed covered charge** *80% of allowed covered charge** *Obesity surgery is only covered in-network through a Center of Excellence. Notify UHC for details.*	*80% of allowed covered charge** *80% of allowed covered charge** *(Prior authorization required.)*
Emergency Room	*80% of allowed covered charge**	
Emergency/Non-Emergency Ambulance - Ground or Air (if medically necessary)	*80% of allowed covered charge to nearest facility**	
Skilled Nursing Care	*80% of allowed covered charge**	*80% of allowed covered charge** *(Prior authorization required)*
Home Health Care	*80% of allowed covered charge**	*80% of allowed covered charge** *(Prior authorizationn required)*
Hospice	*80% of allowed covered charge**	*Covered in-network only*
Durable Medical Equipment	*80% of allowed covered charge** *Prior authorization applies for devices that exceed $1,000 in cost per device.*	*Covered in-network only*
Prosthetic Devices	*80% of allowed covered charge**	*Covered in-network only*
Physical/Occupation/Speech Therapy	*80% of allowed covered charge** *Maximum 60 combined treatment days per calendar year in- and out-of-network (visit limit does not apply for therapy related to a Autism Spectrum disorder).*	*80% of allowed covered charge** *Maximum 60 combined treatment days per calendar year in- and out-of-network (visit limit does not apply for therapy related to a Autism Spectrum disorder).*
Cardiac or Pulmonary Therapy	*80% of allowed covered charge** *Maximum 36 days per calendar year in- and out-of-network*	*80% of allowed covered charge** *Maximum 36 days per calendar year in- and out-of-network*
Chiropractic Services	*80% of allowed covered charge** *Maximum 12 visits per calendar year in- and out-of-network*	*50% of allowed covered charge** *Maximum 12 visits per calendar year in- and out-of-network*

Plan #0248 | UHC Access CarePlus (continued)

Benefit	In-Network (Options PPO)	Out-of-Network
Imaging and Laboratory Services	*80% of allowed covered charge**	*80% of allowed covered charge**
Organ Transplants *(Must use a URN provider)*	*80% of allowed covered charge** *(Must be approved by UHC)*	*Covered in-network only*
Mental Health Services *Office Visits* *Inpatient Care* *Outpatient Care*	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge**	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge**
Substance Abuse Services *Office Visits* *Inpatient Care* *Outpatient Care*	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge**	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge**
Prescription Drugs *31-day supply* *90-day supply for maintenance drugs* *(Mail order program is available)*	Participating Pharmacy *80% of allowed covered for Tier 1 drugs** *80% of allowed covered for Tier 2 drugs** *80% of allowed covered for Tier 3 drugs**	Non-Participating Pharmacy *Covered in-network only*
Hearing (benefit payable once every 36 months) *Exam* *Hearing Aids* *Hearing Aid Management Services (HAMS) Network (where available)* *Exam* *Hearing Aids* *(Contact UHC for a list of providers)*	 *100% of allowed covered charge - $70 benefit maximum** *100% of allowed covered charge - $1,000 ($500 per ear) benefit maximum** *100% of allowed covered charge* *100% of allowed covered charge for pre-determined hearing aids**	
Vision Care *Eye Exam* *Single Vision Lens* *Bifocal Vision Lens* *Trifocal Vision Lens* *Lenticular Vision Lens* *Frame* *Contact Lenses*	Participating UHC Vision Provider *100% of allowed covered charge after $5 copayment for adults age 19 and over. Copay is waived for children under age 19.* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $50 copayment* *Frames once per 12 months, combined in and out-of-network.* *Exam and lenses (glasses or contacts) every 12 months, combined in and out-of-network.*	Non-Participating UHC Vision Provider *100% of allowed covered charge for children under age 19. $43.70 maximum reimbursement for adults age 19 and over* *$35.00 maximum reimbursement per pair* *$52.50 maximum reimbursement per pair* *$70.00 maximum reimbursement per pair* *$87.40 maximum reimbursement per pair* *$24.80 maximum reimbursement* *$52.50 maximum reimbursement per pair* *Frames once per 12 months, combined in and out-of-network.* *Exam and lenses (glasses or contacts) every 12 months, combined in and out-of-network.*
Dental Services	*Services provided through UnitedHealthcare*	
Coordination of Benefits	*Non-Duplication of Benefits*	

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

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Plan #0249 | UHC Access CarePlusMAX

Benefit	In-Network (Options PPO)	Out-of-Network
Annual Deductible	$2,400 for single coverage or $4,800 for family coverage per calendar year	
Maximum Out-of-Pocket Expense *Does not include dental, vision, or charges in excess of reasonable and customary.*	$3,900 for single coverage or $7,800 for family coverage per calendar year	
Physician Services - General *Office Visits* *Hospital Visits* *Surgical Procedures (Office, Outpatient & Inpatient)* *Maternity Care* *Allergy Testing* *Allergy Injections*	*90% of allowed covered charge** *90% of allowed covered charge** *90% of allowed covered charge** *90% of allowed covered charge* (For employee and spouse only. Dependents not eligible)* *90% of allowed covered charge** *90% of allowed covered charge**	*90% of allowed covered charge** *90% of allowed covered charge** *90% of allowed covered charge** *90% of allowed covered charge* (For employee and spouse only. Dependents not eligible)* *90% of allowed covered charge** *90% of allowed covered charge**
Physician Services - Preventive** *Preventive Exam* *Mammograms* *Pap Tests* *Well-Child Care* *Immunizations* *Screenings (Cholesterol, Osteoporosis, Expanded Women's preventive health)* ***Based upon U.S. Preventive Services Task Force (USPSTF) guidelines and the Affordable Care Act guidelines.*	*100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge*	*100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge*
Hospital Services *Inpatient Care* *Outpatient Care*	*90% of allowed covered charge** *90% of allowed covered charge** *Obesity surgery is only covered in-network through a Center of Excellence. Notify UHC for details.*	*90% of allowed covered charge** *90% of allowed covered charge** *(Prior authorization required.)*
Emergency Room	*90% of allowed covered charge**	
Emergency/Non-Emergency Ambulance - Ground or Air (if medically necessary)	*90% of allowed covered charge to nearest facility**	
Skilled Nursing Care	*90% of allowed covered charge**	*90% of allowed covered charge** *(Prior authorization required)*
Home Health Care	*90% of allowed covered charge**	*90% of allowed covered charge** *(Prior authorization required)*
Hospice	*90% of allowed covered charge**	*Covered in-network only*
Durable Medical Equipment	*90% of allowed covered charge** *Prior authorization applies for devices that exceed $1,000 in cost per device.*	*Covered in-network only*
Prosthetic Devices	*90% of allowed covered charge**	*Covered in-network only*
Physical/Occupation/Speech Therapy	*90% of allowed covered charge** *Maximum 60 combined treatment days per calendar year in- and out-of-network (visit limit does not apply for therapy related to a Autism Spectrum disorder).*	*90% of allowed covered charge** *Maximum 60 combined treatment days per calendar year in- and out-of-network (visit limit does not apply for therapy related to a Autism Spectrum disorder).*
Cardiac or Pulmonary Therapy	*90% of allowed covered charge** *Maximum 36 days per calendar year in- and out-of-network*	*90% of allowed covered charge** *Maximum 36 days per calendar year in- and out-of-network*
Chiropractic Services	*90% of allowed covered charge** *Maximum 12 visits per calendar year in- and out-of-network*	*50% of allowed covered charge** *Maximum 12 visits per calendar year in- and out-of-network*

Plan #0249 | UHC Access CarePlusMAX (continued)

Benefit	In-Network (Options PPO)	Out-of-Network
Imaging and Laboratory Services	*90% of allowed covered charge**	*90% of allowed covered charge**
Organ Transplants *(Must use a URN provider)*	*90% of allowed covered charge** *(Must be approved by UHC)*	*Covered in-network only*
Mental Health Services *Office Visits* *Inpatient Care* *Outpatient Care*	 *90% of allowed covered charge** *90% of allowed covered charge** *90% of allowed covered charge**	 *90% of allowed covered charge** *90% of allowed covered charge** *90% of allowed covered charge**
Substance Abuse Services *Office Visits* *Inpatient Care* *Outpatient Care*	 *90% of allowed covered charge** *90% of allowed covered charge** *90% of allowed covered charge**	 *90% of allowed covered charge** *90% of allowed covered charge** *90% of allowed covered charge**
Prescription Drugs *31-day supply* *90-day supply for maintenance drugs* *(Mail order program is available)*	Participating Pharmacy *90% of allowed covered for Tier 1 drugs** *90% of allowed covered for Tier 2 drugs** *90% of allowed covered for Tier 3 drugs**	Non-Participating Pharmacy *Covered in-network only*
Hearing (benefit payable once every 36 months) *Exam* *Hearing Aids* *Hearing Aid Management Services (HAMS) Network (where available)* *Exam* *Hearing Aids* *(Contact UHC for a list of providers)*	 *100% of allowed covered charge - $70 benefit maximum** *100% of allowed covered charge - $1,000 ($500 per ear) benefit maximum** *100% of allowed covered charge* *100% of allowed covered charge for pre-determined hearing aids**	
Vision Care *Eye Exam* *Single Vision Lens* *Bifocal Vision Lens* *Trifocal Vision Lens* *Lenticular Vision Lens* *Frame* *Contact Lenses*	Participating UHC Vision Provider *100% of allowed covered charge after $5 copayment for adults age 19 and over. Copay is waived for children under age 19.* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $10 copayment* *100% of allowed covered charge after $50 copayment* *Frames once per 12 months, combined in and out-of-network.* *Exam and lenses (glasses or contacts) every 12 months, combined in and out-of-network.*	Non-Participating UHC Vision Provider *100% of allowed covered charge for children under age 19. $43.70 maximum reimbursement for adults age 19 and over.* *$35.00 maximum reimbursement per pair* *$52.50 maximum reimbursement per pair* *$70.00 maximum reimbursement per pair* *$87.40 maximum reimbursement per pair* *$24.80 maximum reimbursement* *$52.50 maximum reimbursement per pair* *Frames once per 12 months, combined in and out-of-network.* *Exam and lenses (glasses or contacts) every 12 months, combined in and out-of-network.*
Dental Services	*Services provided through UnitedHealthcare*	
Coordination of Benefits	*Non-Duplication of Benefits*	

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

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Plan #0250 | UHC International 90/50% (Expat)

Benefit	International (Outside the U.S)	U.S. In-Network	U.S. Non-Network
Annual Deductible (Single/Family) *In-and Out-of-Network deductibles cross-accumulate*	$0/$0	$750/$1,500	$1,500/$3.000
Maximum Out-of-Pocket Expense *Includes deductable and Pharmacy. International and U.S in-network cross apply*	$2800 / $5,600	$2,800 for single coverage or $5,600 for family coverage per calendar year	$5,600/$11,200
Coinsurance *Covered expenses after deductible*	*90%*	90%	50%
Rx/Pharmacy *Mail Order Pharmacy coverage is included in the United States*	*90%*	Retail: 90% No ded MOD: 90% No ded	70% No Ded
Commonly Used Benefits *Primary Physician Office Visit* *Specialist Phsyician Office Visit* *Urgent care Center Services* *Emergency Services - Outpatient* *Hospital - Inpatient Stay*	 *90%* *90%* *90%* *90%* *90%*	 *90% after deductable* *90% after deductable* *90% after deductable* *90% after deductable* *90% after deductable*	 *50% after deductable* *50% after deductable* *50% after deductable* *90% after deductable* *50% after deductable*
Physician Services - Preventive *Mammogram* *Colonoscopy/sigmoidoscopy* *Cervical cancer screening* *Prostate cancer screening* *Bone mineral density tests* *Routine Physical Examinations* *Well-baby/Well-child care* *Immunizations* *Hearing Screenings*	*100% no deductible*	*100% no deductible*	*50% after deductible*
Accupuncture-$2500 per year	*90%*	*90% after deductable*	*50% after deductible*
Ambulance (Air and Ground)	*90%*	*90% after deductable*	
Skilled Nursing Facility (120 days per year)	*90%*	*90% after deductable*	*50% after deductible*
Home Health Care (limited to 120 visits per year)	*90%*	*90% after deductable*	*50% after deductible*
Hospice	*90%*	*90% after deductable*	*50% after deductible*
Durable Medical Equipment; includes customized othotics in the US only *Limited to a single purchase of each type every 3 years*	*90%*	*90% after deductable*	*50% after deductible*
Prosthetic Devices - A single purchase of each type of prosthetic device every three years	*90%*	*90% after deductable*	*50% after deductible*
Physical/Occupation/Speech Therapy (combined 60 visits per year	*90%*	*90% after deductable*	*50% after deductible*
Cardiac (36 visits/yr) or Pulmonary Therapy (20visits/yr)	*90%*	*90% after deductable*	*50% after deductible*
Lab, X-Ray, and Diagnostics-Outpatient	*90%*	*90% after deductable*	*50% after deductible*
Lav, X-Ray, and Major Diagnostics-CT, PET, MRI, MRA & Nuclear Medicine-Outpatient	*90%*	*90% after deductable*	*50% after deductible*

Plan #0250 | UHC International 90/50% (Expat) (continued)

Habilitative Services (Deps only)	*Not covered*	*90% after deductable*	*50% after deductible*
Hearing Aids *Limited to a single purchase (including repair/replacement) per hearing impaired ear every three years)*	*90%*	*90% after deductable*	*50% after deductible*
Infertility Treatment, inluding Assisted Reproductive Technologies (IVF, GIFT, ZIFT, etc)	*Not covered*	*90% after deductable*	*50% after deductible*
Pregnancy-Maternity Services	*90%*	*90% after deductable*	*50% after deductible*
Manipulative Treatment (20 visits per year)	*90%*	*90% after deductable*	*50% after deductible*
Preventative PT for MS only (60 visits per year)	*Not covered*	*90% after deductable*	*50% after deductible*
Post-Cochlear Implant Auroal Theraphy (30 visits per year)	*90%*	*90% after deductable*	*50% after deductible*
Cognitive Rehabilitation Therapy (20 visits per year)	*90%*	*90% after deductable*	*50% after deductible*
Surgery-Outpatient	*90%*	*90% after deductable*	*50% after deductible*
Temporomandibular Joint Disorder	*90%*	*90% after deductable*	*50% after deductible*
Wigs ($5000 every 24 months)	*Not covered*	*90% after deductable*	*50% after deductible*
Mental Health and Substance Use Disorders/ Neurobiological Disorders *Inpatient* *Outpatient*	 *90%* *90%*	 *90% after deductable* *90% after deductable*	 *50% after deductible* *50% after deductible*
		Prior authorization is required	
Vision Care *Eye Exam - 1 exam every 2 years* *Hardware- $200 every 12 months*	 *90%* *100%*	 *90% after deductable* *100% no deductible*	 *50% after deductible* *100% no deductible*
International Wellness			
UnitedHealthcare Global Insurance International Wellness Program - welcome call / pre-assignment outreach, follow-up emails and assessments, 24/7 access and support, MyBrain training access, and up to five telephonic counseling sessions.			
International Employee Assistance Program			
Five hours face-to-face counseling. Re-integration support for employees and their families returning to their home country.			
Medical Evacuation and Repatriation	*100%*	*100%*	*100%*

Plan #0253 | UHC International 100/50% (Inpat)

Benefit	In-Network (Choice Plus)	Out-of-Network
Annual Deductible	None	None
Maximum Out-of-Pocket Expense *Does not include dental, vision, or charges in excess of reasonable and customary.*	None	Unlimited
Physician Services - General *Office Visits* *Hospital Visits* *Surgical Procedures (Office, Outpatient & Inpatient)* *Maternity Care* *Allergy Testing* *Allergy Injections*	*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 not eligible)* *100% of allowed covered charge* *100% of allowed covered charge*	*50% of allowed covered charge* *50% of allowed covered charge* *50% of allowed covered charge* *50% of allowed covered charge(For employee and spouse only. Dependents not eligible)* *50% of allowed covered charge* *50% of allowed covered charge*
Physician Services - Preventive** *Preventive Exam* *Mammograms* *Pap Tests* *Well-Child Care* *Immunizations* *Screenings (Cholesterol, Osteoporosis, Expanded Women's preventive health)* ***Based upon U.S. Preventive Services Task Force (USPSTF) guidelines and the Affordable Care Act guidelines.*	*100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge*	*50% of allowed covered charge* *50% of allowed covered charge* *50% of allowed covered charge* *50% of allowed covered charge* *50% of allowed covered charge* *50% of allowed covered charge*
Hospital Services *Inpatient Care* *Outpatient Care*	*100% of allowed covered charge* *100% of allowed covered charge* *Obesity surgery is only covered in-network through a Center of Excellence. Notify UHC for details.*	*50% of allowed covered charge* *50% of allowed covered charge* *(Prior authorization required.)*
Emergency Room	*100% of allowed covered charge*	
Emergency/Non-Emergency Ambulance - Ground or Air (if medically necessary)	*100% of allowed covered charge to nearest facility*	
Skilled Nursing Care	*100% of allowed covered charge*	*50% of allowed covered charge* *(Prior authorization required)*
Home Health Care	*100% of allowed covered charge*	*50% of allowed covered charge* *(Prior authorization required)*
Hospice	*100% of allowed covered charge*	*Not covered*
Durable Medical Equipment	*100% of allowed covered charge*	*Not covered*
Prosthetic Devices	*100% of allowed covered charge*	*Not covered*
Physical/Occupation/Speech Therapy	*100% of allowed covered charge* *Maximum 60 combined treatment days per calendar year in- and out-of-network (visit limit does not apply for therapy related to a Autism Spectrum disorder).*	*50% of allowed covered charge* *Maximum 60 combined treatment days per calendar year in- and out-of-network (visit limit does not apply for therapy related to a Autism Spectrum disorder).*
Cardiac or Pulmonary Therapy	*100% of allowed covered charge* *Maximum 36 days per calendar year in- and out-of-network*	*50% of allowed covered charge* *Maximum 36 days per calendar year in- and out-of-network*
Imaging and Laboratory Services	*100% of allowed covered charge*	*50% of allowed covered charge*
Chiropractic Services	*100% of allowed covered charge-Maximum 6 visits per calendar year*	

Plan #0253 | UHC International 100/50% (continued)

Benefit	In-Network (Choice Plus)	Out-of-Network
Organ Transplants *(Must use a URN provider)*	*100% of allowed covered charge* *(Must be approved by UHC)*	*Not covered*
Mental Health Services *Office Visits* *Inpatient Care* *Outpatient Care*	 *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge*	 *50% of allowed covered charge* *50% of allowed covered charge* *50% of allowed covered charge*
Substance Abuse Services *Office Visits* *Inpatient Care* *Outpatient Care*	 *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge*	 *50% of allowed covered charge* *50% of allowed covered charge* *50% of allowed covered charge*
Prescription Drugs *31-day supply* *90-day supply for maintenance drugs* *(Mail order program is available)*	**Participating Pharmacy** *100% of allowed covered for Tier 1 drugs* *100% of allowed covered for Tier 2 drugs* *100% of allowed covered for Tier 3 drugs*	**Non-Participating Pharmacy** *Not covered*
Hearing (benefit payable once every 36 months) *Exam* *Hearing Aids* *Hearing Aid Management Services (HAMS) Network (where available)* *Exam* *Hearing Aids* *(Contact UHC for a list of providers)*	 *100% of allowed covered charge - $70 benefit maximum* *100% of allowed covered charge - $1,000 ($500 per ear) benefit maximum* *100% of allowed covered charge* *100% of allowed covered charge for pre-determined hearing aids**	
Vision Care *Eye Exam* *Lenses and Frames*	**Participating UHC Vision Provider** *100% of allowed covered charge* *Exam every 24 months if age 19 or older; otherwise, every 12 months, combined in and out-of-network.* *Not Covered*	**Non-Participating UHC Vision Provider** *100% of allowed covered charge for children under age 19. $43.70 maximum reimbursement for adults age 19 and over.* *Exam every 24 months if age 19 or older; otherwise, every 12 months, combined in and out-of-network.* *Not covered*
Dental Services	*Services provided through UnitedHealthcare*	
Coordination of Benefits	*Non-Duplication of Benefits*	

Allowed charge means, in order, contracted rates, reasonable and customary charges and billed charges. This is a summary only.
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Plan #0263 | UHC Choice Plus PPO 4000

Benefit	In-Network (Choice Plus)	Out-of-Network
Annual Deductible *Deductible cross-accumulates Out-Of-Network to In-Network only*	$4,000 for single coverage or $8,000 for family coverage per calendar year	$8,000 for single coverage or $16,000 for family coverage per calendar year
Maximum Out-of-Pocket Expense *Does not include dental, vision, or charges in excess of reasonable and customary.*	$6,000 for single coverage or $12,000 for family coverage per calendar year (no individual family member will have greater than $6,000).	Unlimited
Physician Services - General *Office Visits* *Hospital Visits* *Surgical Procedures* *Office* *Outpatient and Inpatient* *Maternity Care* *Allergy Testing and Allergy Injections*	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge* (For employee and spouse only. Dependents not eligible)* *80% of allowed covered charge**	 *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge* (For employee and spouse only. Dependents not eligible)* *50% of allowed covered charge**
Physician Services - Preventive** *Preventive Exam* *Mammograms, Pap Tests, Well-Child Care, and Immunizations* *Screenings (Cholesterol, Osteoporosis, Expanded Women's preventive health)* ***Based upon U.S. Preventive Services Task Force (USPSTF) guidelines and the Affordable Care Act guidelines.*	 *100% of allowed covered charge* *100% of allowed covered charge* *100% of allowed covered charge*	 *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge**
Hospital Services *Inpatient Care and Outpatient Care*	*80% of allowed covered charge** *Obesity surgery is only covered in-network through a Center of Excellence. Notify UHC for details.*	*50% of allowed covered charge** *(Prior authorization required.)*
Emergency Room	*80% of allowed covered charge**	
Emergency/Non-Emergency Ambulance - Ground or Air (if medically necessary)	*80% of allowed covered charge to nearest facility**	
Skilled Nursing Care and Home Health Care	*80% of allowed covered charge**	*50% of allowed covered charge* (Prior authorization required)*
Hospice	*80% of allowed covered charge**	*Covered in-network only*
Durable Medical Equipment	*80% of allowed covered charge**	*Covered in-network only*
Prosthetic Devices	*80% of allowed covered charge**	*Covered in-network only*
Physical/Occupation/Speech Therapy	*80% of allowed covered charge** *Maximum 60 combined treatment days per calendar year in- and out-of-network (visit limit does not apply for therapy related to a Autism Spectrum disorder).*	*50% of allowed covered charge** *Maximum 60 combined treatment days per calendar year in- and out-of-network (visit limit does not apply for therapy related to a Autism Spectrum disorder).*
Cardiac or Pulmonary Therapy	*80% of allowed covered charge** *Maximum 36 days per calendar year in- and out-of-network*	*50% of allowed covered charge** *Maximum 36 days per calendar year in- and out-of-network*
Chiropractic Services	*80% of allowed covered charge* -Maximum 6 visits per calendar year*	
Imaging and Laboratory Services	*80% of allowed covered charge**	*50% of allowed covered charge**

Plan #0263 | UHC Choice Plus PPO 4000 (continued)

Benefit	In-Network (Choice Plus)	Out-of-Network
Organ Transplants *(Must use a URN provider)*	*80% of allowed covered charge* (Must be approved by UHC)*	*Covered in-network only*
Mental Health Services *Office Visits* *Inpatient Care* *Outpatient Care*	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge**	 *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge**
Substance Abuse Services *Office Visits* *Inpatient Care* *Outpatient Care*	 *80% of allowed covered charge** *80% of allowed covered charge** *80% of allowed covered charge**	 *50% of allowed covered charge** *50% of allowed covered charge** *50% of allowed covered charge**
Prescription Drugs *31-day supply* *90-day supply for maintenance drugs* *(Mail order program is available)*	Participating Pharmacy *80% of allowed covered for Tier 1 drugs** *60% of allowed covered for Tier 2 drugs** *50% of allowed covered for Tier 3 drugs**	Non-Participating Pharmacy *Covered in-network only*
Hearing *Exam* *Hearing Aids* *(Contact UHC for a list of providers))*	*Not Covered – limited preventive screening under Preventive Services – Well-Child Care*	
Vision Care	*Not Covered – limited preventive screening under Preventive Services – Well-Child Care*	
Dental Services	*Not Covered – limited preventive screening under Preventive Services – Well-Child Care*	
Coordination of Benefits	*Non-Duplication of Benefits*	

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

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Plan #0051 | No Coverage (Medical)

Employees choosing this plan will NOT have medical coverage for self or any family members.

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Plan Health Care Management Services

When you receive services from participating providers under the Medical Plan, certain cost-management procedures happen automatically. If you're using the point-of-service feature, inpatient care for you and your covered dependents will be managed through the Coordinated Care Services program. This program, designed to help manage the quality and cost of your care, provides a variety of services.

Inpatient Pre-Authorization

Pre-authorization is required for inpatient care in a hospital, qualified extended care facility, or residential substance abuse facility. If your hospitalization is scheduled, the stay must be pre-certified prior to admission.

If you use your in-network participating physician, they will take care of the pre-certification for you. If you are using out-of-network providers through the point-of-service feature, you are responsible for pre-certifying your stay.

If you or a family member has an emergency hospital stay, you must call the phone number on the back of your benefit card within 48 hours of admission.

Concurrent Review

Once you're admitted as an inpatient, your stay will be monitored to make sure the length of your confinement is appropriate based on your medical condition. If your inpatient 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, 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 may 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 to you is appropriate and medically necessary.
- A provider 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.

Prior Authorization

Prior authorization is used by the claim's administrator to determine benefit coverage and whether or not the service is Medically Necessary. Periodically, updates are made to the - prior authorization/notification list following clinical review. Services on the list are those that are high cost, have safety implications, or may not have adequate evidence-based guidelines.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in the Plan document
- Provided to a Covered Person who meets the Plan's eligibility requirements
- Not otherwise excluded in the Plan document

Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

Medically Necessary – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related

and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness substance-related and addictive disorders disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling the number on your ID card, and to Physicians and other health care professionals on **UnitedHealthcareOnline**.

Strategic Exclusions

UnitedHealthcare will implement a long-term exclusion capability for select injectable and infusion therapies. Medical benefit drug exclusions will encourage providers to select more affordable medications that are therapeutically equivalent — defined as having similar efficacy and adverse events – but at lower cost to the member and the plan.

Interpretation of Benefits

The company and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Summary of Material Modifications (SMM) or plan amendments.
- Make factual determinations related to the Plan and its benefits.

The company and UnitedHealthcare may delegate this discretionary authority to other persons or entities including UnitedHealthcare's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and UnitedHealthcare's discretion. In order to receive benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, the company may, in its discretion, offer benefits for services that would otherwise not be covered health services. The fact that the company does so in any particular case shall not in any way be deemed to require them to do so in other similar cases.

Expenses Covered by All Medical Plan Options

The Plan pays benefits for a wide variety of medical services and supplies. These expenses are described under the sections outlined below. The level of benefits paid depends on the option you choose.

Hospital Charges

The 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 on an inpatient basis
– 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)
– 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 treatment do not qualify as hospitals.

While you are confined to a hospital, the Plan covers room and board charges for a semi-private room. If a semi-private room is not available, the Plan pays benefits at the hospital's private room rate. If a semi-private room is available, the Plan pays benefits up to the 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).

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).

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
– 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

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.

Ambulance Services

Professional ambulance service for emergencies and non-emergencies are covered for ground and air (if medically necessary) transportation:

- When you are taken to a hospital and confined, or from hospital to hospital if the services required are not available at the first hospital.
- When you suffer an injury resulting in a Medical Emergency.
- When you are taken to a hospital and are dead on arrival.
- When you are taken from a hospital to nursing home when transportation via ambulance is medically necessary.

In no event will Allowed Charge for ambulance service exceed the charge for conveyance by a professional ambulance service to the nearest facility equipped and staffed to provide the necessary emergency, surgical, or rehabilitative treatment.

Organ/Tissue Transplant Services

The Medical Plan requires the use of a network of facilities for all transplant services. Within this network, several centers of excellence are available for transplant services. Transplants performed outside of a center of excellence are not covered under the Plan.

There is also a transplant nurse specialist who will work with you and your physician to choose the facility 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 will need to 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 (within six to 12 months of the transplant procedure), are considered part of the transplant service.

Transplant Donors

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

Extended-Care Services

Skilled care in a qualified extended care facility, such as a nursing home, is 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.

When Extended Care Facility Benefits Are Not Paid

Benefits for care in an extended care facility will not be paid if benefits are payable under other parts of the Plan, or if:

- 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
- The charges are connected with drug addiction, chronic brain syndrome, alcoholism, or dementia
- The stay is primarily for custodial reasons (see Expenses Not Covered By Any Medical Option, Custodial Care)

Home Health Care

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. All home health care requests must be initiated by a physician and preauthorized by your health plan carrier.

When Home Health Care Benefits Are Not Paid

Benefits for when home health care will not be paid:

- 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

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.

Orthognathic surgery is covered for the treatment of congenital anomaly, deformity resulting from chromosomal abnormality, acute traumatic injury, accident, dislocation, tumors, cancer or the result of cancer treatment, results of medical or surgical treatment that has left an individual with impaired critical functions or obstructive sleep apnea. The purpose of orthognathic surgery for these conditions must meet the definition of reconstructive surgery and is not deemed to be cosmetic.

Surgical treatment of obesity when provided by or under the direction of a physician when all of the following are true:

- You have enrolled in the Bariatric Resource Services (BRS) program.
- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under your plan, unless there were complications with your first procedure.

You must access the Bariatric Resource Services program by calling the number on your ID card.

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.

Maternity Charges

Maternity expenses and expenses for obstetrical procedures incurred by employees or their covered spouses are covered by the Plan. 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

No benefits are paid for routine medication (such as nonprescription vitamins), taken during pregnancy. If you (or your covered spouse), are pregnant when medical coverage ends, you must continue coverage under COBRA (see Plan Administration, Continuing Coverage through COBRA) in order to continue receiving benefits.

Maternity benefits and obstetrical procedures are provided for employees and spouses only. Coverage is not extended to other covered dependents, including sponsored dependents except for preventive prenatal care at no cost for dependent children as required by the Affordable Care Act.

Some medical conditions that arise during a pregnancy require care from other medical specialists. In these situations, normal Plan deductible/copayments/ coinsurance will apply.

An obstetrical procedure includes delivery of a child or children, caesarean section, abdominal operation for extra uterine or ectopic pregnancy, miscarriage, false labor, threatened abortion, and abortion (including elective abortion).

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).

Contraceptive devices are covered (except Norplant). Oral contraceptives are covered under the prescription drug benefit.

Physician's Charges

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

- Temporomandibular Joint (TMJ) services related to the evaluation and treatment of TMJ syndrome is covered for those enrolled in CarePlus, CarePlusMAX, and the Expat plan.
- Daily visits: from your attending physician during a stay in a hospital or qualified extended care facility.
- Medically necessary consultations.
- Telehealth services and virtual care services with designated network providers. Virtual care services are offered by UnitedHealthcare and contracted providers through a national service. Telehealth visits are a covered benefit that allow you to connect with a local network medical provider through live video conferencing or over the phone.
- Urgent care facilities.
- Medically necessary office or home visits.
- Surgical procedures: to include postoperative hospital and office visits or to assist in surgery (when 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.
- Nutritional counseling: three sessions per lifetime per condition
- Travel immunizations
- The Plan offers a voluntary second opinion education service, which is a live interactive video experience, powered by 2nd.MD. A dedicated nurse will oversee medical records collection, selection, and scheduling with post- consultation support. For additional information regarding the program, please contact the number on your ID card.
- A second or third opinion: after a surgeon has recommended major elective (nonemergency) surgery. For the point-of-service feature, an out-of-network 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.

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 (see the benefit description under the option you choose). The procedures may be performed either in or out of a hospital. Procedures and tests not covered include the following items:

- Dental X-rays (covered under the dental plan).
- Tests covered by other Plan provisions.

Physical/Speech/Occupational Therapy

Benefits are payable for physical, speech, and occupational therapy for up to 60 combined outpatient treatment days per calendar year (visit limit does not apply for therapy related to Autism Spectrum Disorder).

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 a conflict of interest.

Physical, speech, and occupational therapy must be prescribed by a physician and performed by a licensed physical, speech, or occupational therapist. Occupational therapy does not include vocational, educational, or recreational therapy, or vocational rehabilitation.

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

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 the condition from worsening and to reduce a person's 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.

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
- Chemotherapy treatment

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.

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.

- Artificial limbs and eyes
- Post surgical lenses used during convalescence from cataract surgery, and contact lenses for the treatment of keratoconus
- Supplies (including bags, belts, tubing, and adhesive), necessary to furnish a colostomy or ureterostomy in the abdomen created surgically to aid discharge
- Tracheostomy speaking valves
- Ostomy supplies
- External, indwelling, and intermittent urinary catheters for incontinence or retention. Includes related urologic supplies for indwelling catheters limited to: (1)Urinary drainage bag and insertion tray (kit), (2) Anchoring device, and (2) Irrigation tubing set.

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

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

Durable Medical Equipment

Rental of durable medical equipment, prescribed by a physician for medical treatment or physical mobility, is covered by the Plan. In some cases, the purchase of the equipment may be approved, if appropriate. To be covered, the equipment must be able to withstand repeated use, serve a medical purpose, and be appropriate for treatment at home. Examples include oxygen tanks, wheelchairs, crutches, canes, walkers, circulatory aids, and glucose monitors for insulin-dependent Type I diabetics. The Plan also covers:

- Augmentative and alternative communication devices where medically necessary
- 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
- Passive motion devices
- Special therapeutic shoes for severe diabetics
- Orthotics (foot): one pair every two years regardless of diagnosis
- Over-the-counter glucose test tablets, strips, reagent and stylets
- Cranial banding
- Prosthetics: replacement every three years

Durable medical equipment that is not covered includes, but is not limited to:

- Diagnostic and therapeutic supplies such as thermometers, blood pressure kits, heating packs, etc.
- Dentures (see Dental Care)
- 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, etc.
- Ace bandages

- Orthopedic shoes
- Special pads or mattresses
- Equipment used for hygienic purposes
- Van modification for wheelchair patients
- Wheel chair ramps
- Other devices that do not serve a meaningful and necessary therapeutic purpose
- Durable medical equipment is not covered while confined to hospital or qualified extended care facility. Not all durable medical equipment is covered, even if ordered by a physician and/or Medically Necessary.
- Motorized mobility scooters

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 MCO.

Mental Health/Substance Use Disorder Services

The Plan pays benefits for the diagnosis, evaluation, and treatment of mental health, neurocognitive, and substance use disorders. To receive mental health and substance abuse benefits, you are encouraged to contact UnitedHealthcare for coordination of care, consulting, and referral to ensure you receive the appropriate level of care from the right type of provider.

Inpatient Care

Inpatient care for a hospital stay or for an approved stay in a residential substance abuse facility is covered. Successive hospital or approved residential-substance-abuse-facility stays for the same or a related cause will be considered one period of disability. 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 and used 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.

Outpatient Mental Health Care

The Plan pays benefits to a psychiatrist, psychologist or other providers based on the benefit design of your plan. You are encouraged to contact UnitedHealthcare for coordination of care, consulting, and referral to ensure you receive the appropriate level of care from the right type of provider. Psychological testing that is conducted by a psychologist is covered.

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.

Outpatient Substance Abuse Care

The Plan pays benefits to an outpatient substance abuse facility, approved by the health plan, which provides detoxification and rehabilitation services.

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 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; or
- Expenses for services related primarily to treatment of a disorder for diseases that do not constitute a mental or nervous disorder under the Plan.

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

Prescription Drug Benefits

The Plan pays prescription drug benefits according to the schedule described under the medical option you choose. Your benefits may vary depending upon where you fill your prescription, and on the type of drug you receive.

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 plan benefits use a participating (or network) pharmacy. For prescriptions submitted on paper claim forms or from nonparticipating pharmacies, your level of reimbursement will depend upon the benefit option.

Covered Medications

The following medications are covered by the Plan:

– "Legend" drugs—meaning the wording, "Caution: Federal law prohibits dispensing without a prescription," must appear on the container.
– "Non-legend" 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 and are covered under the Plan.
– "Listed drugs"—certain prescribed medications you take on a continuing basis over a long period. Available as a three-month 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.

Using Your Prescription Drug Benefit

For most prescriptions you fill, you can receive up to a one-month supply per prescription. For approved listed drugs, you can receive up to a three-month 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 appropriate amount. No claim forms are needed.
– At nonparticipating pharmacies. You must pay the full cost of your prescription. Your level of reimbursement will depend upon the benefit option.
– Mail order program. For "listed drugs" on the three-month supply list, you will receive a three-month supply at the level of reimbursement of the benefit option. For all other drugs, you receive the same benefits payable at participating pharmacies, with the added convenience of mail order service.

Prescription Expenses Not Covered:

– The Plan does not pay benefits for some prescription-drug expenses, including drugs available over the counter, unless by 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 or convenience purposes.
– Charges for the administration of prescription drugs.
– Therapeutic appliances and devices, bandages and similar supplies, support garments, and other non-medicinal supplies.
– Charges for quantities of more than a one month's supply (or a three-month's 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).
– 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 States Pharmacopeia Dispensing Information or American Hospital Formulary Service Drug Information.
– Drugs covered by Medicare.
– Smoking cessation drugs.
– 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.
– Infertility drugs above the lifetime maximum of $10,000 for covered pharmacy

services for those enrolled in all plans except plan 263. Infertility services are not covered for plan 263. Services up to the lifetime maximum will be covered based on medical necessity at a UnitedHealthcare Center of Excellence.

- Drugs dispensed by a facility other than a licensed pharmacy.
- Drugs that are fraudulently obtained or demonstrate abuse.
- Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available pharmaceutical product.

Dental Care

Generally, dental benefits are provided under the Dental Plan and you must enroll in the Dental Plan to receive this coverage. However, there are some situations where dental benefits are paid by the Medical Plan. Allowed dental charges under the Medical Plan are:

- Dental procedures performed by a physician, dentist or oral surgeon due to a medical emergency or dental accident or injury
- Hospital expenses you incur for dental care

Vision Care

Generally, benefits for vision care are payable according to the schedule in the section describing your Plan option.

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.
- One eye examination in any period of 12-consecutive months.
- Charges to prepare corrective lenses: up to two lenses per prescription.
- Up to two lenses and one frame in any period of 12-consecutive months.
- Charges for frames: if corrective lenses are prescribed.

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. In addition, vision care provided by an optometrist in a medical emergency is covered by all medical options.

Hearing Care

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

- Otologist: a physician who specializes in the diagnosis and medical or surgical treatment of ear diseases and defects
- Otolaryngologist: a physician who specializes in ear, nose, and throat problems
- Audiologist: a specialist who has an advanced degree in audiology (the science of hearing), or speech pathology (the study of speech defects and abnormalities). The audiologist must have a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association, be licensed by the state in which they practice, 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

Covered Hearing Expenses

The following expenses are covered, up to the levels indicated in the section describing your 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)
- Prescription hearing aids: for the purchase and dispensing of a hearing aid (once every 36 months)

- Bone-anchored hearing aids when medically necessary are covered for those enrolled in CarePlus and CarePlusMAX.
- Replacement of a hearing aid that is lost or broken if Plan benefits were not paid within the last 36 months

Hearing Expenses Not Covered:

- 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, or 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 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
- Over the counter hearing aids

Travel & Lodging Expenses

Travel and lodging expenses are covered in the following two situations:

- Covered healthcare services not available within 300 miles of your home residence
- Covered healthcare services not available in your state of residence as a result of law or regulation

The travel and lodging benefit for these two situations has an annual maximum of $2,000 and expenses will apply to your deductible.

Here are the details of what is covered with this travel and lodging benefit.

Lodging

Lodging will be reimbursed up to $50 per day for the member and $100 per day if the member is accompanied by a caregiver or a relative. If the member receiving care is under age 18, two caregivers or relatives may accompany the member.

Travel

Travel will be reimbursed for the cost of a rental car and fuel fees, train, bus, ferry, subway, taxi, Uber, and Lyft. The benefit will cover the fuel cost for your personal car but there will not be a mileage reimbursement. It will also cover domestic airfare for economy/coach tickets and parking and tolls.

This benefit does not cover food, entertainment, or personal items. You will need to complete a Travel and Lodging Reimbursement claim form and submit all receipts to receive reimbursement. To be reimbursed for airfare, you will need to provide both your flight itinerary and paid ticket receipt.

Call UnitedHealthcare at 1-888-JDEERE1 or sign into myuhc.com and visit the forms section to obtain a claim form. You have up to one year from the date expenses were incurred to complete a claim for reimbursement.

Travel and lodging expenses are also covered when an employee or their family member is referred to a center of excellence through the UHC Transplant, Bariatric, Cancer, and Congenital Heart Disease Resource Services.

If you have any questions on this benefit, call 1-888-JDEERE1.

Coverage for Gender Dysphoria

The covered services for the treatment of gender dysphoria provided by and under the direction of a physician are limited to the UnitedHealthcare standard procedures, which are subject to change. For the purpose of this benefit, “gender dysphoria” is a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Getting Approvals

When you visit your network provider for care, the physician may identify a service (for example, chest reconstruction) that requires prior authorization to be covered under your health plan. If your doctor has questions about coverage, they should contact UnitedHealthcare to discuss the proposed service. UnitedHealthcare will review the request to verify the service is medically necessary and performed at the appropriate location (doctor’s office, outpatient surgical center, inpatient, etc.). UnitedHealthcare will then inform you and your doctor about the decision. Together you should review the determination letter and establish a course of care. If you have questions about the status of your request, reach out to a myHEALTH Advocate at 1-888-JDEERE1 (1-888-533-3731).

For more details, refer to the Transgender Information Guide at Deere.com/Wellbeing or call the gender identity support team at UnitedHealthcare at 1-800-326-9166.

Preventive Services

The plan provides preventive services according to the U.S. Preventive Services Task Force (USPSTF) guidelines and the Affordable Care Act (ACA) at no cost sharing to the member. This includes preventive prenatal care for covered dependents of a household.

Fertility Services

The plan provides fertility services up to a lifetime maximum of $20,000 for covered medical services and $10,000 for covered pharmacy services. Coverage is not available for dependent children or surrogacy. Services up to the lifetime maximum will be covered based on medical necessity at a UnitedHealthcare Center of Excellence. Contact the UnitedHealthcare Fertility Solutions group at 866-774-4626 for guidance on the covered fertility services and to be referred to a Center of Excellence.

The following fertility services are covered:

- InVitro Fertilization (IVF) including Egg/Oocyte retrieval, Embryo transfer, Intracytoplasmic sperm injection ICSI, assisted hatching, cryopreservation and storage of embryos for 12 months, embryo biopsy for PGT-M or PGT-SR.
- Frozen embryo transfer cycle including the associated cryopreservation and storage of emryos for 12 months
- Artificial Insemination (AI)
- Intrauterine Insemination (IUI)
- Ovulation induction and controlled ovarian stimulation
- Fertility surgical procedures
- Fertility preservation when planned cancer or other medical treatment is likely to produce infertility/sterility. Storage cost covered for up to one year.

Fertility Solutions is a program administered by the claims administrator or its affiliates made available to you. The Fertility Solutions program provides:

- Specialized clinical consulting services to enrolled members to educate them on fertility treatment options.
- Access to specialized network facilities and physicians for fertility services.
- Provides education, specialized clinical counseling, treatment options and access to national network of premier fertility services treatment clinics.

The Plan pays benefits for the fertility services described above when provided by designated providers participating in the Fertility Solutions program.

Covered Persons who do not live within a 60 mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Network Provider prior to starting treatment.

For fertility services and supplies to be considered covered health services, you must contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the designated provider performing the services (even if you self-refer to a network provider).

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Clinical Trials

In addition to clinical trial coverage through the Affordable Care Act (ACA), the plan will provide coverage for clinical trials conducted in relation to the detection or treatment of non-life threatening conditions and diseases. Coverage for clinical trails requires prior authorization.

Expenses Not Covered by Any Medical Option

In addition to exclusions outlined in each benefit section, the following exclusions apply to the entire Plan.

- Claims submitted more than one year after the date of services
- Expenses in excess of 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 cosmetic surgery (procedures or services that change or improve appearance without significantly improving physiological function and complications arising from such surgery), except for reconstructive surgery resulting from injuries sustained in an accident or to correct a functional impairment from a birth defect or disease or for procedures meeting established medical necessity guidelines (Generally Accepted Standards of Medical Practice based on scientific clinical evidence, prevailing medical standards and clinical guidelines) for improving or restoring physiologic function (where the organ or body part is made to work better), as well as mandated coverage for breast reconstruction under the Women's Health and Cancer Rights Act of 1998; the forgoing exclusions shall not apply to benefits otherwise covered under the Plan that are approved for treatment of gender dysphoria
- Charges for services, treatment, technology, prescription drugs, or supplies that are not medically necessary (see medically necessary)
- Charges incurred while confined to a government hospital that are the result of a military service connected disability
- Convenience or personal comfort items
- Charges for any dental service provided by a dentist or services provided by an oral surgeon, unless due to emergency or accident
- Charges that you (or John Deere) are not legally required to pay
- Charges that are related to a hospital stay that started before 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, diet counseling, special diets, and drugs used to treat obesity unless provided as a preventive benefit for qualifying individuals within a Benefit Option
- Biofeedback treatment and relaxation therapy
- Nonprescription vitamins, nutritional supplements, special formula for infants, children or adults, and special diets except for enteral nutrition. Enteral nutrition benefits are covered for enteral formula and low protein modified food products, administered orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. It also includes prescription or over-the-counter formula when a physician or written order stating the formula or product is medically necessary for the therapeutic treatment of a condition requiring specialized nutrients, quantity, and duration.
- Exercise equipment or devices
- Special shoes unless attached to a brace, corset, other article of clothing, or cosmetic device
- Court-ordered services, unless 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, Gamete Intrafallopian Tube Transfer (GIFT), or other artificial fertilization techniques that exceed the lifetime maximum of $20,000 for covered medical services and $10,000 for covered pharmacy services for those enrolled in all plans except plan 263. Infertility services are not covered for plan 263. Services up to the lifetime maximum will be covered based on medical necessity at a UnitedHealthcare Center of Excellence. Contact the UnitedHealthcare Fertility Solutions group at 866-774-4626 for guidance on covered fertility services. Infertility services are not covered for dependent children. Natural cycle insemination is not covered in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor. Benefits are not available for elective fertility preservation.
- Reversal of voluntary sterilizations (and complications from this procedure)
- Charges for surgery to the cornea to improve vision by changing the refraction (e.g., radial keratotomy, LASIK, and complications from these treatments)
- Charges incurred for drug counseling or behavior modification guidance related to smoking cessation
- Charges for transportation other than covered ambulance services and as specified under organ transplant
- Charges for any services that are not specified as covered under this Plan
- Services for mental retardation or nontreatable mental deficiency and for mental disorders that are not likely to improve through accepted psychiatric practice
- Services for learning problems, family or marital counseling, antisocial behavior, aggressive or non-aggressive conduct disorders (unless there is an associated psychiatric disorder), pyromania, and kleptomania (exclusion does not apply to services that cover Intensive Behavior Therapy or Applied Behavior Analysis for participants diagnosed with Autism Spectrum Disorder)
- Services for diversional activities or for general counseling or advice
- Charges associated with the storage of blood
- 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 services and services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy
- Charges incurred by someone who is not covered
- Hospital utilization fees
- Interest and taxes
- Experimental/Investigational Care
- Charges for vocational, educational, or recreational therapy and vocational rehabilitation
- Charges for acupuncture except for qualifying individuals enrolled in the expat plan
- 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 wigs except for the expat plan
- 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
- High intensity residential care, including American Society of Addiction Medicine (ASAM) criteria, for covered persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Custodial Care

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

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

Experimental/Investigational or Unproven Care

Charges in connection with certain experimental or investigational, or unproven, drugs, devices, medical treatment, or procedures, and for complications arising from these procedures are not covered by the Plan unless they are for routine patient care provided in a qualified clinical trial.

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

- The drug or device requires approval of the FDA and the drug or device has not been approved to be lawfully marketed for that use when furnished (a drug or device approved for investigational use is deemed to be experimental, investigational, or unproven); or
- Reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing phase I, II, or III clinical trials for the patient's medical condition (except for National Cancer Institute-approved phase III clinical trials for cancer);
- 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 peer review medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.
- Participants must notify the third-party administrator as soon as the possibility of participation in a clinical trial arises. If the third-party administrator is not notified, the participant will be responsible for paying all charges and no benefits will be paid.

Excluded Providers

John Deere health plan carriers may, in 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.

Medical Benefits in Retirement

When you retire according to the retirement conditions of the pension plan, you may be eligible for healthcare in retirement based on the unit from which you retired, employment history at other units, and date of hire. The medical and dental plan options available in retirement (if you are eligible for retiree health coverage), are outlined in the John Deere Health Benefit Plan for Salaried Employees. Your plan options will be communicated in your fall enrollment information or can be obtained by calling the John Deere Benefits Center at 1-844-689-7833 or by accessing the benefit portal at www.yourbenefitsresources.com/deere.

Participation

When you retire, you decide whether or not you want to continue medical and dental coverage (if you are eligible for retiree health coverage). If you are eligible and choose to continue coverage, each year, you may elect to change your coverage during the annual flex enrollment period; otherwise your previous election (or applicable replacement plan), will be continued at prices relative to your retiree health cost category (see categories and retiree health coverage groups outlined below). You can choose a new medical and dental option during flex enrollment or when there is a family status change. Your medical election will apply to dental coverage.

If you discontinue your medical and dental coverage you may reenroll during the annual open enrollment or within 31 days of when you lose other coverage.

If you are eligible for retiree health coverage, you can cover dependents who are eligible for the Plan as of the day you retire as long as they remain eligible (as defined in Flexible Benefit, Eligibility). Individuals age 26 or older who are employees or retirees of the company are eligible to be covered under their own coverage or as a dependent by another John Deere employee or retiree, but not both. You cannot add newly acquired dependents (including spouses), after you retire unless you pay the full cost of coverage

Beginning January 1, after a retiree, or the spouse of a retiree, becomes eligible for benefits under Medicare, they will no longer be eligible for coverage under a CarePlus or CarePlusMAX plan. If eligible for subsidized retiree medical, they will be eligible for company contributions to the retiree's Retiree Medical Credit Account. This provision shall not apply to Medicare retirees, or spouses, with End Stage Renal Disease or Early Medicare pursuant to a disability.

Coverage

Medical and dental options and coverage can change from time to time. You will be notified of changes during the annual enrollment period.

Paying for Coverage

When you retire, you continue to contribute to the cost of your medical coverage. Your payments will be on an after-tax basis and your cost is deducted from your pension payments automatically while enrolled in a John Deere sponsored plan. If, however, your pension amount is not sufficient to cover the cost of the coverage you elect or you defer your pension, you will be required to submit payment to the John Deere Benefits Center on a monthly basis. The cost for coverage can change each year. You will be notified of changes during the annual enrollment period.

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.

Health Care in Retirement, Breakdown by Group and Category

Currently, we have six categories of health benefit coverage in retirement. Employee hire date, industry norms for specific units or business groups, unit start-up date, acquisition dates and benefit costs are among the factors that have been considered in designing these categories.

If, at any time during the employee's last period of continuous employment with John Deere, he/she was eligible for subsidized retiree medical and dental benefits based upon his/her date of hire and unit assignment, the employee will not lose eligibility for subsidized retiree medical and dental benefits based on a transfer to a unit without subsidized retiree medical and dental benefits. If this situation applies, upon retirement, the employee's subsidized retiree medical and dental benefits will be based on benefits as outlined under Group 1 units.

Effective Jul. 1, 2021, the Plan was modified to terminate the provision that allows an employee without post-retirement healthcare (hired prior to Apr. 1, 2000) to gain this benefit by transferring to a unit with post-retirement healthcare. This change also prevents an employee from gaining retiree healthcare that transfers to a salary position from a production wage position.

The 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.

Group 1 Units

1000-A&T Sales Marketing	LV00-Augusta - C&CE
0500-Raleigh	M 00-Horicon
1700-Const Eq - Marketing Admin	MI00-Southeast Engineering Center
1800-JD Power Systems - Waterloo	N 00-Des Moines
2800-Construction Equipment OVS	PC00-JD ISG
3L00-JD Mexico Trading Co	R 00-Waterloo Works
4B00-JD Global Trading Co	RE00-Product Engineering Center
9000-World Headquarters	RF00-Waterloo Foundry
CS00-JD Foundry	RG00-Waterloo Engine
DW00-Davenport	T 00-Dubuque
DY00-Parts Distribution Center	TC00-Turf Care
E 00-Ottumwa	VC00-Global Vehicle Communication
GX00-Greeneville	YZ00-JD Coffeyville
H 00-Harvester East Moline	7900-JD Financial-Johnston
H 01-Cylinder – Moline	9A00-JD Financial-Madison
H 02-Harvester Seeding Group	YK00-John Deere Performance Upgrade

Employees that worked at a Group 1 unit prior to Jul.1, 2021 and meet the retirement conditions of the pension plan would be eligible if they meet the hire date and retirement date criteria below. Cost of coverage will be based on the Company subsidized premium rates until eligible for coverage under Retiree Medical Credits.

– Group 1 Units (except Greeneville): Hired prior to April 1, 2000

– Greeneville: Hired prior to April 1, 2000 and retired on or after April 1, 2013

Not eligible for flexible healthcare benefits in retirement.

– Group 1 Units (except Greeneville): Hired on or after April 1, 2000

– Greeneville: Hired on or after April 1, 2000 or retired prior to April 1, 2013

Group 2 Units

KV00-Knoxville	VG00-Vehicle Group

Eligible for flexible healthcare benefits upon retirement. Cost of coverage will be based on the Company subsidized premium rates until eligible for coverage under Retiree Medical Credits.

– Hired prior to July 14, 1996

Not eligible for flexible healthcare benefits in retirement.

– Hired on or after July 14, 1996

Group 3 Unit - Retiree Only

9F00-JD Health

Eligible for flexible healthcare benefits. Cost of coverage based on the Company subsidized premium rates until eligible for coverage under Retiree Medical Credits.

– Retirees hired prior to April 1, 2000

Not eligible for flexible healthcare benefits.

– Retirees hired on or after April 1, 2000

Group 4 Units

8100-JD Insurance	9E00-JD Transp - Brookfield
8200-JD Life Insurance	

Eligible for Traditional Pre-Flex healthcare benefits. Cost of coverage will be fully subsidized by the Company.

– Retired prior to January 1, 1995

Eligible for flexible healthcare benefits. Cost of coverage based on the Company subsidized premium rates until eligible for coverage under Retiree Medical Credits.

– Retired on or after January 1, 1995

Group 5 Units

A800-JD Seeding Valley City	SB00-Sunbelt
AI00-JD Agri Svcs – Atlanta Legacy	SE-JD Reman-Springfield
AN00-A&I Products US	T800-JD Thibodaux
JL00-JD Paton	TR00-Special Technologies Group
PH00-John Deere Electronic Solutions – Fargo	V300-JD Cons Prod – Charlotte
PS00-John Deere Electronic Solutions – Springfield	

Not eligible for flexible healthcare benefits in retirement.

Group 6 Units

Employees of employer acquisitions made after April 1, 2000 are not eligible for flexible healthcare benefits in retirement unless specifically added to a group above.

A Word about Medicare

Once you or your spouse turns age 65 and you are eligible for company subsidized retiree healthcare, you will be eligible for Medicare in addition to any benefits from the company in the form of Retiree Medical Credits. (You or your spouse also may be eligible for Medicare before age 65 as a result of an End Stage Renal Disease or a disability.)

As long as you are an active employee or the spouse of an active employee, the John Deere Medical Plan will be your primary plan. Also, there are certain situations where Medicare-eligible individuals for whom the John Deere Medical Plan pays benefits first and Medicare pays benefits second:

- John Deere 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.

There will be situations where you're eligible for Medicare coverage and your benefit from the company is provided in the form of Retiree Medical Credits, but your spouse or dependents are not. In these cases, the Plan would be primary for your spouse or dependents so long as they are enrolled in a John Deere plan.

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; the John Deere 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.

Medicare Part B Premiums

Medicare coverage is divided into four parts. Part A provides coverage for hospital bills and Part B pays benefits for physician charges and other eligible medical expenses. Part A benefits are yours automatically when you turn age 65 (you pay no premium). Once you enroll, a monthly premium is deducted from your Social Security check for Part B coverage. The company does not provide reimbursement for your Medicare Part B premiums. In addition to Parts A and B, Medicare also provides Medicare Part C – Medicare Advantage and Part D – Prescription Drug Coverage.

You will want to be sure to enroll in Medicare Part B and Part D at your first eligibility; otherwise you may have a penalty for late enrollment. The John Deere Medical Plan requires you or your dependents to enroll in Medicare Part A and Part B, when eligible. If you do not enroll when eligible, the John Deere Medical Plan will not pay for benefits that would be covered under Medicare, so this coverage is important to you.

Retiree Medical Credit Accounts in Retirement

The Company will provide Retiree Medical Credits (RMC) to eligible retirees and surviving spouses. The RMC are for the reimbursement of Medicare premiums and qualified personal medical expenses.

Who's Eligible?

You are eligible to receive Retiree Medical Credits (RMC) from the company into a Retiree Medical Account if you are:

- a retiree (or an eligible surviving spouse of the retiree), of the company, hired prior to April 1, 2000 and you are eligible for company subsidized retiree health care benefits
- eligible for Medicare Part A and Part B or enrolled in other health care coverage such as TriCare, another employer's group plan, or an individual insurance policy
- are not a Pre-94 retiree
- are not covered by a John Deere High deductible health plan (HDHP)
- Retiree Medical Credits will be provided for eligible spouses, surviving spouses, and qualified disabled dependents of an eligible retiree.

For a surviving spouse, their RMC eligibility rights will be based upon the deceased active employee's or retiree's health care in retirement provisions. A Sponsored Spouse, one in which the marriage occurs after retirement, will never qualify for RMC credits. However, in all situations, the spouse may use any unclaimed RMC credits, after the death of the retiree, for reimbursement of eligible expenses.

The company will also provide RMC for an eligible disabled dependent when the retiree or spouse becomes eligible for Medicare Part A and Part B and is no longer covered by CarePlus or CarePlusMAX.

Contributions to Retiree Medical Credit Account (RMC Account)

Contributions into your RMC account are made solely by the company. You may not contribute to your Retiree Medical Credit Account. The company's contributions or "credits" will start the first day of the month after you become eligible. The 2024 annual RMC allocation will be:

- $4,800/eligible retiree
- $4,300/eligible spouse, surviving spouse or disabled dependent

Should you opt-out of a CarePlus or CarePlusMAX plan at any time other than January 1, the annual amounts will be pro-rated based upon the remaining number of months in the calendar year. The RMC credit amount is subject to change at any time. The company reserves the right to terminate, modify, suspend, or amend, in whole or in part in any manner, at any time and for any reason.

Opt Out

Prior to Medicare eligibility, if you along with your spouse and all dependents opt-out of the John Deere coverage, you could receive RMC credits. You may opt back into coverage again during the annual open enrollment or within 31 days of losing other medical coverage. RMC are not available to employees hired on or after April 1, 2000.

If you opt back into the John Deere High Deductible Health Plan (HDHP), such as CarePlus or CarePlusMAX, any unspent RMC will be frozen. You will not have access or be able to use your RMC credits for reimbursement of any expenses while you are enrolled in a HDHP. If you disenroll from a company-sponsored HDHP, you will once again have access to and may use RMC credits for reimbursement of qualified expenses.

Medicare Part A and Part B eligibility Transition Year Options

When you become eligible for Medicare, you will have the option to remain in the John Deere HDHP plans for the remainder of the calendar year or begin to receive RMC credits. You will only be eligible to remain in the HDHP for the balance of the year that you become eligible for Medicare.

RMC Reimbursement of Expenses

Credits in your RMC Account may only be used for eligible, substantiated expenses that were incurred on or after your eligibility date to receive any RMC credit. Expenses that you incurred before your RMC Account was effective are not eligible for reimbursement from the RMC account.

Eligible expenses shall include, but not be limited to:

- Qualifying medical, prescription, vision, dental, hearing, and Over-The-Counter (OTC) expenses
- Medicare premiums (Part B, Part D, Medicare Supplemental, and Medicare Advantage)
- Supplemental vision and dental premiums
- Long-Term Care premiums

Filing a RMC Claim for Reimbursement of Expenses

In order for an expense to be eligible for reimbursement under your RMC Account, all expenses must be substantiated and submitted by December 31 of the next calendar year following the date of service.

How to Access Your RMC Account

All the information you need to successfully manage your RMC account can be found on the benefit portal at www.yourbenefitsresources.com/deere, where you can:

- Get your account balance
- View eligible expenses
- Submit claims and documentation
- Check the status of your claims and reimbursements

You may also contact the John Deere Benefits Center at 1-844-689-7833 for information.

How to Get Reimbursed for Premiums

Alight's Your Spending Account (YSA) offers a "premium auto-reimbursement" feature that allows eligible premiums to automatically be reimbursed from your RMC account. Depending on the insurer you enrolled through, you may have one or both of the following options for setting up premium auto-reimbursement.

Alight Retiree Health Solutions or AFI
If you enrolled in coverage through the Aon Retiree Health Exchange with a participating carrier, you will be enrolled in premium auto-reimbursement through YSA. If you enrolled through Advantage Freedom, Inc. (AFI), AFI will automatically send the amount of your premium to YSA.

Any Other Insurer or Broker
Note: This section also applies to Medicare Part B premiums

If you are not enrolled with the Alight Retiree Health Solutions or AFI, you must manually submit a paper claim form by mail or fax, or by completing the online claims process through the benefit portal at www.yourbenefitsresources.com/deere. You must provide acceptable supporting documentation with your claim.

If your premium changes and you've set up auto-reimbursement for your monthly premiums, you'll need to update your claim online through the benefit portal or submit a new claim using the paper form. You'll need to provide documentation showing the amount of your new monthly premium.

For monthly-paid premiums, you can select automatic reimbursement so you do not have to manually submit a claim to YSA each month. For premiums paid on another frequency (such as quarterly or annually), you must submit a claim each time. If you paid premiums for multiple months at one time, your request will be treated as a one-time reimbursement request. Automatic reimbursement is only available for premiums paid on a monthly basis.

Acceptable Premium Documentation
Your premium must be accompanied by acceptable documentation showing the insurance company name, insured person, coverage period (start and end date), premium type or description, premium amount, and proof of payment. Acceptable documents include:

- Premium coupon
- Bank statement showing the name of the insurance company, premium type, and amount

How to Get Reimbursed for Non-Premium Expenses

To be reimbursed for eligible out-of-pocket expenses *other than your premiums*, you will need to manually submit your claims to YSA using one of these options:

App: Download the free ReimburseMe mobile app and follow the step-by-step instructions.

Online: Complete the online claims process through the benefit portal at www.yourbenefitsresources.com/deere.

Mail or fax: Complete the Health Care Expenses section of the paper claim form and send to the address or fax number listed on the back of this brochure. Note: Don't make copies of the paper claim form for others to use, because the bar code is specific to your account. You can make copies for your own use.

Acceptable Claims Documentation

All expense claims must be accompanied by an itemized receipt showing the:

- Amount and type of expense
- Date the expense was incurred
- Name of service provider

In addition to receipts, acceptable documentation can include bills, invoices, and insurance explanations of benefits.

Reimbursement from your RMC account depends on your account balance:

If you have enough credits in your account to cover the entire expense, you will receive full reimbursement.

If your account balance is less than the amount of your claim, you will be reimbursed for the current balance in your account. Then, as you receive more credits into your account, the balance of your claims will be paid automatically.

Carry Over of Unused RMC

If you have a remaining, unused balance in your RMC Account at the end of a calendar year, the balance will carry over for you to use for qualified medical expense reimbursement in the following calendar year.

In the event of your death, however, any unclaimed RMC credits will be transitioned into a RMC Account for your surviving spouse. RMC credits will continue to accrue for the benefit of your surviving spouse and any related qualified disabled Dependent.

Upon the death of you and your surviving spouse, RMC credits will stop accruing and any unclaimed RMC credits will revert back to the company, unless there is a qualified disabled dependent. The qualified disabled dependent may use the remaining RMC Account balance for reimbursement of qualified medical expenses.

The company reserves the right to amend, modify, suspend, or terminate the RMC credit(s), in whole or in part, at any time and for any reason.

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 regulation.

Dental Care

Joining the Plan

You and your eligible dependents can join the Dental Plan as of the first day of the month after you start work, or during an annual enrollment period.

Electing Coverage

Active employees will make an annual dental election. The company shall have the discretion and shall reserve the right to modify any dental enrollment year by adding, terminating, or modifying applicable plan options.

Broad Coverage

Three types of expenses are covered—preventive, basic, and major. To be covered under the Dental Plan, an expense must relate to a service provided by a dentist or oral surgeon.

Avoiding Costly Surprises

Learn in advance what the Plan will pay for extensive treatment.

– What the Plan Pays
– Determining Benefits in Advance
– Benefits for Dental Emergencies
– What's Not Covered by the Plan
– Filing a Claim
– Dental Benefits in Retirement
– Situations That Affect Your Dental Benefits
– Plan Amendments and Modifications
– Frequently Asked Questions

What the Plan Pays

Preventive/Diagnostic Expenses

Covered preventive/diagnostic services for each person include:

– Oral examinations: two checkups each calendar year.
– Routine cleanings: two cleanings during each calendar year.
– Fluoride treatments: applications as needed.
– Dental sealants: one per tooth every 3 years (teeth numbers 2, 3, 14, 15, 18, 19, 30 and 31).
– X-rays: bitewing X-rays, twice each calendar year; for full-mouth or panorex X-rays, once every 36 months.

Basic Expenses

Covered basic services for each person include approved:

- Fillings: amalgam (silver), composite, or resin fillings; to restore the structure of teeth and prevent further decay
- Extractions
- Gum and mouth treatments: including surgery for the treatment of gum and mouth diseases. Also includes 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 natural teeth and prevent further decay. Except that payments for benefits on porcelain crowns and repair of such crowns on tooth number 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
- Repairs: to repair or recement crowns, bridgework, dentures, occlusal guards, and implants that were covered by the Plan; also relining of dentures
- Oral surgery: approved surgical procedures including the removal of impacted teeth, except emergency surgery as a result of an accident which is covered under the Medical Plan
- General anesthesia: for oral surgery; 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.

Major Services

Covered major services for each covered person include approved:

- 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 60 consecutive months old and no longer usable
- Orthodontia: the use of braces, examinations, appliances, extractions, and appliance adjustments to correct crooked, crowded, or protruding teeth

How Dental Benefits Are Paid

Dental Services	Benefit Description			
	Pay This Deductible:	The Plan Pays:*	Maximums:	Example
Preventative/ Diagnostic	None	100%	Not subject to calendar year maximum	Exams Cleanings X-Rays Sealants
Basic/Restoratives	$25 per individual/ $50 per family annually	80%	$1,500 per person annually** ($1,500 per person lifetime orthodontia maximum)	Fillings Crowns Extractions Oral Surgery
Major/ Prosthodontics & Orthodontics	$25 per individual/$50 per family annually	50%		Dentures Orthodontia Bridgework

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

Determining Benefits in Advance

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.

The Review Process

Ask your dentist or oral surgeon to submit a description of the proposed course of treatment, related charges, appropriate X-rays (if available), 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 with potential alternative treatment options (if appropriate). 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.

Importance of Predetermination

Predetermining benefits eliminates financial guesswork for you. Predetermination is not required but it will help you determine your benefit coverage before you receive dental services, will help prevent surprises, and it makes good consumer sense. If other insurance is available through Coordination of Benefits (COB), the estimated payment amount may be altered or lowered.

Benefits for Dental Emergencies Due to Accidental Injury (Trauma)

Dental services required due to an accidental injury (trauma) will be covered as a medical service payable at the level of benefits according to your medical plan.

Services Covered

The services covered will include the initial care and treatment by a dentist and/or oral surgeon for services performed within 72 hours. Also included are services provided by a dentist and/or oral surgeon after 72 hours, but within six months, to restore natural teeth and structures to the pre-accident state.

Coverage Under the Dental Plan

If you or your eligible dependents are enrolled ONLY in the dental plan your benefits will be provided under the dental plan.

If you or your eligible dependents are enrolled in the dental plan and a medical plan, and your medical plan does not cover emergency dental services and follow-up, your benefits will be provided under the dental plan.

What's Not Covered By The Plan

Excluded expenses are:

- Services in excess of allowed charges
- Services that are not deemed professionally necessary to correct the dental condition
- Analgesia/anesthesia which does not render the patient unconscious in connection with covered oral surgery
- Treatment of Temporomandibular Joint (TMJ) dysfunction
- 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 malshaped or malpositioned 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 its agencies (except as required under Medicaid provisions or federal law)
- Services provided by any person who is not a dentist or dental hygienist, or provided by any person in your or your dependent's immediate family
- Charges for which benefits are paid by the Medical Plan
- Replacement in less than 60 consecutive months of prosthetic devices including bridgework, partials, full dentures, etc.
- Replacement of a lost, missing, or stolen prosthetic device or orthodontic appliance
- Porcelain on posterior teeth
- 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
- Charges for any services that are not specified as covered under this Plan
- 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 osteotomy or condylotomy, except for situations which meet rigid criteria as specified and covered by the Medical Plan
- Implants except for situations which meet rigid criteria

Dental Benefits in Retirement

When you retire from John Deere, you can continue to receive dental coverage under the company-sponsored Dental Plan. Your cost will be based upon your Health Care In Retirement. Your dental enrollment will be the same elections as your medical coverage, and subject to re-enrollment annually.

If you enroll, you pay a portion of the cost of your dental coverage on an after-tax basis. Your cost is deducted from your pension payments automatically. The cost for coverage may change each year.

The 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. You will be notified of any changes in the Dental Plan during the enrollment period.

Situations that Affect Your Dental Benefits

The Dental Plan is designed to help pay your family's dental costs. However, there are some situations that could cause a loss of benefits.

The Plan pays benefits only for those services and supplies listed as covered expenses in this section.

Benefits are paid only to the extent that the service or supply is necessary to treat your condition and the charge is reasonable.

Dental Plans Quick Links

Dental Plan Options

Plan options are determined according to your eligibility as outlined in the John Deere Health Benefit Plan for Salaried Employees. Your medical plan options will be communicated in your fall enrollment information or can be obtained by calling the John Deere Benefits Center at 1-844-689-7833 or accessing the benefit portal at www.yourbenefitsresources.com/deere.

Plan #2188 | UHC Dental (Flex)

Plan #2189 UHC International Dental (Inpat)

Plan #2191 UHC International Dental (Expat)

Plan #2051 | No Coverage (Dental)

*Deductible applies. Allowed charge means, in order, contracted rates, reasonable and customary charges and billed charges. This is a summary only.

**Based upon U.S. Preventative Services Task Force (USPSTF) guidelines.

Plan #2188 | UHC Dental (Flex)

Benefit	Coverage
Annual Deductible	$25 per individual and $50 per family per calendar year. Applies to basic/restorative, major and orthodontic
Calendar Year Maximum	$1,500 per individual
Orthodontic Lifetime Maximum	$1,500 per individual
Preventive and Diagnostic	Not subject to calendar year maximum.
Examination and routine cleanings *X-rays* *Sealants (Teeth 2, 3, 14, 15, 18, 19, 30, 31)* *Fluoride treatments*	*100% of allowed covered charge. Two per calendar year.* *100% of allowed covered charge. Bitewings twice per calendar year. Panoramic/full mouth every 36 months.* *100% of allowed covered charge. One per tooth every three years. (Limited to certain teeth, up to age 19)* *100% of allowed covered charge.*
Benefit	Coverage

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.

Plan #2188 | UHC Dental (Flex) (continued)

Basic/Restorative	All subject to annual deductible and calendar year maximum.
Fillings	*80% of allowed covered charge**
Space maintainers	*80% of allowed covered charge**
Non-surgical periodontal procedures	*80% of allowed covered charge**
Injection of non-anesthetic medication	*80% of allowed covered charge**
Occlusal adjustment	*80% of allowed covered charge**
Occlusal guards	*80% of allowed covered charge**
Authorized general anesthesia	*80% of allowed covered charge**
Application of desensitizing medications	*80% of allowed covered charge**
Extractions - simple	*80% of allowed covered charge**
Crowns/inlays (repair/re-cement crowns and inlays)	*80% of allowed covered charge**
Root canal/pulp caps	*80% of allowed covered charge**
Scaling, curettage, maintenance cleaning following perio surgery (Four times first year, two times annually thereafter if needed in place of prophylaxis)	*80% of allowed covered charge**
Repair, re-cement, adjust denture/bridgework and reline dentures	*80% of allowed covered charge**
Guided tissue regeneration	*80% of allowed covered charge**
Laboratory tests related to oral surgery	*80% of allowed covered charge**
Prosthodontics (limit one every five years)	**All subject to annual deductible and calendar year maximum.**
Dentures - full or partial, over dentures	*50% of allowed covered charge**
Bridgework	*50% of allowed covered charge**
Precision attachments	*50% of allowed covered charge**
Prosthodontic devices	*50% of allowed covered charge**
Orthodontics	**All subject to annual deductible and orthodontics lifetime maximum.**
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**
Oral Surgery (partial list)	
Apicoectomy	*80% of allowed covered charge**
General anesthesia associated with removal of impacted teeth	*80% of allowed covered charge**
Removal of impactions	*80% of allowed covered charge**
Biopsies	*80% of allowed covered charge**
Alveoloplasty	*80% of allowed covered charge**
Tooth reimplantation/stabilization as the result of an accident	*80% of allowed covered charge**
Removal of tumors, cysts, neoplasms and bone tissue	*80% of allowed covered charge**
Treatment of fractures, foreign bodies, sutures	*80% of allowed covered charge**

Exclusions (partial list)

Consultations (other than for orthodontics)
Implants
Bleaching
Replacement in less than five 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

Plan #2189 | UHC International Dental (Inpat)

Benefit	Coverage
Annual Deductible	None
Calendar Year Maximum	$1,500 per individual
Orthodontic Lifetime Maximum	Not Covered
Preventative and Diagnostic	Not subject to calendar year maximum.
Examination and 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 (Teeth 2, 3, 14, 15, 18, 19, 30, 31)	*100% of allowed covered charge. One per tooth every three years. (Limited to certain teeth, up to age 19)*
Fluoride treatments	*100% of allowed covered charge.*
Basic/Restorative	All subject calendar year maximum.
Fillings	*100% of allowed covered charge**
Space maintainers	*100% of allowed covered charge**
Non-surgical periodontal procedures	*100% of allowed covered charge**
Injection of non-anesthetic medication	*100% of allowed covered charge**
Occlusal adjustment	*100% of allowed covered charge**
Occlusal guards	*100% of allowed covered charge**
Authorized general anesthesia	*100% of allowed covered charge**
Application of desensitizing medications	*100% of allowed covered charge**
Extractions - simple	*100% of allowed covered charge**
Crowns/inlays (repair/re-cement crowns and inlays)	*100% of allowed covered charge**
Root canal/pulp caps	*100% of allowed covered charge**
Scaling, curettage, maintenance cleaning following perio surgery (Four times first year, two times annually thereafter if needed in place of prophylaxis)	*100% of allowed covered charge**
Repair, re-cement, adjust denture/bridgework and reline dentures	*100% of allowed covered charge**
Guided tissue regeneration	*100% of allowed covered charge**
Laboratory tests related to oral surgery	*100% of allowed covered charge**
Prosthodontics (limit one every five years)	All subject calendar year maximum.
Dentures - full or partial, over dentures	*100% of allowed covered charge**
Bridgework	*100% of allowed covered charge**
Precision attachments	*100% of allowed covered charge**
Prosthodontic devices	*100% of allowed covered charge**
Orthodontics	
Orthodontic exams/consultation	*Not covered*
Extractions for orthodontic reasons	*Not covered*
Orthodontic work-up	*Not covered*
Orthodontic treatment	*Not covered*
	Not covered

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

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.

Plan #2189 | UHC International Dental (Inpat) (continued)

Oral Surgery (partial list)	
Apicoectomy	*100% of allowed covered charge**
General anesthesia associated with removal of impacted tooth	*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 five 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

Plan #2191 | UHC International Dental (Expat)

Benefit	Coverage
Annual Deductible	$25 (individual) $50 (family)
Calendar Year Maximum	$1,500 per person
Orthodontic Lifetime Maximum	$1,500 per person
Preventative and Diagnostic	Not subject to calendar year maximum.
Examination and routine cleanings	*100% of allowed covered charge. Two per calendar year.*
X-rays	*100% of allowed covered charge.*
Lab and other Diagnostic Tests	*100% of allowed covered charge.*
Sealants	*100% of allowed covered charge.*
Space Maintainers	*100% of allowed covered charge.*
Fluoride treatments	*100% of allowed covered charge.*
Basic Services	All subject calendar year maximum.
Restorations (Amalgams or Composite)	*80% of allowed covered charge**
General Services	*80% of allowed covered charge**
Simple Extractions	*80% of allowed covered charge**
Oral Surgery (includes surgical extractions)	*80% of allowed covered charge**
Periodontics, Endodontics, and Emergency Treatment	*80% of allowed covered charge**
Major Services	All subject calendar year maximum.
Inlays/Onlays/Crowns	*50% of allowed covered charge**
Dentures and other Removable Prosthetics	*50% of allowed covered charge**
Fixed Parial Dentures (Bridges)	*50% of allowed covered charge**
Orthodontics	All subject calendar year maximum.
Diagnose or correct misalignment of the teeth or bite	*50%*

Plan #2051 | No Coverage (Dental)

Employees choosing this plan will NOT have dental coverage for self or any family members.

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.

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 regulation.

Flexible Benefits

Choices

Through flexible benefits, you choose medical and dental coverage. And, you have the opportunity to participate in flexible spending accounts and health savings accounts (if eligible).

Tax Savings

Flexible benefits are tax-effective because you pay for benefits coverage with pre-tax dollars that are automatically deducted from your pay.

Electing Coverage

Each year, you can change your flexible benefits elections. Or you may make limited changes during the year if you have a qualified change in employment or family status.

How Flexible Benefits Work

Flexible benefits allow you to tailor your medical and dental coverage to meet your needs.

Your Coverage Options

Deere flexible benefits give you annual choices in your medical, dental and flexible spending accounts.

Medical and Dental

The availability of medical and dental options depend on your eligibility as outlined in the John Deere Health Benefit Plan for Salaried Employees.

The medical and dental plans below will be the only options available for certain active employees and eligible retirees who are not Pre-94 Retirees, and their dependents.

For purposes of this section, a Pre-94 Retiree is an individual who is either disabled under the Long-Term Disability Plan or retired:

(1) prior to July 1, 1993 (from any business unit designated by the Company as eligible for subsidized retiree medical benefits at the time)

(2) prior to January 1, 1994 from John Deere Financial

(3) prior to January 1, 1995 from John Deere Insurance Group.

(Any individual who does not fall within (1), (2), or (3) is not considered a Pre-94 Retiree.)

- UHC CarePlus (Plan #0246)
- UHC CarePlusMAX (Plan #0247)
- UHC Access CarePlus (Plan #0248)
- UHC Access CarePlusMAX (Plan #0249)
- UHC Choice Plus PPO 4000 (Plan #0263)
- UHC Flex Dental (Plan #2188)
- Medical No Coverage #0051 (Opt out; no coverage)
- Dental No Coverage #2051 (Opt out; no coverage)

The medical and dental plans below will be limited to active employees, and their dependents, while on international assignment.

- Medical No Coverage #0051 (Opt out; no coverage)
- Dental No Coverage #2051 (Opt out; no coverage)
- UHC International 90/50% - Expat (Plan #0250)
- UHC International 100/50% - Inpat (Plan #0253)
- UHC International Dental - Inpat (Plan #2189)
- UHC International Dental - Expat (Plan #2191)

Once a retiree, or spouse of a retiree, becomes eligible for benefits under Medicare, they shall cease being eligible for the benefits under the above plans as of the first day of the first month (January 1) of the calendar year immediately following the calendar year of Medicare eligibility. An eligible Retiree or Spouse of a Retiree shall only be eligible for company contributions to the Retiree's Retiree Medical Credit Account. Special provisions apply for End stage Renal Disease or Early Medicare.

Tax Advantaged Accounts

- Health Savings Accounts, if enrolled in any CarePlus or CarePlusMAX medical plan option.
- Health Care Flexible Spending Account.
- Dependent Care Flexible Spending Account.

Coverage Categories

When you make medical and dental elections, you also need to decide who should be covered by the Plans. The coverage categories are:

- Employee only
- Employee and spouse
- Employee and child(ren)
- Employee, Spouse and Children
- Spouse Only (retiree)
- Spouse and child(ren)(retiree)
- Child Only (retiree)

Eligibility

For You

As an employee of Deere & Company and/or of a business unit designated by Deere & Company as eligible to participate in a particular flexible benefit plan or program, you are eligible to enroll in flexible benefits.

For Your Dependents

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

- Your domestic partners; Coverage available for same-sex and opposite-sex domestic partners and their children, if applicable, will be eligible for medical and dental coverage. This eligibility applies to a domestic partner of an active salary employee (excluding inpats, interns, and part-time students). Enrollment can be done 31 days following the start of employment or a qualified life event. It can also be done each year during the annual enrollment period. Following your enrollment election, you will receive a Domestic Partner Affidavit that must be completed, signed, and returned to the John Deere Benefits Center. If your domestic partner and/or their children are considered tax dependents according to the IRS, you will need to complete a declaration of tax status form.

  If your domestic partner and/or their children are not considered dependents according to the IRS, the portion of your premiums related to the dependents of your domestic partnership will be paid on an after-tax basis and you will be responsible for imputed income based on the value of the subsidized healthcare provided by the company.
- Your spouse; If he or she is not enrolled or receiving benefits from another company-sponsored medical or dental plan
- Your children under age 26; includes a natural child, a stepchild, a legally adopted child or a child placed with you for adoption.
- Your children who are totally and permanently disabled and rely on you for at least 50% of their support.

"Totally and permanently disabled" means any medically determined physical or mental condition that prevents your dependent from being gainfully employed and which is expected to continue indefinitely or result in death.

Your children are not eligible for coverage if they are enrolled in benefits as an employee or through another employee or retiree of the company. Proof of your child's eligibility for coverage may be requested from time to time.

Sponsored Dependents

In addition to the dependents described previously, you may also elect flexible benefits coverage for a dependent who qualifies as a "sponsored dependent."

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

To enroll a sponsored dependent in Deere flexible 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 definition described above.

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 determining the price of sponsored dependent coverage, individuals age 25 and under are considered children, and those age 26 and over are considered adults. Sponsored dependent children are enrolled as members of a group and sponsored dependent adults are enrolled as individuals.

You are responsible for paying the 100% continuation rate of the sponsored dependent. The company will not make any HSA contribution or alternative payment for the sponsored dependent. The cost of sponsored dependent coverage is deducted on a pre-tax or after-tax basis, depending on your work status.

For more information on sponsored dependents and the price for their coverage, contact the John Deere Benefits Center.

If You Transfer From a Subsidiary or Affiliate

If you transfer from a subsidiary or affiliate of Deere & Company, you and your dependents are eligible to enroll in flexible benefits. However, your maximum medical and dental benefits could be limited, depending on any benefits you already received under subsidiaries or affiliates health care plans.

Enrolling

To enroll in flexible benefits, you must contact the John Deere Benefits Center or access the benefit portal within 31 days of becoming eligible. Then, each fall, you have the opportunity to make new medical and dental elections and new flexible spending account elections for the upcoming calendar year.

If You Don't Enroll

Newly eligible active employees must enroll within 31 days of becoming eligible to participate in a Health Care Flexible Benefit Plan or the following default coverage will be assigned according to their eligibility as outlined in the John Deere Flexible Benefits Plan. In general, the default coverages for Health Care are:

If eligible for any CarePlus or CarePlusMAX medical plan option, the default coverage will be employee only coverage in a CarePlusMAX medical plan option.

If eligible for the UHC International 90/50 (expat), the default coverage will be employee only coverage in International 90/50 (expat).

Coverage will be:

- For you only (your family will not be covered)
- No dental coverage; and
- No contributions to the flexible spending accounts.

If you already have any flexible benefits coverage and you fail to notify the John Deere Benefits Center or access the benefit portal to change your benefits elections by the end of the annual enrollment period, your coverage will be as follows:

- Your previous health and dental plan and coverage options (or applicable replacement plan) will remain in effect.
- Unless you have an approved employment or family status change, you are not allowed to change your flexible benefits coverage until the next annual flex enrollment period. Any changes must be consistent with your employment or family status change.
- If you are declining enrollment for yourself or your dependents (including your spouse), because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that coverage (or if the employer stops contributing towards your or your dependents' other coverage). However you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). To request special enrollment or obtain more information, contact the John Deere Benefits Center.

Special Enrollment Period–Children's Health Insurance Program (CHIP) and Medicaid

Effective April 1, 2009, John Deere will allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or CHIP coverage because you are no longer eligible, or become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days from the date of the Medicaid/CHIP eligibility change to request enrollment in John Deere group health plan.

When Coverage Begins

Here's when flexible benefits coverage begins for you and your dependents:

- For annual enrollments: every January 1
- For new hires: the first day of the month after you join the company.
- For newly eligible employees transferring to participation status such as wage to salary: the day you transfer to salary.
- For employees away from work, for example on a leave of absence: on the day you return to work.

Special Notes for the Medical Options: Medical benefits for dependents (except newborns and children placed for adoption), who are hospitalized when coverage is scheduled to take effect do not begin until the date of discharge from the hospital. Coverage for newborns and children placed for adoption takes effect the day they are born or placed for adoption (if you enroll them for coverage within 31 days of their birth or placement for adoption). Contact the John Deere Benefits Center or access the benefit portal to enroll.

Changing Your Elections

If you have a permitted change in employment or family status, you may be able to change your flexible benefits elections before the annual flex enrollment period

Family status changes include:

- Your marriage, divorce, legal separation or annulment
- Birth or adoption of a child, including children for whom legal adoption proceedings have begun
- Death of your spouse or child
- Loss of eligibility of last dependent or sponsored dependent
- Start or termination of your spouse's group health coverage
- Termination of your spouse's employment
- Significant cost or coverage change (as defined by Internal Revenue Service (IRS) guidance)

Any such other event as the Plan Administrator determines is a family status change in accordance with the procedures established by the Plan Administrator for such purpose and consistent with IRS Code Section 125 regulations and guidance.

If you have a family status change, you may be able to:

- Change your medical and/or dental coverage categories
- Start, stop, increase, or decrease your contributions to the flexible spending accounts, so long as it is consistent with the family or employment status change.

If you transfer and/or are relocated at the company's request to a John Deere location and you gain health plan options, you may have an employment status change. You can make the change on the date of transfer or when you and/or your family relocate. When this happens, you may change your medical option only; you are not allowed to add or drop dependents.

In all cases, a change in your coverage category or medical option or flexible spending account must be due to and consistent with your change in family status or employment.

Special Enrollment for New Dependents

A new dependent due to marriage, birth, adoption, or placement for adoption triggers a special enrollment period for each family member who is eligible but not enrolled in the Plan. The special enrollment request must be submitted at least 31 days after the date of the event. 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 the John Deere Benefits Center.

For Health Care coverage if you have a change in employment or family status, you should notify the John Deere Benefits Center or access the benefit portal within 31 days of the change. Your coverage is retroactive to the date of the employment or family status change. Your payment for coverage is also retroactive, and will be taken for the full pay period in which the change occurred.

If you wait longer than 31 days to notify the John Deere Benefits Center or change your election on the benefit portal, your change is effective on the date of notification. No retroactive coverage is granted. Your payment for coverage begins the next full pay period after the change occurred. You may also wait until the next annual enrollment period to change your health care flexible benefits elections.

For Limited Purpose Flexible Spending Accounts or Dependent Care Flexible Spending Accounts, if you have a change in employment or family status, you should notify the John Deere Benefits Center or access the benefit portal within 31 days of the qualifying status change. Otherwise, no changes will be allowed until the next annual enrollment period to change your flexible benefit election.

For more information on permitted changes in family status or employment, see Administrative Information or contact the John Deere Benefits Center.

Participating

You are considered to be participating in a Flexible Benefit Plan when you contribute to the Plan through contributions on a pre-tax basis or in certain situations, you can continue contributions on an after tax basis through COBRA. Claims must be incurred when you are participating in the Plan. Contact the John Deere Benefits Center or access the benefit portal for more information.

Paying For Benefits with Pre-tax Dollars through Payroll Deferral

Your contributions for medical and dental coverage, as well as contributions to the flexible spending accounts, and health savings accounts, are deducted from your pay before federal, Social Security, and most state income taxes. Paying with pre-tax dollars reduces your taxable income, and that means you may pay less in taxes.

Even though you reduce your income for tax purposes by paying for flexible benefits with pre-tax dollars, you are not reducing the value of your other pay-related benefits. Those benefits, such as life insurance, long-term disability, the Pension Plan, the Savings and Investment Plan, and the Stock Purchase Plan are based on your pay before flexible benefit payments are considered.

However, paying for benefits with pre-tax dollars may affect your future Social Security retirement benefits. This could happen if your payments for flexible benefits reduce your taxable pay below the Social Security wage base.

Tax Advantage Accounts

Health Savings Account (HSA)

A Health Savings Account (HSA) is a trust or account established by an employee in accordance with the provisions of Internal Revenue Code section 223(d) for the reimbursement of qualified medical expenses. A HSA is the personal account and responsibility of the employee. The company shall have no responsibility with respect to such HSAs. The company's role shall be limited to

(1) any contributions that the company may make, in its discretion, to the HSA established by an employee (annual company contribution is $750 for employee/retiree only coverage and $1,500 for family coverage) or

(2) any alternative payment that the company may make, in its discretion, to or on behalf of such employee. Other than as specifically provided, the company shall have no further responsibility with respect to such HSAs.

Eligibility

For You

If you are enrolled in a High Deductible Health Plan (HDHP) and meet the eligibility requirements as defined by the Internal Revenue Service (IRS) (examples of a HDHP include the CarePlus or CarePlusMAX medical plan options), then you may contribute to an HSA.

For those employees eligible for a HDHP and Expat healthcare plan, they will be offered to the Limited Purpose Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account. A Limited Purpose Health Care Flexible Spending Account covers only qualified dental and vision expenses.

For Your Dependents

If your spouse is enrolled in a HDHP and meets the eligibility requirements as defined by the IRS (examples of a HDHP include CarePlus or CarePlusMAX medical plan options), then your spouse may contribute to his or her own HSA account.

Tax Savings

HSAs allow you to pay for IRS qualified medical and dental expenses with pre-tax dollars.

Changing Your Payroll HSA Elections

You can change your payroll HSA elections anytime by going to www.netbenefits.com or calling Fidelity at 1-800-354-3427. All changes will take effect in the next occurring payroll cycle.

Enrolling

To enroll in a HSA, you must first elect coverage in a John Deere CarePlus or CarePlusMAX medical plan option. You must then open an HSA with FIdelity by logging onto the benefit portal at www.yourbenefitsresources.com/deere and accept the Terms and Conditions if eligible. In order to make contributions into and withdrawals out of the HSA, the HSA must be opened. The HSA must be opened prior to the date of service of any IRS qualified medical and dental expense.

Contributing to an HSA and Paying For Benefits With Pre-tax Dollars Through Payroll Deferral

If you are an eligible employee for purposes of establishing a HSA, the company provides you with a choice between receiving cash compensation and making additional, pre-tax contributions through payroll deductions to the HSA. Specifically, you may elect to forego receiving a portion of your earnings and, instead of receiving those earnings in cash, you may elect to have an amount equal to your foregone earnings credited to your HSA for the reimbursement of qualified medical expenses.

Your HSA contributions, through payroll, are deducted from your pay before federal, Social Security, and most state income taxes (except New Jersey, Alabama, and California as of December 2013). Paying with pre-tax dollars reduces your taxable income, and that means you may pay less in taxes.

HSA Limits and Catch-up Contributions

If you are enrolled in a HDHP, and meet the IRS eligibility requirements for contributing to an HSA, you can make tax advantaged contributions to your HSA. The 2024 HSA contribution limits are: $4,150 single coverage or $8,300 family (household). In addition, if you are age 55 by the end of the calendar year and you are not enrolled in Medicare, you may qualify for an additional catch-up contribution to your HSA (for 2024 the catch-up contribution amount is $1,000).

For more information, please refer to the IRS or your tax advisor. A HSA is a personal, tax advantaged account established by you. The company does not assume any responsibility for the account. You are responsible for keeping track of your annual HSA contributions and for all proper IRS reporting.

Limited Purpose Health Care Flexible Spending Account

The Limited Purpose Health Care Flexible Spending Account can help you save money by using pre-tax dollars to pay for anticipated out-of-pocket expenses for qualified vision and dental services. Participation in the account is voluntary. You decide whether you can benefit from the tax savings the account offers.

Who this Account Applies to

This account can be utilized by active flex salaried employees and their survivors who are eligible for CarePlus, CarePlusMAX, Access CarePlus, and Access CarePlusMAX medical plan options (the High Deductible Health Plans) or enrolled in the Expat health coverage.

How the Account Works

Each year during the annual enrollment period, you can elect whether to participate (make contributions), and if you do, how much you want to contribute.

Participating

You are considered to be participating in a Flexible Benefit Plan when you contribute to the Plan through contributions on a pre-tax basis or in certain situations, you can continue contributions on an after tax basis through COBRA. Claims must be incurred when you are participating (making contributions) in the Plan. Contact the John Deere Benefits Center or access the benefit portal for more information.

Separate Accounts

The law requires that money in your Limited Purpose Health Care Flexible Spending Account cannot be used to pay for Dependent Care expenses through the Dependent Care Flexible Spending Account, and vice versa.

Eligible Expenses

Out-of-pocket expenses for qualified vision and dental services are eligible expenses.

Here is a list (but not all-inclusive), of some eligible dental and vision expenses:

- Contact lenses
- Eyeglasses
- Guide dog
- Your portion of the vision copayment or out-of-pocket expenses
- LASIK Eye Surgery
- Optometry services
- Orthodontia
- Temporomandibular joint (TMJ) syndrome treatment (if performed by a dentist)
- Your portion of the dental deductible or coinsurance expenses

Keep in mind that when you claim reimbursement for out-of-pocket expenses for qualified covered or non-covered vision and dental services through your Limited Purpose Health Care Flexible Spending Account, they cannot be reimbursed in any other way, such as by your John Deere Medical or Dental Plan, your spouse's plan, or any other health plan (and vice versa).

Expenses being applied to meet your annual deductible under the John Deere Medical Benefit Plan, even though not reimbursed under the Medical Benefit Plan or any other health plan, are not eligible for reimbursement through your Limited Purpose Health Care Flexible Spending Account.

IRS Publication #502 (http://www.IRS.gov) describes vision and dental expenses that are deductible on your federal tax return. This publication can also be used as a guideline for vision and dental expenses that are reimbursable under the Limited Purpose Health Care Flexible Spending Account.

However, not all expenses listed in IRS Publication #502 are eligible for reimbursement through the Limited Purpose Health Care Flexible Spending Account. Some of these expenses may be partially covered under your Medical or Dental Plan. You can use your Limited Purpose Health Care Flexible Spending Account to pay yourself back for the portion of certain expenses, as described above that are not covered by the Medical or Dental Plan.

Forfeiture Rule

What is the Dental/Vision FSA Rollover provision?

You are allowed to rollover $610 of unused funds from your 2024 FSA into the next year. You must continue to participate by making contributions to your FSA during the rollover year; otherwise, these funds will be forfeited.

If I roll over funds from last year, will it affect the amount I can elect this year?

No. The rollover has no impact on your maximum annual election. The rollover amount is in addition to your regular election for the following plan year.

Does the Rollover apply to both the Dental/Vision FSA and Dependent Care FSA?

No, the rollover only applies to Dental & Vision FSAs. The rules for the Dependent Care FSA remain the same.

Will I need to do anything special to move unused Dental/Vision FSA funds into a new plan year?

No, the rollover funds will be automatically moved after March 31 of the following year (the run-out period to submit claims for the prior year).

If I don't elect to participate in the Dental/Vision FSA in the new plan year, will the unused funds be refunded to me?

Unfortunately, no. IRS rules still prohibit refunding unused FSA funds to those participants who have a balance in their account at the end of the plan year.

How do I sign up for the Rollover feature?

When you elect to enroll in the FSA in the new plan year, the rollover is automatically part of your plan. No extra steps are required.

What happens to my unused funds if my participation in the Dental/Vision FSA ends during the plan year?

The rollover feature only applies to participants who are covered as of the last day of a plan and participate in the subsequent year. If your FSA terminates mid-year, your unused funds will be forfeited unless you submit receipts for expenses incurred while your account was active, or you elect to continue the plan via COBRA.

Any amounts forfeited will be used to reduce Deere & Company's costs for administering the spending account. Contact the John Deere Benefits Center or access the benefit portal to review your contributions, projected year end contributions, and current account balance for your FSAs.

Contribution Limits

Limited Purpose Health Care Flexible Spending Account:

Minimum Annual Contribution
– $48 ($2 per pay period if paid semi-monthly, $1 per pay period if paid weekly)

Maximum Annual Contribution
– $3,050

Depending on your payroll cycle, your annually elected contribution will be rounded to the nearest whole cent per pay period.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account can help you save money by allowing you to use pre-tax dollars to pay for Dependent Care expenses.

Participation in the Dependent Care Flexible Spending Account is voluntary. You decide whether you can benefit from the tax savings the account offers.

Participating

You are considered to be participating in a Flexible Benefit Plan when you contribute to the Plan through contributions on a pre-tax basis. Claims must be incurred when you are participating in the Plan. Contact the John Deere Benefits Center or access the benefit portal for more information.

The account permits you to pay yourself back for dependent care expenses that allow you (and your spouse, if you're married), to work outside the home, or allow your spouse to attend school as a full-time student.

Eligible Dependent Care Expenses

Expenses for these family members are eligible for the Dependent Care Flexible Spending Account:

- Children under age 13 who qualify as dependents on your federal income tax return.
- Other family members who are physically or mentally unable to care for themselves (such as a parent whom you support), and who qualify as dependents on your tax return.
- If you're divorced, special rules apply. You should consider contacting a tax advisor in these situations.
- Care may be provided in your home, in another person's home, or in a licensed day care center. The care provider may be a relative as long as that person is age 19 or older and is not also your dependent.
- If services are provided outside of your home, your dependent must regularly spend at least eight hours a day in your home. If the facility provides care for more than six individuals, it must meet state and local licensing requirements.
- For children too young for kindergarten, the cost for nursery school may be assumed to be for Dependent Care. For older children, tuition expenses are not eligible for reimbursement. If the tuition can be separated between education and before- or after-school care, however, a portion of these expenses may be eligible.
- Other expenses eligible for reimbursement include:
- Temporary Leaves of Absences: Expenses incurred during short, temporary absences from work, such as for minor illness or vacation, are employment-related if dependent care payments are made on a weekly or longer basis.
- Specialized Day Camps: Expenses for computer, soccer, and other day camps can be employment-related expenses. Expenses for overnight camp are not.
- Part-time Work: Part-time workers must allocate expenses between days worked and days not worked, unless day-care expenses must be paid on a weekly or longer basis.
- Agency and Application Fees: Agency and application fees required to obtain the services of an au pair or other care provider may be employment-related expenses. Costs for a care provider's room and board and any employment taxes paid on behalf of a care provider also may be employment-related expenses.

Using the Federal Tax Credit

Depending on your situation, you may benefit from using the Dependent Care Flexible Spending Account or the tax credit, or both. The maximum amount that can be used for the tax credit is reduced by any amount you use through the Dependent Care Flexible Spending Account. Please consult with your tax advisor to determine which approach is best for your situation

Forfeiture Rule

Any unused funds from your 2024 FSA will be forfeited based on IRS requirements.

Any amounts forfeited will be used to reduce the company's costs for administering the reimbursement account. Contact the John Deere Benefits Center to review your contributions, projected year-end contributions, and current account balance for your FSA.

Contribution Limits Dependent Care Flexible Spending Account:

Minimum Annual Contribution

- $48 ($2 per pay period if paid semi-monthly, $1 per pay period if paid weekly)

Maximum Annual Contribution

- $5,000

Depending on your payroll cycle, your annually elected contribution will be rounded to the nearest whole cent per pay period.

Filing Flexible Spending Account Claims

Step 1: You decide at enrollment how much to put into each of your accounts for the year. Remember, participation in both health care and dependent care accounts are separate elections. Eligibility for the Flexible Spending Accounts depend upon your eligibility for enrollment in the HDHPs and Expat plans (for example, the CarePlus or CarePlusMAX medical plan options).

Step 2: Enter your claim on line through the benefit portal or by using the ReimburseMe Mobile App. To submit by paper claim form, call the John Deere Benefits Center. You will be required to provide proof of service incuding the date of service, provider of service, expense amount, description, and recipient of the service. Claims must be incurred (date of service) while you are participating in the spending account.

Step 3: Provide the receipt from your provider by uploading through the benefit portal or the mobile app. For dependent care expenses, the mobile app offers e-signature from your provider. For healthcare expenses partially covered by your health plan, provide a copy of your health plan's explanation of benefits (EOB). For expenses related to your purchase of a prescription drug, include the drug's name on your claim for reimbursement. Be sure to keep a copy of the receipt and, if applicable, your form in case you need to provide more information about your claim. More information regarding documentation requirements is available through the benefit portal.

Step 4: After you submit your claim(s), it is reviewed within 3 to 5 business days. Payment of approved expenses is either sent to you by check or direct deposit. If you want to have your reimbursement automatically deposited into your checking or savings account, you can sign up for direct deposit through the benefit portal.

Step 5: You have until March 31 of each year to submit claims for dates of services incurred during the previous calendar year provided you were participating in the Account(s) when the expense was incurred. If you participated through the end of the calendar year, claims and sufficient supporting receipts must be received by the John Deere Benefits Center by March 31 to be eligible for reimbursement for the previous calendar year Account. If your participation ends prior to December 31st due to a life event, claims and supporting receipts must be received by the John Deere Benefits Center by March 31st of the following year. Claims received after March 31 will be denied and any remaining balance will be forfeited.

You can submit claims to your Limited Purpose Health Care Flexible Spending Account up to your total annual election at any time during the year even if you have not yet contributed that amount.

The amount you are reimbursed from your Dependent Care Spending Account depends on the balance in your account:

- If you have enough money in your account to cover the entire expense, you will receive full reimbursement.
- If your account balance is less than the amount of your claim, you will be reimbursed for the current balance in your account. Then, as you contribute more to your account, the balance of your claims will be paid automatically.

Situations That Affect Your Benefits

When There's Another Medical or Dental Plan

You or a covered dependent may be covered by more than one group medical or dental plan; for example, under your spouse's employer's plan. The John Deere Medical and Dental Plans have a coordination of benefits (COB) feature to prevent duplication of payments in these cases. See Administrative Information for details.

When Coverage and Pre-tax Contributions End

Your coverage under Deere flexible benefits, and the ability to use pre-tax dollars to pay for benefits, stops when you no longer meet the eligibility requirements described in the Overview. Your dependents' coverage under the Plans ends when they no longer meet the definition of a dependent, as described in the Eligibility section.

Important information about how flexible benefits can be continued in special cases is found in Administrative Information.

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 Administrative Information section.

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.

Claims

Filing an Insurance Medical Claim

If you enroll in the John Deere Plan and you use a participating provider, you do not need to submit a claim for benefits to your TPA/MCO. If you use the point-of-service feature of a managed care option, you may need to submit your claims to the TPA/MCO as follows.

Non-Medicare Health Care Claims Procedures

When to Submit a Claim

If you receive a bill, and it was not previously submitted to your TPA/MCO, for covered health services from a provider, you must send the bill to TPA/MCO for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to TPA/MCO at the address on the back of your ID card.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described below:

– you are asked to pay the full cost of the prescription drug when you fill it and you believe that the Plan should have paid for it
– you pay a copay and you believe that the amount of the copay was incorrect

If a pharmacy (retail or home delivery), fails to fill a prescription that you have presented and you believe that it is a covered health service, you may submit a pre-service claim as described below.

How to File Your Claim

You can obtain a claim form by calling the toll-free number on your ID card. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

– your name and address
– the patient's name, age and relationship to the employee
– your member ID number as shown on your ID card
– the name, address and tax identification number of the provider of the service(s)
– the date of service
– an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the sickness or injury began; and
  - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

After the TPA/MCO has processed your claim, you will receive payment for benefits that the Plan allows. It is your responsibility to pay the provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

The TPA/MCO will pay medical care or dental care benefits to you unless:

– the provider notifies the TPA/MCO that you have provided signed authorization to assign medical care or dental care benefits directly to that provider; or

– you make a written request for the provider to be paid directly at the time you submit your claim.

The TPA/MCO will only pay medical care or dental care benefits to you or your provider, and not to a third party, even if your provider has assigned benefits to that third party.

The TPA/MCO will send you an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them.

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 Administration Information section.

Important

All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any medical care or dental care benefits for that eligible expense, or benefits will be reduced, as determined by TPA/MCO. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

Medicare Health Care Claims Procedures

When you receive medical care, you or your provider, must submit a claim for benefits to be paid.

Here's what you should do:

– Show your benefit card and ask your provider to bill Medicare as the primary carrier.

– After Medicare has considered the charge(s), you or your provider, must submit a copy of the claim and a copy of Medicare's Explanation of Benefits to the address indicated on your benefit card.

– If the provider will not submit your claim, you may need to pay your bill and then submit a claim for reimbursement, as follows:

  • Ask your provider to complete a HCFA-1500 Medical Form or a UB04 Hospital Form, for submission to Medicare

  • Please keep a copy of the HCFA-1500 form for submission to your carrier, after you receive Medicare's Explanation of Benefits from Medicare

– For submission to Medicare the bill must be an original and 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 charge(s)

  • Any accident details (if applicable)

  • The provider's name, addresses, phone number, and tax ID number

– In addition, you will need to supply your name, member identification number, home address and telephone number

– Send the bill with the attached information to Medicare for consideration

– After Medicare has considered the charge(s), a copy of the claim and a copy of Medicare's Explanation of Benefits must be sent to the address indicated on your benefit card

Filing an Insurance Dental Claim

To file a dental claim, follow these steps:

– You or your dental provider must submit your claim on an ADA Dental Claim Form, which should be available in the provider's office.

– Your dental provider must complete the form and you must sign it.

– You or your dentist submits the completed 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.

Claims Process

Deere & Company has delegated to UnitedHealthcare the Plan's Claims Administrator obligation 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 Claims 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 may call the Claims Administrator at the number on your ID card before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file appeal as described below. 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 Claims 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 time frames.

If you wish to appeal a denied pre-service request for benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination.

You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card
- the provider's name
- the date of medical service
- the reason you disagree with the denial
- any documentation or other written information to support your request

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare – Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for benefits that have been denied, you or your provider can call the Claims Administrator at the toll-free number on your ID card to request an appeal.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for benefits: a request for benefits provided in connection with Urgent Care services, as defined in Definitions
- Pre-Service request for benefits: a request for benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided
- Post-Service: a claim for reimbursement of the cost of non-Urgent Care that has already been provided

Claim Recovery Process for Overpayments

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which the Claims Administrator makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Payment of Benefits

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a non-Network provider without the Claims Administrator's consent. When you assign your Benefits under the Plan to a non-Network provider with the Claims Administrator's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When the Claims Administrator has not consented to an assignment, the Claims Administrator will send the reimbursement directly to you for you to reimburse the non-Network provider upon receipt of their bill. However, the Claims Administrator reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, the Claims Administrator may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will the Claims Administrator pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by the Claims Administrator to an assignment or to waive the consent requirement. When the Claims Administrator in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although the Claims Administrator may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.

– All or some of the payment the Plan made exceeded the Benefits under the Plan.

– All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which the Claims Administrator makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

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 24 hours of receipt of this additional information

If the Claims Administrator denies your request for benefits, you must appeal an adverse benefit determination no later than 180 days after receiving the adverse benefit determination. The Claims Administrator must notify you of the appeal decision within 72 hours after receiving the appeal.

**You do not need to submit Urgent Care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an Urgent Care request for benefits.*

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

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for benefits and decided according to the time frames described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service time frames, whichever applies.

Pre-Service Claims

If the initial request for benefits is complete you will be notified of the claim decision within 15 calendar days after receipt of the claim.

If you or your authorized representative does 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 five days following the failure.

If your request for benefits is incomplete 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 receipt of the additional information (if the initial request for benefits is incomplete).

A "pre-service" claim is a claim for a benefit for which prior authorization or approval is required by the Plan.

Post-Service Claims

If the initial request for benefits is complete, you will be notified of the claim denial within 30 calendar days after receipt of the claim. If your request for benefits is incomplete and additional information is needed to make a claim decision, you will be advised of the specific information needed 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 receipt of the additional information (if the initial claim is incomplete).

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
- In case of a claim denial involving urgent care, you will receive an explanation of the expedited review process

If the Claims 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 Claims 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 Claims 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 Claims 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 Claims 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 three 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 forty-eight hours of receipt of 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
- 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

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the External Review Program. This program only applies if the adverse benefit determination is based on:

- clinical reasons
- the exclusions for Experimental or Investigational Services or Unproven Services
- rescission of coverage (coverage that was cancelled or discontinued retroactively)
- as otherwise required by applicable law

This External Review Program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if the Claims Administrator fails to respond to your appeal in accordance with applicable regulations.

If the above conditions are satisfied, you may request an independent review of the adverse benefit determination. Neither you nor the Claims Administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four months of the date you receive the adverse benefit determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by UnitedHealthcare and has no material affiliation or interest with the Claims Administrator or Deere & Company. UnitedHealthcare will choose the IRO based on a rotating list of appropriately accredited IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable time frames of the Claims Administrator's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records
- all other documents relied upon by the Claims Administrator in making a decision on the case
- all other information or evidence that you or your Physician has already submitted to the Claims Administrator

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and the Claims Administrator will include it with the documents forwarded to the IRO. A decision will be made within applicable time frames. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and the Claims Administrator with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

Disability Claims (Including Disability Claims Under the Pension Plans)

If a Disability Claim Is Denied

If a disability claim is denied, the Plan Administrator or its delegate will notify you of the claim denial no later than 45 days after receiving the claim. The 45-day period may be extended for up to 30 days if the Plan Administrator or its delegate (1) determines the extension is necessary because of matters beyond the Plan's control, and (2) notifies you, before the end of the 45-day period, why the extension is needed and the expected decision date.

If the Plan Administrator or its delegate determines, before the end of the 30-day extension, that due to matters beyond the Plan's control a decision cannot be made within the extension period, the Plan Administrator or its delegate may extend the determination period for up to an additional 30 days. However, the Plan Administrator or its delegate must notify you why the extension is necessary and what the expected decision date is before the end of the first 30-day extension period.

The extension notice will explain (1) the standards on which benefit entitlement is based; (2) the unresolved issues that prevent a claim decision; and (3) any additional information needed. You will have at least 45 days to provide any additional information needed.

If your claim is denied in whole or in part, you will be notified of the claim decision. This notification will be provided in a culturally and linguistically appropriate manner (including oral language services and upon request a notice in any applicable non-English language) and will include:

- The specific reason(s) for denial
- Reference to the specific Plan provisions on which the denial is based
- A description of any additional material and/or information necessary for you to perfect the claim and an explanation of why that information is necessary
- A description of the Plan's review procedures, the applicable time limits for such procedures, and your rights to bring a civil action under ERISA Section 502(a) following an appeal denial
- If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request; and
- Either the specific internal rules, guidelines, protocol standards or other similar criteria of the Plan relied upon in making the adverse determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
- A discussion of the decision including an explanation of the basis for disagreeing with or not following:
  - The views that you presented to the Plan presented by health care professionals treating you and vocational professionals who evaluated you,
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
  - A disability determination made on your behalf by the Social Security Administration, presented by you to the Plan.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals

You or your authorized representative may appeal a denied claim within 180 days after receipt of a claim denial notice.

During the 180-day period, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim, and you may request copies free of charge. You may submit written comments, documents, records, and other information relating to the claim to the Plan Administrator or its delegate.

Review of your appeal shall take into account all comments, documents, records, and other information, without regard to whether such information was submitted or considered in the initial claim decision. The review of your claim denial will not defer to the initial determination made by the Plan Administrator or its delegate.

The individual who will review your appeal will be independent from the individual who reviewed your claim. If your appeal involves a medical judgment, the Plan Administrator or its delegate will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be an individual who was neither consulted in connection with the claim decision nor the subordinate of any such individual.

Before an adverse determination on appeal is issued, the Plan Administrator or its delegate will provide you free of charge with any new or additional evidence considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you.

Before an adverse determination on appeal is issued based on a new or additional rationale, the Plan Administrator or its delegate will provide you free of charge with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you.

If your appeal is denied, the Plan Administrator or its delegate will provide written notification of its decision to you. The Plan Administrator or its delegate will notify you within 45 days after the appeal is received by the Plan Administrator or its delegate (or within 90 days if the Plan Administrator or its delegate determines special circumstances require an extension of time for considering the appeal, and if written notice of such extension and circumstances is given to you within the initial 45 day period).

If your appeal is denied, you will receive a notification in a culturally and linguistically appropriate manner (including oral language services and upon request a notice in any applicable non-English language) that includes:

- The specific reason(s) for the decision
- Reference to the specific Plan provision(s) on which the decision 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) and a description of any contractual limitations period applicable to your right to bring such action, including the calendar date on which such contractual limitations period expires for the claim
- If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
  - Either the specific internal rules, guidelines, protocol standards or other similar criteria of the Plan relied upon in making the adverse determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
  - A discussion of the decision including an explanation of the basis for disagreeing with or not following:
  - The views that you presented to the Plan presented by health care professionals treating you and vocational professionals who evaluated you,
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
  - A disability determination made on your behalf by the Social Security Administration, presented by you to the Plan.

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, Deere & Company, One John Deere Place, Moline, Illinois 61265 (or at the address of any entity designated by the Plan Administrator).

The Plan Administrator may delegate authority to decide questions about eligibility and/or benefits to another entity. If any authority is delegated to another entity, you will be told whom it is.

You will receive written notification of the decision within 90 days after receipt of your claim.

The notice will explain:

- The reason(s) why your claim was granted or denied;
- The specific plan provisions on which the decision was based;
- Any additional material or information that is needed before a decision can be made and the reason(s) why the material or information is necessary; and
- The procedures for appealing the decision, including the time limits applicable to such procedures, and your right to bring a civil action under ERISA Section 502(a) following an appeal denial.
- If the Plan Administrator or their delegates 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
- Request an opportunity to review all relevant documents relating to your claim
- Submit any issues, written comments, documents, or additional information as may be appropriate to your claim
- Your request for an appeal of your claim denial must be received within 60 days after you receive notice of denial
- Within 60 days after receipt of your request for a review, a decision on your appeal request will be made

You will receive a written or electronic notification of the decision that includes: (1) the specific reason(s) for the decision and references to the Plan provisions on which the decision was based; (2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and (3) a statement describing the Plan's voluntary appeal procedures, your right to obtain information about such procedures, and your right to bring an action under ERISA Section 502(a).

If the Plan Administrator or its delegate determine that special circumstances require a review period of longer than 60 days, the time for making a final decision may be extended. In this case, you will receive a written notice of extension prior to the end of the initial 60-day period; this notice will provide the special circumstances that require an extension and the date that the Plan expects to render a decision. However, the total review period cannot be more than 120 days.

If 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.

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), the John Deere 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 John 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 the John Deere Plan.

COB applies to you if you are covered by more than one health benefits 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
- 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
  - 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

- the spouse of the parent with custody of the child
- the parent not having custody of the child
- 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 no benefits.

– If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

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

– individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare), will be the allowable expense. Medicare payments, combined with Plan benefits, will not exceed 100% of the total allowable expenses.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Coverage Pursuant to a Qualified Medical Child Support Order

If you become separated or divorced, a Qualified Medical Child Support Order (QMCSO) may provide that one parent provide health benefit coverage, such as medical coverage, for your children.

Deere & Company follows certain procedures to determine if an medical child support order is "qualified." You may obtain a copy of these QMCSO procedures, free of charge. If you have any questions or would like a copy of the written procedures used to determine whether a medical child support order is a QMCSO, please contact the John Deere Benefits Center.

Continuing Coverage Through COBRA

When flexible benefits coverage ends, in some situations you can continue your medical and dental benefits and participation in the Limited Purpose Health Care Flexible Spending Account at your own expense under provisions of a federal law—the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Under COBRA, each qualified beneficiary who would lose coverage under the Plan due to a COBRA qualifying event may elect, within the applicable election period, to continue participation in the Plan benefits in which he or she participated in immediately before the COBRA qualifying event. You, your spouse, and your eligible dependent children could become qualified beneficiaries under the Plan if Plan coverage is lost due to a qualifying event.

If you or your eligible dependents have experienced a COBRA qualifying event, in order for you or your dependents to qualify for continuation of coverage under COBRA, you and/or your dependents must be covered by the Plan at the time of the qualifying event and notify the John Deere Benefits Center within 60 days after the later of: (1) the date the you would lose coverage due to the qualifying event; or (2) the date on which the Plan or its COBRA administrator provides you with a notice of your COBRA rights to continue Plan coverage.

COBRA Qualified Beneficiaries

For purposes of COBRA, a "qualified beneficiary" is an individual who is covered under the Plan on the day before a COBRA qualifying event. COBRA qualified beneficiaries include an employee, retiree, spouse, and eligible dependent children. A dependent who is born to or placed for adoption with an employee during a period of COBRA continuation coverage is a qualified beneficiary if timely notice of the dependent's birth or adoption is provided to the Plan.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their eligible children.

COBRA Qualifying Events and Duration of COBRA Coverage

Coverage for you, your spouse, and your eligible dependent children can continue for up to 18 months if you lose coverage because of these COBRA qualifying events:

- Your employment ends for any reason except gross misconduct
- Your hours are reduced so that you no longer qualify for Deere flexible benefits

If you, your spouse, or eligible dependent is disabled as determined under the Social Security Act at the time you leave Deere or your hours are reduced, or at any time during the first 60 days of COBRA coverage, then the disabled person may be able to extend coverage under COBRA for up to an extra 11 months, in addition to the 18-month period (for a total of 29 months under COBRA).

In case of a qualified beneficiary who is determined to be disabled under the Social Security Act, he must provide notice of such determination to the John Deere Benefits Center within 60 days from the date of determination and before the end of the original 18 months of COBRA coverage in order to obtain the 11-month extension of COBRA coverage.

Such disabled qualified beneficiary's extended coverage beyond 18 months shall end on the later of (1) either the month that begins more than 30 days after the date the final determination is made under the Social Security Act that such person is no longer disabled, or the 29th month after the date on which such termination of employment, reduction in hours, retirement or layoff occurred; or (2) the end of the maximum coverage period that applies to the qualified beneficiary without regard to extension of COBRA coverage due to disability.

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
- You die

If a qualifying event that gives rise to an 18 month maximum coverage period is followed (within that 18-month period), by a second qualifying event, such as a death or divorce, the original 18-month period is expanded to 36 months, but only for those individuals who were qualified beneficiaries under the Plan as of the first qualifying event and participated under the Plan as qualified beneficiaries at the time of the second qualifying event.

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 has been notified that a qualifying event has occurred. The company will notify you or your dependents if coverage ends due to termination of employment or a reduction in your work hours.

For all other 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 the John Deere Benefits Center as soon as possible and no later than 60 days after the later of: (1) the date of the qualifying event; or (2) the date when coverage would otherwise be lost under the Plan due to the qualifying event.

If you or your family member does not notify the John Deere Benefits Center of these qualifying events within the applicable 60 day period, then Deere & Company is not required to provide COBRA continuation coverage to a qualified beneficiary.

Time Period for Electing COBRA Continuation Coverage

You have 60 days from the later of (1) the date that you would lose coverage under the Plan due to the qualifying event or (2) the date that notice is provided to you of your right to elect COBRA continuation coverage, to elect COBRA continuation coverage.

Paying for COBRA Continuation Coverage

COBRA allows you to continue the same medical, dental, and Health Care Spending Account coverage you had before the qualifying event. However, premiums and continued contributions to the spending 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). The cost for the last 11 months of COBRA coverage (months 18 through 29), for a disabled qualified beneficiary is the disability rate for COBRA (150% of the cost of coverage).

Any company-subsidized continuation offered automatically will count toward the 18-, 29-, and 36-month periods.

The first payment for COBRA continuation coverage is due within 45 days after you elect COBRA continuation coverage. After that, payments are due by the first day of each calendar month of participation, with a 30-day grace period.

When COBRA Continuation Coverage Ends

Continued coverage under COBRA will end on the earliest of the following:

- The last day of the maximum COBRA continuation coverage period described above (for example: 18 months; 29 months; or 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 the John Deere Benefits Center at 1-844-689-7833.

Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep the John Deere Benefits Center informed of any changes in the addresses of your family members. Also, for your records, please keep a copy of any notices that you send to the Plan Administrator or the John Deere Benefits Center.

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
- 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 January 1, 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, Group Life/AD&D, or Optional Life Insurance Plans end 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 by contacting the John Deere Benefits Center.

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.

Back to Quick Links

My Income Protection Plans Quick Links

Group Life/Accidental Death and Dismemberment (AD&D) Insurance

Income Protection Plans

Group Life/Accidental Death and Dismemberment (AD&D) Insurance

The company automatically provides group life insurance (minimum $25,000), and Accidental Death and Dismemberment (AD&D) coverage (minimum $25,000), as of your first day of active work.

Optional Life Insurance

You can purchase, on an after-tax basis, additional life insurance of up to eight times your annual salary (limit of $1,500,000). Different coverage levels are also available for your spouse and/or dependent children.

Disability Insurance

Salary Continuance/Short-Term Disability

All or part of your monthly salary may be continued for up to 12 months (depending on length of service and date of hire).

Long-Term Disability (LTD) Insurance

If you continue to be disabled after exhausting salary continuance/short term disability , based on medical substantiation of your continued total disability, you may continue to receive up to 60% of your monthly salary.

Voluntary Benefits

You have the option to enroll in three voluntary benefits that will provide income protection - Critical Illness, Accident, and Hospital Indemnity.

Group Life/Accidental Death & Dismemberment

Deere & Company provides you with group life insurance (minimum $25,000), and Accidental Death and Dismemberment (AD&D), coverage (minimum $25,000), as of your first day of active work.

Eligibility

If you are an employee of Deere & Company covered by this Summary Plan Description, you are eligible for group life insurance with AD&D coverage on your date of hire.

Your participation in group life insurance and AD&D coverage is automatic, starting on your first day of active work. The company pays the full cost of this benefit.

If you were hired, rehired or transferred to participation status under this SPD on or after November 1, 2014 , are a salaried employee at Seeding Valley City and are receiving Long-Term Disability (LTD) benefits, your company-provided group life insurance will continue at the time your LTD benefits start for a duration of 24 months. You will have the option to continue coverage as an individual policy and Securian Financial will provide you the information to do so. Please contact the John Deere Benefits Center if you have questions.

Group Life Insurance Coverage

If you were hired, rehired, or transferred to participation status under this SPD prior to January 1, 2018 or a salary employee of John Deere Reman Electronic Solutions (f/k/a Ciona), the company provides you with group life

insurance in the amount of two times your annual salary with a $25,000 minimum amount of coverage. Otherwise, the company provides you with group life insurance in the amount of one times your annual salary with a $25,000 minimum amount of coverage. The annual salary used is the amount in effect on the basis of coverage date. Any changes in the amount of coverage take effect on January 1 of each year.

AD&D Coverage

AD&D coverage pays a benefit to you if you are dismembered in an accident or to your beneficiary if you die as a result of an accident. AD&D benefits are paid in addition to group and/or optional life insurance benefits (if you elect coverage), in the case of your death.

If you die within one year of an accident that is not job-related, your beneficiary will receive a benefit equal to your group life insurance amount, or $25,000, whichever is higher. If you die within one year of a job-related accident, your beneficiary will receive a benefit equal to half your group life amount, plus Workers' Compensation benefits.

AD&D benefits will be paid to you according to the chart below, if you suffer a loss within one year of an accident.

Only one benefit payment—the largest—will be made for any one accident.

Type of Loss	AD&D Benefit Paid
Both hands, both feet, or sight in both eyes	Equal to group life amount
One hand and one foot, one hand and sight in one eye, or one foot and sight in one eye	Equal to group life amount
One hand or one foot	Half your group life amount
Sight in one eye	Half your group life amount

AD&D benefits will not be paid for death, dismemberment or loss of use caused by:

- Bodily or mental infirmity
- Disease or medical or surgical treatment for the disease
- Disease or its treatment
- Infection (except infection from an accidental cut or wound)
- Any armed conflict, war, or any act of war (declared or undeclared)
- Intentionally self-inflicted injuries or suicide (while sane or insane)

Naming a Beneficiary

When you join the company, you will be asked to designate one or more beneficiaries—these are the people who will receive group life insurance and AD&D benefits if you die. You may change your beneficiaries at any time by contacting Securian Financial.

If you have not named a beneficiary at the time of your death, completion of a Preference Beneficiary Affidavit will be required to determine surviving relatives—spouse, children, parents, siblings. If there are no surviving relatives at the time of your death, benefits will be paid to your estate.

When Coverage Ends

Your group life insurance/AD&D coverage ends the day after you terminate employment and the end of the pay period following a leave of absence.

You may convert this coverage to an individual policy at your own expense if you apply to the insurance carrier within 31 days of the date your employment terminates.

When You Retire

If you were an eligible employee as of June 30, 1993, your group life insurance at retirement will equal your annual salary as of June 30, 1993 (as of December 31, 1993 for John Deere Health and as of December 31, 1999 for John Deere Financial Services) (or $25,000, whichever is more). If you're hired on or after July 1, 1993, but prior to November 1, 2014, your coverage will be in the amount of $25,000 when you retire.

If you were hired, rehired or transferred to participation status under this SPD on or after November 1, 2014 you will have no group life insurance in retirement. Employees hired into or working at the following units, regardless of their hire date, have no group life insurance: A&I Products, JD Seeding Valley City, and Sunbelt. AD&D coverage stops automatically when you retire. You must meet the retirement conditions of the pension plan when you retire to be eligible for retiree life coverage based on the criteria above.

Applying For Benefits

For Group Life/AD&D and Optional Life

Deere Direct must be notified of an active employee death and the John Deere Benefits Center must be notified of a retiree death. A claim form must be submitted to the insurance carrier, before any benefits will be paid. A certified copy of the death certificate is required.

The insurance company will explain to your beneficiary what benefits are payable and the form of payment. Your beneficiary may select a lump-sum payment or installment payments.

If a Claim is Denied

- 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 Administrative Information section.

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.

Optional Life Insurance

You may supplement your group life insurance by selecting optional life insurance for yourself. You also have the opportunity to cover your eligible spouse and/or dependent children.

Eligibility

You're eligible for the Optional Life Insurance Plan if you're an employee of Deere & Company and you are covered under the Group Life/AD&D Insurance Plan. You're eligible to enroll for optional life insurance on your date of hire (or any time thereafter).

Enrolling

To enroll in optional life insurance, you must complete enrollment on the benefit portal at www.yourbenefitsresources.com/deere or by calling the John Deere Benefits Center at 1-844-689-7833. Questions regarding enrollment in optional life insurance may be directed to the John Deere Benefits Center.

During the 31-day open enrollment period, which starts from your date of hire, you may enroll yourself, your spouse, and/or dependent children without completing Evidence of Insurability in most cases. After the open enrollment period, the policy requires Evidence of Insurability and approval before coverage begins – regardless of the amount.

An employee who experiences a qualified status change (marriage, birth or adoption or otherwise acquiring a newly eligible child) may make the following election changes without providing Evidence of Insurability, provided enrollment is made within 31 days of the status change and the insured receiving the increase has not previously been declined any insurance amount under this policy due to failure to provide satisfactory evidence of insurability:

- An employee may increase existing optional life insurance by one level of coverage, provided the resulting amount of insurance does not exceed the guaranteed issue amount of the lesser of five times annual salary or $375,000. Evidence of Insurability will be required if you:
  - Elect coverage after 31 days from your date of hire.
  - Increase your coverage or coverage for your eligible spouse and/or dependent at a future date.
  - If you elect optional life insurance for yourself in the amount of $375,000 or more, you may need to provide a medical exam report from a qualified physician in addition to Evidence of Insurability. The insurance company reserves the right to accept or reject your enrollment based on the Evidence of Insurability and/or physician's report.

The Cost

The cost of optional life insurance depends on your age and the amount of insurance you elect—you pay the entire cost of coverage. After-tax payments are deducted from your paycheck in equal amounts each pay period. Costs are subject to change each year depending on your age and the claim experience of the Plan. For information on the cost of this benefit, see Premiums or contact the John Deere Benefits Center.

When Benefits Are Paid

Optional life insurance benefits are payable in a lump sum, unless installment payments are arranged. Benefits are payable to the same beneficiary you designate for group life/AD&D insurance unless you designate another beneficiary. Benefits for spouse or dependent life insurance are paid to you. Be sure to keep your beneficiary designation current. 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.

When Coverage Begins and Ends

When Coverage Begins:

If you enroll when first eligible, optional life insurance for yourself or your eligible spouse and/or dependents begins on the first day of the month in which the first payroll deduction is taken for coverage. If you enroll any time after you're first eligible, coverage begins the first day of the month after your enrollment has been approved and the first payroll deduction is taken for coverage. In either case, if you are not at work on this day, coverage begins on the first day you return to work. If Evidence of Insurability and/or a medical exam is required, coverage will not begin until these documents have been submitted to and approved by the insurance company.

There are two exceptions to this effective date for your eligible spouse and/or child dependents:

- If an eligible spouse or child dependent is hospitalized or institutionalized as of the effective date, coverage will not begin until a physician authorizes his or her release
- If an eligible spouse or child dependent is diagnosed as having a terminal illness before the effective date of coverage, he or she is not eligible for coverage.

When Coverage Ends:

Optional life insurance coverage will terminate at the end of the pay period in which you last worked before you terminate employment, retire, or become ineligible.

If you elect not to maintain insurance coverage during a family leave, when you return to work, insurance will be reinstated at the same level. Under these conditions, evidence of insurability will not be required.

If your covered eligible spouse or child dependent dies, it is your responsibility to notify the John Deere Benefits Center who will verify the eligibility and initiate the claim with Securian Financial.

If your covered eligible spouse or child dependent is no longer eligible for any other reason, it is your responsibility to terminate the applicable coverage with the John Deere Benefits Center. No benefit will be paid for the death of an ineligible dependent (even if you continue making premium contributions).

If you elect to discontinue optional life insurance while employed; coverage will terminate the end of the pay period in which you terminate coverage with the John Deere Benefits Center.

You may convert any of your Deere & Company life insurance policies—at your own expense—to an individual policy, if you apply within 31 days of when your coverage ends. Contact the insurance carrier to assist you in this process.

If you are away from work on a leave of absence or disability, you may be able to continue coverage. For details see The Life Event Chart: What Happens When … You Take a Leave of Absence.

Coverage for You

You may choose among the coverage levels in the list below when electing optional life insurance for yourself.

You may elect optional life insurance for yourself up to a maximum of 800% of your annual salary or $1,500,000, whichever is less. You may change your level of coverage at any time by completing new enrollment and providing Evidence of Insurability. If at any time you elect coverage in the amount of $375,000 or more, you may also be required to submit a medical exam report from a physician.

In determining your coverage, your annual salary multiplied by your coverage level is rounded up to the next $1,000. The annual salary used is the amount in effect on the basis of coverage date. Any changes in the amount of your coverage take effect on January 1 of each year.

Coverage Levels

- 50% of your annual salary
- 100% of your annual salary
- 150% of your annual salary
- 200% of your annual salary
- 300% of your annual salary
- 400% of your annual salary
- 500% of your annual salary
- 600% of your annual salary
- 700% of your annual salary
- 800% of your annual salary
- $10,000
- $20,000

Coverage for Your Eligible Spouse and/or Children

If you choose optional life insurance for yourself, you also may elect life insurance for your eligible spouse and/or children at one of the coverage levels shown on the next page.

Your eligible dependents include:

- Your spouse who is not eligible to participate in the Optional Life Insurance program as a John Deere employee. (Employees who were covered under their John Deere spouses prior to October 1, 2011 are grandfathered and are allowed to retain coverage.)
- Children from live birth up to age 26
  - Your children who include natural born and legally adopted children, stepchildren and children for whom legal adoption proceedings have been started.

Your totally and permanently disabled children (regardless of age) as long as you submit medical evidence that the disability started before age 26. "Totally and permanently disabled" means any medically determined physical or mental condition that prevents your dependent from being gainfully employed and that is expected to continue indefinitely or result in death.

Your children are not eligible if they are covered employees of Deere & Company. Also, no child may be covered as a dependent of more than one employee.

Spouse/Child Dependent Life Insurance Options

– Coverage Options for spouse:

- Spouse guarantee issue $200,000 within first 31 days
- $25,000, $50,000, $75,000, $100,000, $150,000, $200,000, $250,000, $300,000, or $375,000

Dependent Child Life Insurance Options

– Coverage Options for dependent child:

- $5,000 per child
- $10,000 per child

Premiums

Through payroll deduction you pay the full cost of Optional Life Insurance on an after-tax basis. The cost depends on your age at enrollment and will automatically change each January 1 thereafter, when a higher age bracket (based upon age in years on January 1), is reached and/or an increased amount of insurance is effective. Otherwise, the premium will change only after the insurance carrier receives and approves a change in your elected coverage option.

The rates shown below represent the basis for determining the monthly premium. You will pay an equal portion of the monthly premium each pay period. The rate shown for dependent children is the same regardless of the number of children insured.

Monthly Premiums*			
Employee's Age at Determination Date (January 1)	$1,000 of Employee Insurance	$1,000 of Spouse Insurance	$1,000 of Dependent Children Insurance
Under Age 30	$.022	$.039	$.104
30-34	$.028	$.047	$.104
34-39	$.038	$.062	$.104
40-44	$.059	$.080	$.104
45-49	$.092	$.103	$.104
50-54	$.153	$.190	$.104
55-59	$.252	$.326	$.104
60-64	$.413	$.576	$.104
65+	$.734	$1.007	$.104

**Premiums are subject to change.*

Applying For Benefits

For Group Life/AD&D and Optional Life

Deere Direct must be notified of an active employee death and the John Deere Benefits Center must be notified of a retiree or dependent death. A claim form must be submitted by the John Deere Benefits Center to the insurance company, before any benefits will be paid. A certified copy of the death certificate (if applicable), is required.

The insurance company will explain to your beneficiary what benefits are payable and the form of payment. Your beneficiary may select a lump-sum payment or installment payments.

If a Claim is Denied

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 Administrative Information section.

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.

Disability Insurance

Your income is protected automatically under the Salary Continuance Plan or Short-Term Disability Plan and Long-Term Disability (LTD) Insurance. The company pays the entire cost of coverage.

Participation and Cost

If you are an employee covered by this Summary Plan Description, you are eligible for salary continuance or short-term disability. All eligible employees are covered by LTD insurance. The company pays the entire cost of these coverages.

You do not need to enroll in salary continuance, short-term disability or LTD insurance—your coverage begins automatically on your date of hire.

Salary Continuance

Salary Continuance applies to those employee populations not covered by the Short-Term Disability.

What if I am absent from work?

All employees are required to report any absence to their manager/supervisor.

If you are away from work because of a job-related illness or injury, 100% of your monthly salary may be continued (less any state or Federal government benefit for which you may be eligible), until you either:

- Recover from your disability
- Qualify for LTD
- Fail to comply with the conditions and actions necessary to maintain eligibility
- Terminate employment
- Retire
- Die

If you are absent from work because of a disability due to a non-occupational accident or sickness, you are required to notify your supervisor or manager and follow your Unit's respective absence reporting procedures for the first five consecutive working days.

The Company provides Salary Continuance when you miss more than five consecutive days of work due to your non-occupational injury or illness that totally disables you from work. Medical substantiation sufficient to the Company is required for any absence to qualify for Salary Continuance. On the 6th day of absence, you are required to notify John Deere Disability and Leave Services to begin a Salary Continuance case. Disability Services will inform you what will be required to comply with all requirements in order for you to receive Salary Continuance.

Salary Continuance may also be available to employees for periods of absence based on medical evaluation of chronic conditions which disables an employee to work on a full time basis (or an employee's regular work schedule if employee is participating in the Part-Time Employment Program (PEP).

The Company may continue your salary for a period of time based on your length of continuous employment and previous record of absence for up to 12 months for employees hired prior to November 1, 2014, or 6 months for employees hired, rehired or transferred to participation status under this SPD on or after November 1, 2014 and salaried employees at Seeding Valley City less any state or Federal government benefit for which you may be eligible) until you either:

– Recover from your disability
– Qualify for LTD
– Fail to comply with the conditions and actions necessary to maintain eligibility
– Terminate employment
– Retire
– Die

Benefits will be according to the following schedules based on your hire date and years of continuous employment.

Hired before November 1, 2014

Years of continuous employment	100% of your monthly salary will be continued...	65% of your monthly salary will be continued...
Less than 1 year	10 days	355 days
1-2 years	31 days	334 days
2-3 years	61 days	304 days
3-4 years	92 days	273 days
4-5 years	122 days	243 days
5-6 years	152 days	213 days
6-7 years	183 days	182 days
7-8 years	213 days	152 days
8-9 years	244 days	121 days
9-10 years	274 days	91 days
10-11 years	305 days	60 days
11-12 years	335 days	30 days
12 or more years	365	0 days

Hired on or after November 1, 2014

Years of continuous employment	100% of your monthly salary will be continued...	65% of your monthly salary will be continued...
Less than 1 year	10 days	173 days
1-2 years	31 days	152 days
2-3 years	61 days	122 days
3-4 years	92 days	91 days
4-5 years	122 days	61 days
5-6 years	152 days	31 days
6 or more years	183 days	0 days

Example:
Assume you have a 12 month benefit based on eligibility criteria, your monthly salary is $5,000, and you've been with the company for 10 years when you go on salary continuance. You would receive your regular $5,000 a month for up to 305 days (183 days if hired on or after November 1, 2014). If your disability continues beyond 305 days, you would receive $3,250 a month for up to 60 additional days (unless hired on or after November 1, 2014).

Short-Term Disability

Short-Term Disability applies to Interns.

Regular Part- time, temporary and seasonal employees are not eligible for Short-Term Disabiliy or Salary Continuance.

The Company provides a Short-Term Disability benefit after a waiting period of 7 consecutive calendar days due to your non-occupational injury or illness that totally disables you from work. Your short term disability will begin on the 8th consecutive calendar day. Medical substantiation, sufficient to the company, is required for any absence to qualify for Short-Term Disability. You are required to notify John Deere Disability and Leave Services who will inform you what will be required in order for you to receive Short-Term Disability. The waiting period is unpaid. If you have PTO available, you may choose to use PTO for all or part of those days. If you do not have, or choose not to use PTO, this waiting period will be unpaid and considered personal no pay (PNP).

Short-Term Disability may also be available to employees for periods of absence based on medical evaluation of chronic conditions which disables an employee to work on a full time basis (or an employee's regular work schedule if employee is participating in the Part-Time Employment Program (PEP).

The Company may continue your salary at 65% of your monthly salary (less any state or Federal government benefit for which you may be eligible) until you either:

– Reach the maximum duration of 26 weeks of Short-Term Disability pay dating back to the first day of missed work for employees hired, rehired or transferred to participation status under this SPD on or after November 1, 2014
– Reach the maximum duration of 52 weeks of Short-Term Disability pay dating back to the first day of missed work for employees hired prior to November 1, 2014 and not meeting the criteria for having a maximum duration of 26 weeks as described above
– Recover from your disability
– Qualify for Long-Term Disability
– Fail to comply with the conditions and actions necessary to maintain eligibility
– Terminate employment
– Retire
– Die

Attention Employees Living in: California; New Jersey; New York; or Rhode Island. Your state provides State Disability Insurance.

Employees living in a state with a state disability benefit are required to apply for their state's disability insurance and submit the award amount to John Deere Disability and Leave Services. Once Disability Services receives proof of the state application and award amount, the Company will begin paying Short-Term Disability which will be offset by the amount of the state's payment to the employee.

Employees Receiving Salary Continuance Or Short-Term Disability—Applying For Social Security Disability

If you remain totally disabled and unable to work after five months, you will be required to apply for disability benefits under Social Security. If you qualify for Social Security disability benefits, your salary continuance or short term disability will be reduced by the disability amount payable under Social Security and/or state disability from the starting date of payment of benefits.

The total benefit received from the combination of salary continuance or Short-Term Disability, Social Security disability and/or state disability will not exceed the amount of benefit you are eligible to receive.

In many cases, Social Security and/or state disability benefits will be paid retroactively. If you qualify for Social Security and/or state disability benefits and receive a retroactive payment, you will be required to reimburse the Company for the amount that exceeds your eligible benefits as stated above.

Recoupment of any mistaken or overpayment of a disability benefit will be required as soon as practicable after the Company is aware of it. The recoupment of any mistaken or overpayment disability benefit may be made from any and all future salary continuance, Short-Term Disability or LTD payments unless other arrangements are made.

Long-Term Disability Insurance

LTD benefits would begin after your salary continuance or Short-Term Disability benefits end, whichever is applicable and after you have applied for LTD benefits and your LTD is approved. To qualify for benefits, you must be totally disabled and provide evidence satisfactory to the Company. For the first 24 months of disability under LTD, an employee is deemed to be totally disabled when, on evidence satisfactory to the Company and the Company's Medical Director or the Company's designate, the employee is unable to perform the duties of the assigned job with reasonable accommodations. After 24 months of disability under LTD that started on or after November 1, 2014, an employee is deemed to be totally disabled when, on evidence satisfactory to the Company and the Company's Medical Director or the Company's designate, the employee is unable to perform the duties of any job for which the employee is or may reasonably become qualified based on education, training or experience due to a physical or mental condition caused by illness or injury. The type of job that would qualify in this category would be expected to pay at least 60% of the employee's straight-time salary payments in the anniversary year preceding the commencement of disability.

Monthly LTD benefits are 60% of your monthly straight-time salary payments in the anniversary year preceding your disability. Employees compensated on base salary plus commissions or incentives payments, will have these earnings received during the anniversary year preceding disability included.

If your disability starts at or prior to your attainment of age 62, LTD benefits will be paid until the earliest to occur of the following list:

- The later of attainment of age 65 or the date the 42nd monthly benefit is paid (whichever is later)
- Recovery from disability
- The date of death
- Termination of employment
- Retirement
- Failure to comply with the conditions and actions necessary to maintain eligibility

If your disability begins at age 63 or older, benefits will be paid until the earlier of one of the following list:

- Recovery from disability
- Date of death
- Termination of employment
- Retirement
- Failure to comply with the conditions and actions necessary to maintain eligibility
- Disability begins at age 63: the date the 36th monthly benefit is paid
- Disability begins at age 64: the date the 30th monthly benefit is paid
- Disability begins at age 65: the date the 24th monthly benefit is paid
- Disability begins at age 66: the date the 21st monthly benefit is paid
- Disability begins at age 67: the date the 18th monthly benefit is paid
- Disability begins at age 68: the date the 15th monthly benefit is paid
- Disability begins at age 69 or older: the date the 12th monthly benefit is paid

Vacation Eligibility while on LTD

You will stop earning vacation when your LTD benefit starts. If you return from disability, your eligibility and vacation accrual resume. The amount of vacation earned on your next anniversary year will be pro-rated. Any remaining unused vacation and accrued vacation will be paid.

Other Disability Coverage

Salary continuance, short-term disability and LTD benefits you receive from the company are offset by any disability payments you receive from Workers' Compensation (including State of California Unemployment Compensation Disability Law—U.C.D.), Social Security, the Pension Plan, any state disability plans, or any other benefit plans to which the company contributes. Any recoupment of over payments will be made from any and all future benefit payments.

Working for Rehabilitation

The LTD Plan allows someone who's disabled to ease back into a work routine. With written approval, you can undergo vocational rehabilitation by doing paid work that is primarily training-oriented. LTD benefits continue while you're in rehabilitation; benefits provided on LTD will be reduced by the amount of rehabilitation earnings.

Disability Prior to November 1, 1998

If you were permanently and totally disabled prior to November 1, 1998 under the disability retirement provisions of the John Deere Pension Plan for Salaried Employees, you will continue to be administered under the provisions stated in the Retirement section of the 1998 Summary Plan Description.

Applying For Benefits

For Salary Continuance, Short-Term Disability and LTD

For salary continuance and Short-Term Disability, you must contact your supervisor or Human Resources Department as soon as you're away from work due to illness or injury. On the 6th day of absence, you are required to notify John Deere Disability and Leave Services will inform you what you will need to provide to comply with all requirements in order to receive Salary Continuance or Short-Term Disability.

It is your responsibility to complete all employee forms and provide medical documentation from an appropriate health care provider within the required timelines. Any costs associated with the completion of paperwork are the responsibility of the employee.

After you have exhausted your Salary Continuance or Short-Term Disability benefit, you must apply for LTD benefits by completing the forms John Deere Disability and Leave Services will provide to you. LTD benefits are payable only after a written claim has been filed and benefits are approved.

LTD benefits are not payable for a disability resulting from:

- Any act of war or the participation by the employee in an insurrection, rebellion, riot or criminal act
- A disability resulting from an intentional, self-inflicted injury or sickness
- Written proof of your disability will be required before benefit payments begin

If a Claim is Denied

- 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 Administrative Information section

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.

Voluntary Benefits

The following voluntary benefits are available for active employees (excluding inpats, expats, interns, and part-time students) through UnitedHealthcare (UHC) and include Critical Illness, Accident, and Hospital Indemnity Insurance.

Critical Illness Protection

Critical Illness Protection Plan helps give you or your family more financial security if you or a covered family member are diagnosed with a covered condition. The plan pays a lump-sum benefit for the diagnosis of a covered critical illness. The Critical Illness Protection Plan sends a lump-sum payment directly to you after diagnosis of a covered condition. The plan pays a lump-sum benefit for the diagnosis of a covered critical illness including, but not limited to:

- 12 conditions including heart attack, stroke and cancer
- 6 additional conditions including Alzheimer's, Parkinson's and multiple sclerosis
- 6 child-only conditions including cerebral palsy, cystic fibrosis and Down syndrome

Accident Protection

Accident insurance helps cover the added costs you may face following an injury to you or someone in your family. If you have a covered injury during the plan year and submit a claim, the Accident Protection Plan will pay you a cash benefit directly. Any payment you receive is in addition to the benefits your health plan gives you. Plus, you don't have to meet a deductible to receive the money — and you can use the money any way you want.

Hospital Indemnity Protection

A hospital indemnity plan through UHC provides you and your family with the extra financial help needed to focus on feeling better during a hospital stay. Get a direct payment after hospital care. Covered hospital expenses include: hospital admission, hospital confinement, intensive care unit (ICU) admission, ICU confinement, and newborn admission

For more details on the above mentioned benefits, log on to the benefit portal at www.yourbenefitsresources.com/deere to access the benefit guide, FAQ, and Certificate of Coverage from the Other Benefit page. Employees will be responsible for the full premium for these voluntary benefits through a direct billing process established at the time of enrollment. Enrollment can be done 31 days following the start of employment, a qualified life event. It can also be done each year during the annual enrollment period.

My Retirement Quick Links

My Retirement

The company sponsors two retirement plans—the Pension Plan and the Savings and Investment Plan, a (401(k)). If you work at a unit that has adopted the retirement plan(s), and were hired prior to January 1, 2023, you are covered under the Pension Plan automatically. You will be automatically enrolled in the Savings and Investment Plan approximately thirty days following your date of hire or you can elect to participate immediately. Both plans offer advantages.

The company-sponsored Pension Plan builds retirement income over your career, a non-contributory company contribution (if hired on or after January 1, 2023), and the Savings and Investment Plan allows you to build additional retirement income through the company match and pre-tax and after-tax employee contributions to the Plan.

Planning for retirement isn't hard, but it does take time. The first step is learning about the company-sponsored plans by reading this chapter and other important details found in the Administrative Information section.

The Pension Plan - Cash Balance Benefit

The Pension Plan—Cash Balance Benefit

The John Deere Pension Plan—Cash Balance Benefit for Employees is one way the company recognizes your years of service with Deere & Company. It provides monthly benefits for eligible retirees and beneficiaries, including surviving spouses.

Pension Plan Highlights—Cash Balance Benefit

Company-Funded

The Pension Plan—Cash Balance Benefit is 100% funded by the company. You do not need to contribute to the Plan. The Pension Plan—Cash Balance Benefit helps build steady retirement income for you after your career with the company ends.

Coverage/Eligibility Under the Plan

Generally, if you're an employee of Deere & Company or one of its affiliates or subsidiaries that adopts the Plan, you are covered under the Plan automatically, starting on your first day at work if you were hired or rehired after October 31, 2014 and prior to January 1, 2023, and if you elected this pension plan option in 2023. In addition, if your employment status changed so that you first became eligible to participate in the Cash Balance Plan after October 31, 2014, and prior to January 1, 2023, and if you elected this pension plan option in 2023 you are covered under the Plan automatically following your employment status change.

Employees returning to work following a permanent total disability after October 31, 2014, and prior to January 1, 2023, who were previously covered by the Contemporary or Traditional Option will be covered by those options upon reemployment. Leased workers are not eligible to participate.

Pension Benefits

Your pension benefits are determined according to formulas. (See Basic Pension Benefit Calculations—Cash Balance Benefit for basic formulas.)

When You Can Receive Benefits

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

If you have both a cash balance benefit and a benefit under either the Contemporary or Traditional Option, you will also be fully vested in those benefits after three years of service credit.

Although you can take a distribution of your cash balance plan benefit when you terminate employment at any age, the Plan does provide for Normal Retirement at age 65 as well as Early Retirement. These terms are not relevant to the commencement of cash balance benefits because you may request payment when you terminate employment, but these terms may still apply to other benefits from the company to which you may be entitled.

For example, if you have a cash balance benefit and a benefit under either the Contemporary or Traditional Option, you must still wait until your Early or Normal Retirement Date to commence payment of benefits under those options once you have terminated employment, even though you may take an immediate distribution of your cash balance plan benefit when you leave.

Normal retirement age is defined as the later of you reaching the age of 65 or having completed at least five years of service credit. If you want to continue working, you may retire at any later date. Early retirement age is defined as attainment of age 55 if you have at least 10 years of service credit.

How You Receive Benefits
The Plan offers several payment methods.

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

Nonspousal Beneficiaries
The Plan offers protection if you die before or after benefit payments start, as long as you are vested and have named an individual or individuals as a nonspousal beneficiary(ies). If you are married prior to your death, a spousal waiver is required.

Cost—Cash Balance Benefit

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

Basic Pension Benefit Calculations—Cash Balance Benefit

Basic Pension Benefit Components
Your basic pension benefit is derived from a hypothetical account balance that the company established on your behalf in the Plan. Your account may be paid in several different forms. When you first join the Plan, your beginning account value is zero and at the end of each plan year a pay credit and an interest credit are added to your account. The pay credit is calculated by multiplying your annual earnings (including short-term incentive bonus payments), by 4%. The interest credit is calculated by multiplying your beginning of the year account balance by the interest crediting rate for the plan year.

The interest crediting rate is the lesser of 9% or the four-month average of the annual yield on non-inflation adjusted 30-year Treasury constant maturities for the months of June, July, August and September of the plan year preceding the plan year to which the interest credit applies. The interest credit is zero for the first year of your Plan participation because the interest credit is applied to your beginning of the year account balance, which would be zero for the year in which you first commence to participate.

You will receive a prorated interest credit in the year in which your benefit commences to be paid to you.

Eligible earnings are direct pay, short-term incentive bonuses, commissions and most other pay for work performed and paid time-off. It does not include long-term incentive cash bonuses. Compensation is capped by law based on an amount set each year by the Internal Revenue Service. Amounts in excess of the limit are not counted under the Plan.

The cumulative pay credits and interest credits comprise your account.

If you continue working for the company after age 65, the benefit that you could receive if you chose to retire at age 65 will not be paid until you actually retire.

Important: If you believe you are entitled to a benefit that you have not received or if you disagree with any determination made by the Plan Administrator regarding your benefit (such as the amount of your benefit or how it is calculated), you may submit a claim for benefits under the Plan. However, the time period during which you can submit a claim for benefits (including the time period to bring suit after exhausting the Plan's claims and appeals procedures), is limited.

If you fail to make a timely claim for benefits or you fail to timely appeal a denied claim, you may lose your right to those benefits. For important information regarding the process for submitting a claim for benefits and the deadlines for submitting such a claim, including the deadline for filing a claim in court, please see the section of this booklet titled "Claims that are not Group Health or Disability Claims."

Maximum Benefits
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 Supplementary Pension Benefit Plan. This Plan is an unfunded, nonqualified plan with the payment of benefits made from the general assets of the company. You'll be notified if these limits affect you.

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

Receiving Pension Benefits—Cash Balance Benefit

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

- If you're single, you receive a single life annuity or you may elect a lump sum.
- If you're single and designate a nonspousal beneficiary, you may elect to provide a 55% or 75% survivor benefit.

– If you're married, you may elect to provide a 55% or 75% surviving spouse benefit. If you choose to waive the surviving spouse coverage or name a nonspousal beneficiary for the survivor benefit, your spouse must consent to your choice by signing the consent form in the presence of a notary public. Contact the John Deere Savings & Retirement Service Center at www.netbenefits.com or 1-800-354-3427.

Payment Methods:

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

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

55% Survivor Benefit Option. This payment method provides payments for your life and continues payments to your survivor after your death. The survivor payment will be 55% of what you receive in retirement. With this payment form, you agree to a reduction in your benefit.

75% Survivor Benefit Option. This payment method provides payments for your life and continues payments to your survivor after your death. The survivor payment will be 75% of what you receive in retirement. With this payment form, you agree to a reduction in your benefit.

See the Surviving Spouse Benefit reduction examples for further explanation.

When Your Benefits Are Paid

You may commence payment as of the first day of any month following your termination of employment with the Company. However, payments must begin no later than the April 1 following the calendar year in which you reach age 73, unless you are still actively working for the Company.

To Receive Pension Benefits

You may not apply earlier than 180 days and no later than 60 days prior to the date of your intended retirement. Call the John Deere Savings & Retirement Service Center at 1-800-354-3427. You can call between 7:30 a.m. and 11:00 p.m. Central Time, Monday through Friday. Choose the "initiate retirement" option to direct your call to a retirement specialist. Or, you may visit the benefit portal at www.netbenefits.com. This site provides modeling tools and you can even start your pension payment online, without the help of a retirement specialist. Please remember to notify your supervisor of your retirement plans.

If you use vacation to extend your retirement date, you must complete the Retirement to Retirement Election form at Your World at Deere>Recognition, Rewards & Meaningful Work>Your Retirement and email it to RetirementBenefits@JohnDeere.com, no later than 60 days before your last day in the office.

Death After Retirement–Cash Balance Benefit

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

Who's Eligible?

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

Benefits Payable to Your Survivor

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

When Benefits Are Paid

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

Death Before Retirement–Cash Balance Benefit

Who's Eligible?

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

Benefits Payable to Your Surviving Spouse

Your surviving spouse will receive a single life annuity which is the actuarial equivalent of your total cash balance account. Your spouse may elect to receive a single lump sum instead.

If you were unmarried or your spouse waived his or her right to the benefit, your designated beneficiary(ies) will receive a lump sum payment based upon their proportionate share.

Consistent with federal regulations, if you are married and waive the pre-retirement death benefit for your spouse before you reach age 35, in conjunction with designation of a non-spouse beneficiary or otherwise, then your designation will automatically become void on January 1 of the year you reach age 35. However, with your current spouse's consent, you may make a new election to waive the pre-retirement death

benefits, whether or not you name a beneficiary other than your spouse. Your spouse's consent must acknowledge the effect of your election, and must be witnessed by a notary public.

When Benefits Are Paid

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

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

When you have at least three years of service credit (not including additional foundry service credit), you are considered to be "vested" under the Plan. This means that you have 100% ownership rights to your accrued pension benefit, which is payable in the future. You are also 100% vested if you are employed by the company or any of its affiliates when you reach normal retirement age.

If you leave the company for any reason before you are retirement eligible and do not elect to receive your payment even though you are vested, you are eligible for a deferred vested pension benefit.

If you terminate employment before you have three years of service credit and are reemployed by the company before you have five consecutive one year breaks in service, your prior service will be restored to you upon reemployment. Otherwise, your prior service credit will not be restored upon reemployment.

How Your Deferred Vested Pension is Calculated

Pay Credits will cease upon your separation. However, Interest Credits will continue to be added to your existing account balance until you elect to commence your payment(s).

When Deferred Vested Benefits Are Paid

You may not apply earlier than 180 days and no later than 60 days prior to the date of your intended retirement. Call the John Deere Savings & Retirement Service Center at 1-800-354-3427. You can call between 7:30 a.m. and 11:00 p.m. Central Time, Monday through Friday. Choose the "initiate retirement" option to direct your call to a retirement specialist. Or, you may visit the benefit portal at www.netbenefits.com. This site provides modeling tools and you can even start your pension payment online, without the help of a retirement specialist.

You may choose to start payments at any time after your separation date, but no later than April 1 following the calendar year in which you reach age 73.

Benefits are payable starting on the first day of the month.

How Deferred Vested Benefits Are Paid

If you are eligible for a deferred vested benefit and your benefit under the Pension Plan (including your cash balance account and the present value of your benefit under the Contemporary or Traditional Option, if applicable), is less than $7,000 but more than $1,000, you will be notified and asked to make an election to have your benefit paid in cash or rolled over to an IRA or eligible employer retirement plan of your choice. If you do not make an election, the Plan will establish an Individual Retirement Account (IRA) in your name, to which will be transferred your account balance. If your account balance is less than $1,000, it will be paid to you automatically in a lump sum (with 20% federal income tax withholding applied) if you do not make an election to roll it over to an IRA or eligible employer retirement plan. You will be notified if this payment affects you. Otherwise, benefits are paid under one of the options previously described.

Deferred Vested Surviving Spouse Benefit

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

Benefits Payable

Your surviving spouse will receive a monthly benefit which is the actuarial equivalent of 55% of your account, or he/she shall have the option to elect a single lump sum payment. If you designate someone other than your spouse or you are not married, your designated beneficiary(ies) will receive 55% of your account in a single lump sum based upon their proportionate share.

Your spouse may not apply earlier than 180 days and no later than 60 days prior to the date of payment. Your spouse should call the John Deere Savings & Retirement Service Center at 1-800-354-3427. Your spouse may call between 7:30 a.m. and 11:00 p.m. Central Time, Monday through Friday. Or, he/she may visit the benefit portal at www.netbenefits.com.

Making Your Election

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

Pension Benefit Examples—Cash Balance Benefit

Accumulation Phase—Cash Balance Benefit

Hired Nov. 1, 2021	FY2021	FY2022	FY2023
Annual Compensation	$50,000	$51,000	$52,000
Interest Credit Rate	1.40%	1.99%	3.25%
	10/31/2021	10/31/2022	10/31/2023
Beginning of Year Balance	N/A	$2,000	$4,079.80
Pay Credit (4%)	$2,000	$2,040	$2,080
Interest Credit	N/A	$39.80	$132.59
Total Cash Balance Account	$2,000	$4,079.80	$6,292.39

Example One —Cash Balance Benefit

Assume you were hired after October 31, 2014; and prior to January 1, 2023, you retire at age 64 and your survivor is the same age, you have 32 years of service credit, and a total cash balance account value of $181,000.

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

Single Life Annuity Option.

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

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

55% Survivor Benefit Option.

Total Cash Balance Account Value	$181,000
Annuity Conversion Factor	/ 193.161
Monthly Formula Benefit at age 64	**$937.04**

In this case you would be eligible to receive a monthly annuity of $937.04 and upon your death, if your beneficiary survived you, your beneficiary would receive $515.37 per month for his/her lifetime.

75% Survivor Benefit Option.

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

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

Example Two —Cash Balance Benefit

Assume you were hired after October 31, 2014 and prior to January 1, 2023; you retire at age 65 and your survivor is the same age, you have 33 years of service credit, and a total cash balance account value of $190,000.

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

Single Life Annuity Option.

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

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

55% Survivor Benefit Option.

Total Cash Balance Account Value	$190,000
Annuity Conversion Factor	/ 191.8489
Monthly Formula Benefit at age 65	**$990.36**

In this case you would be eligible to receive a monthly annuity of 990.36 and upon your death, if your beneficiary survived you, your beneficiary would receive $544.70 per month for his/her lifetime.

75% Survivor Benefit Option.

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

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

Permanent Separation Benefit Example—Cash Balance Benefit

Assume you were hired after October 31, 2014, and prior to January 1, 2023, you separate from Deere & Company or an affiliate or subsidiary with 15 years of service credit. You are age 38 and your survivor is the same age, and you have a total cash balance account value of $59,000.

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

Single Life Annuity Option.

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

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

55% Survivor Benefit Option.

Total Cash Balance Account Value	$59,000
Annuity Conversion Factor	/ 291.781
Monthly Formula Benefit at age 38	**$202.21**

In this case you would be eligible to receive a monthly annuity of $202.21 and upon your death, if your beneficiary survived you, your beneficiary would receive $111.22 per month for his/her lifetime.

75% Survivor Benefit Option.

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

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

**Conversion factors are illustrative only. Actual factors are based on interest and mortality factors in effect at commencement.*

Situations Affecting Your Retirement Plans—Cash Balance Benefit

- A Few Words About Taxes
- Assignment of Benefits
- Plan Maximums
- Top-Heavy Provisions
- The Pension Benefit Guaranty Corporation (PBGC)
- Mistaken or Excess Pension Payments

The Company's Pension Plan and Savings and Investment Plan are designed to provide you with retirement income. But there are situations that could affect your benefits. Some of these situations are listed here.

A Few Words About Taxes

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

Assignment of Benefits

Your benefits from the retirement plans 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 or Savings and Investment Plan account, contact the John Deere Savings & Retirement Service Center by phone 1-800-354-3427 or http://qdro.fidelity.com. Also, you will need to notify Deere Direct when your divorce is final.

A copy of the Plan's QDRO procedures is available, without charge, upon request.

Plan Maximums

Both plans have maximum benefit limits that apply. See Pension Plan Benefit Limit. For the Savings and Investment Plan (Savings and Investment Contribution Limits), the IRS sets limits on the amount you and the company can contribute to your account each year. These limits generally apply to higher-paid employees. You'll be notified if they affect you.

Top-Heavy Provisions

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

The Pension Benefit Guaranty Corporation (PBGC)

The 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 survivors' pensions. However, the PBGC does not guarantee all types of pensions, and the amount of protection is subject to certain limitations.

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

Mistaken or Excess Pension Payments

As soon as administratively practicable, the Plan Administrator will recoup any mistaken or excess pension benefit from any and all future pension payments unless another arrangement is agreed upon.

The Pension Plan - Contemporary Option

The Pension Plan—Contemporary Option

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

Pension Plan Highlights—Contemporary Option

Company-Funded

The Pension Plan—Contemporary Option is 100% funded by the company. You do not need to contribute to the Plan. The Pension Plan—Contemporary Option helps build steady retirement income for you after your career with the company ends.

Coverage/Eligibility Under the Plan

Generally, if you're an employee of Deere & Company or one of its affiliates or subsidiaries that adopts the Plan, you are covered under the Plan automatically, starting on your first day at work if you were hired after October 31, 1996 or if you elected this Pension Plan Option in 1996. For employees of the former Turf Division the effective date is July 16, 1996. Leased workers are not eligible to participate.

Pension Benefits

Your pension benefits are determined according to formulas. (See Basic Pension Benefit Calculations—Contemporary Option for basic formulas.) Additional benefits may also be payable.

When You Can Receive Benefits

Your pension benefit is vested once you have at least five years of service credit. Normal Retirement begins at age 65. However, the Plan also includes provisions for Early Retirement and Deferred Vested Retirement under the Contemporary Option.

How You Receive Benefits

The Plan offers several payment methods.

Cost—Contemporary Option

Plan Cost

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

Basic Pension Benefit Calculations—Contemporary Option

Basic Pension Benefit Components

Your basic pension benefit is calculated using your career average monthly earnings, (including short-term incentive bonus payments), and your service credit.

The Basic Pension Benefit
Your monthly basic pension benefit at unreduced retirement age is shown below.

Formula
Formula Benefit Multiplier (1.5 %)

x Career Average Monthly Earnings

x Your Years of Service Credit

= Basic Monthly Formula Pension Benefit

Maximum Benefits
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 Supplementary Pension Benefit Plan. This Plan is an unfunded, nonqualified plan with the payment of benefits made from the general assets of the company. You'll be notified if these limits affect you.

When You Retire
Depending on when you retire from the company, the Plan pays benefits for early retirement, normal retirement, and retirement after age 65. These benefits are adjusted depending on the surviving spouse benefit option you choose. See Payment Methods—Surviving Spouse Options for more details.

Normal Retirement—Contemporary Option

Normal Retirement—Retiring at or after Age 65
Normal retirement age is defined as the later of you reaching the age of 65 or having completed at least five years of service credit. If you want to continue working, you may retire at any later date.

Under normal retirement, your unreduced pension eligibility age is listed in the Early Retirement–Contemporary Option chart and is based on your service credit as of January 1, 1997.

How Your Normal Retirement Benefit Is Calculated
Your normal retirement benefit, even if you work past age 65, is calculated as a basic pension benefit, using your career average monthly earnings and your years of service credit on the date you retire. Based on when you retire, you may receive a reduced benefit if you retire before age 67 as shown on the chart in the Early Retirement—Contemporary Option.

When Normal Retirement Benefits Are Paid
Your monthly normal retirement benefit payments start on the first day of the month after your retirement date and are payable the first work day of each month.

Early Retirement—Contemporary Option

Early Retirement—Retiring Before Age 65
You may choose early retirement if you are at least age 55 and you have at least 10 years of service credit.

NOTE: If you elected the Contemporary Option in 1996 and were eligible to retire under the Traditional Option prior to January 1, 1997 you can retire before age 55 under the Contemporary Plan Option.

How Your Early Retirement Benefit is Calculated
Your early retirement benefit is calculated as a basic pension benefit, using your career average earnings and your years of service credit on the date you retire. Your benefit may be reduced, however, depending on when you retire and how your benefit is calculated. See Basic Pension Benefit Calculations—Contemporary Option.

A reduction applies if you retire before your full benefits age as shown in the chart below.

If You Had This Much Service as of January 1, 1997	4% Reduction for Each Year You Receive Your Pension
Under 5 years	67
5-9 years	66
10-14 years	65
15-19 years	64
20-24 years	63
25-29 years	62
30-34 years	61
35 years or more	60

Benefits are reduced 1/3% for each month that benefits begin earlier than your full benefits age.

When Early Retirement Benefits Are Paid
Your early retirement benefits start on the first day of the month after you retire and are payable the first banking work day of each month.

Receiving Pension Benefits—Contemporary Option

How You Receive Plan Payments
Your pension benefits are paid according to the payment form you elect at the time of your retirement:

– If you're single, you receive a single life annuity.

– If you're married, you may elect to provide a 55% or 75% surviving spouse benefit. If you choose to waive the surviving spouse coverage for the portion of your service on and after July 1, 1993 (January 1, 1994 for employees of John Deere Financial Services, John Deere Health and John Deere Insurance), your spouse must consent to your choice by signing the consent form in the presence of a notary public.

Payment Methods:

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

55% Surviving Spouse Benefit Option. This payment method provides payments for your life and continues payments to your surviving spouse after your death. The surviving spouse payment will be 55% of what you receive in retirement. With this payment form, you agree to a reduction in your retirement benefits (in addition to any reduction in early or deferred vested benefits).

75% Surviving Spouse Benefit Option. This payment method provides payments for your life and continues payments to your surviving spouse after your death. The surviving spouse payment will be 75% of what you receive in retirement. With this payment form, you agree to a reduction in your retirement benefits (in addition to any reduction in early or deferred vested benefits).

For the benefit based on service credit earned before July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance), no reduction applies, unless your spouse is more than 10 years younger than you. In this case, your monthly benefit is reduced by 1/2% for each full year in excess of 10 years that your spouse is younger than you.

After your death, your surviving spouse's benefit is equal to 55% of this reduced amount. If you choose to waive the young spouse reduction for credit earned before July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance), your spouse must consent to your choice by signing the consent form in the presence of a notary public. If this coverage is waived, your surviving spouse will receive no benefit for service credit prior to July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance).

There are three options available to you for figuring your benefit and your surviving spouse's benefit:

– Single Life Annuity Option provides you with an unreduced basic monthly pension benefit for all your years of service credit. If you die, your surviving spouse will receive 55% of the benefit you earned for service credited before July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance).

– 55% Surviving Spouse Benefit Option provides you with a reduced basic monthly pension benefit. The reduction applies to the portion of your pension benefit earned on and after July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance). If you die, your surviving spouse will receive 55% of your reduced total pension benefit.

– 75% Surviving Spouse Benefit Option provides you with a reduced basic monthly pension benefit. An additional reduction applies to the benefit value calculated in the 55% Option. If you die, your surviving spouse will receive 75% of your reduced total pension benefit.

See the Surviving Spouse Benefit reduction examples for further explanation.

Social Security Offset Payment Option. If you retire before you are eligible to receive Social Security benefits (generally age 62), you can choose this payment option.

Under this option, you receive higher benefits from the Plan until you reach age 62 and lower benefits from the Plan after age 62. This way, the pension benefit you receive before age 62 is approximately equal to the combined total of your pension benefit and Social Security benefit after reaching age 62 if you choose to apply for Social Security at that time. The reduction for surviving spouse benefits also applies to this option. This payment method is not immediately available for employees hired through an acquisition.

When Your Benefits Are Paid

The date you begin receiving benefits depends on the type of retirement you choose. See Normal Retirement, Early Retirement, and Deferred Vested Pension for more information. However, payments must begin no later than the April 1 following the calendar year in which you reach age 73, unless you are still actively working for the Company.

To Receive Pension Benefits

You may not apply earlier than 180 days and no later than 60 days prior to the date of your intended retirement. John Deere Savings & Retirement Service Center at 1-800-354-3427. You can call between 7:30 a.m. and 11:00 p.m. Central Time, Monday through Friday. Or, you may visit the benefit portal at www.netbenefits.com. This site provides modeling tools and you can even start your pension payment online, without the help of a retirement specialist. Please remember to notify your supervisor of your retirement plans.

If you use vacation to extend your retirement date, you must complete the Retirement Election Form at Your World at Deere>Recognition, Rewards, and Meaningful Work>Your Retirement and email it to RetirementBenefits@JohnDeere.com, no later than 60 days before your last day in the office.

Death After Retirement–Contemporary Option

If you die after you retire, the Plan includes protection for your surviving spouse. Surviving spouse benefits, if any, are paid only to your spouse. The Pension Plan does not provide benefit payments to a beneficiary other than your surviving spouse.

Who's Eligible?

Your spouse is eligible for surviving spouse benefits if you were married to him or her at retirement. You can waive the spousal coverage earned on or after July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance), with your spouse's consent, if he or she signs the consent

form in the presence of a notary public. If you marry during retirement, you must have been married at least one year immediately prior to your death.

Benefits Payable to Your Surviving Spouse

If this coverage is in effect for you on the date of your death, your surviving spouse will receive monthly benefits based upon your election at retirement, or under the 55% Surviving Spouse Benefit Option (described under Payment Methods), if a spouse waiver is not on file and you have been married at least one year.

Cost of Coverage

There is a charge for surviving spouse coverage on the portion of your benefit earned on and after July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance). You pay the cost through a reduction in your benefit. See the examples of the 55% and 75% Surviving Spouse Reduction.

When Benefits Are Paid

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

Death Before Retirement–Contemporary Option

Who's Eligible?

If you die before you retire, your surviving spouse is eligible for surviving spouse benefits as long as you were vested under the Plan (you have at least five years of service credit), and you were married at least one year prior to your death.

Benefits Payable to Your Surviving Spouse

Your surviving spouse will receive monthly benefits equal to 55% of the benefit you would have received if you had lived to your earliest retirement age and retired.

The company pays the full cost of this coverage. However, the surviving spouse benefit will be reduced if your spouse is more than 10 years younger than you. See Payment Methods.

When Benefits Are Paid

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

Disability Retirement–Contemporary Option

If you were permanently and totally disabled prior to November 1, 1998 under the Disability Retirement provisions of the John Deere Pension Plan for Salaried Employees, you will continue to be administered under the provisions stated in the Retirement section of the 1998 Summary Plan Description.

Deferred Vested Pension–Contemporary Option: If You Leave Before Retirement

When you have at least five years of service credit (not including additional foundry service credit), you are considered to be "vested" under the Plan. This means that you have 100% ownership rights to your accrued pension benefit, which is payable in the future.

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

How Your Deferred Vested Pension is Calculated

Your deferred vested pension benefit is calculated using the service credit, the career average earnings, and the Plan provisions in effect on the date you left the company. The benefit is calculated as a Contemporary basic pension benefit.

When Deferred Vested Benefits Are Paid

The company will notify you when you are eligible to begin deferred vested pension benefits. For benefits to begin, you must apply. You may not apply earlier than 180 days and no later than 60 days prior to the date of your intended retirement. Call the John Deere Savings & Retirement Service Center at 1-800-354-3427. You can call between 7:30 a.m. and 11:00 p.m. Central Time, Monday through Friday. Or, you may visit the benefit portal at www.netbenefits.com. This site provides modeling tools and you can even start your pension payment online, without the help of a retirement specialist.

You may choose to start payments at any time after your earliest eligibility to retire (age 55 with 10 or more years of service credit, or age 65 with five or more years of service credit), but no later than April 1 following the calendar year in which you reach age 73.

Benefits are payable starting on the first day of the month, provided you're eligible to receive benefits at that time. Choosing your benefit start date is important, because reductions apply for early payments:

- If you choose to start payments on or after the date of your unreduced benefits age, no age reductions apply.
- If you choose to start payments before your unreduced benefits age, benefits are reduced by 1/3% for each month they start before your unreduced benefits age.

How Deferred Vested Benefits Are Paid

If you are eligible for a deferred vested benefit and the present value of your benefit is less than $7,000 but more than $1,000, you will be notified and asked to make an election to have your benefit paid in cash or rolled over to the financial institution of your choice.

If you do not make an election, the Plan will establish an Individual Retirement Account (IRA) in your name, based on the present value of your benefit. Present value amounts less than $1,000 will be paid to you as a lump sum if you do not make an alternate election. You will be notified if this payment affects you. Otherwise, benefits are paid under one of the options previously described, except the Social Security Offset Payment Option is not available.

Deferred Vested Surviving Spouse Benefit

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

Benefits Payable

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

Your surviving spouse may begin receiving benefits on the date you would have first been eligible to receive a deferred vested pension. Your spouse may not apply earlier than 180 days and no later than 60 days prior to the date of payment. Call the John Deere Savings & Retirement Service Center at 1-800-354-3427. Your spouse may call between 7:30 a.m. and 11:00 p.m. Central Time, Monday through Friday. Or, he/she may visit the benefit portal at www.netbenefits.com.

Cost of Coverage

There is a charge for pre-retirement surviving spouse coverage. You pay the cost through a reduction in your pension benefit. The amount of the reduction depends on your age and how long the coverage is in effect. This coverage is automatic unless both you and your spouse reject it in the presence of a notary public. The chart shows the monthly cost as a percentage reduction in your benefits.

Deferred Vested Benefit—Surviving Spouse Coverage

If You Are This Age	Your Pension Will Be Reduced By This Percentage for Each Year of Coverage:
Under 35	0.0%
35-44	0.1%
45-54	0.3%
55 and older	0.8%

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

Making Your Election

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

Pension Benefit Examples—Contemporary Option

Basic Pension Benefit Example—Contemporary Option

Assume your career average earnings are $3,500. You have 30 years of service credit.

Formula Benefit	
Formula Benefit Multiplier (1.5%)	.015
Career Average Monthly Earnings	x $3,500
Your Years of Service Credit	x 30
Basic Monthly Formula Pension Benefit	$1,575

Early Retirement Benefit Example—Contemporary Option

Assume you were hired after October 31, 1996; you retire at age 64, with 32 years of service credit, and a basic pension benefit of $1,800 each month. You would like to begin receiving early retirement benefits immediately.

Formula (reduced before age 67)	
Basic Monthly Formula Pension	$1,800
Reduction Before Age 67 (1/3% x 36 months x $1,800)	-216
Early Retirement Monthly Formula Benefit	$1,584

You would receive this amount in the example above depending on the surviving spouse benefit option you choose (see Surviving Spouse Benefit Examples).

Assume your unreduced benefits age is 61 and you retire at age 58, with 30 years of service credit, and basic pension benefits of $1,200 each month. You would like to begin receiving early retirement benefits immediately.

Formula (reduced before age 61)	
Basic Monthly Formula Pension	$1,200
Reduction Before Age 61 (1/3% x 36 months x $1,200)	-144
Early Retirement Monthly Formula Benefit	$1,056

Surviving Spouse Benefit Examples—Contemporary Option

Assume that you were hired on January 1, 1997 and you retire on December 31, 2027, with 30 years of service credit. Your basic monthly pension benefit is $1,500.

Surviving Spouse Benefits - Option 1	
Your Basic Unreduced Monthly Pension Benefit	$1,500
Accrued Pension Benefit Before July 1, 1993	$0
Surviving Spouse Benefit Multiplier (55%)	x .55
Surviving Spouse Monthly Pension Benefit	$0

55% Surviving Spouse Benefits - Option 2 - Your Benefit	
Your Basic Unreduced Monthly Pension Benefit	$1,500
55% Surviving Spouse Reduction Factor (Based on Your Age, Your Spouse's Age, and the Plan Year Interest Rate and Mortality Tables in Effect at the Time of Your Annuity Start Date.)	x .9010
Your Reduced Basic Monthly Pension Benefit	$1,351.50

55% Surviving Spouse Benefits - Option 2 - Your Spouse's Benefit	
Your Reduced Monthly Pension Benefit	$1,351.50
Surviving Spouse Benefit Factor (55%)	x .55
Surviving Spouse Monthly Pension Benefit	$743.33

75% Surviving Spouse Benefits - Option 3 - Your Benefit	
Your Reduced Basic Monthly Pension Benefit Under Option 2	$1,351.50
75% Surviving Spouse Reduction Factor (Based on Your Age, Your Spouse's Age, and the Plan Year Interest Rate and Mortality Tables in Effect at the Time of Your Annuity Start Date.)	x .9856
Your Reduced Basic Monthly Pension Benefit	$1,332.04

75% Surviving Spouse Benefits - Option 3 - Your Spouse's Benefit	
Your Reduced Monthly Pension Benefit	$1,332.04
Surviving Spouse Benefit Factor (75%)	x .75
Surviving Spouse Monthly Pension Benefit	$999.03

Deferred Vested Benefit Example—Contemporary Option

Assume you were hired after October 31, 1996 and you left the company at age 40, with 15 years of service credit. Your basic accrued pension benefit, based on your service credit and career average earnings when you left, is $700 a month. You decide to begin receiving benefits at age 63. Therefore, your deferred vested benefit would be:

Unreduced Vested Pension	$700
Reduction (1/3% x 48 months before age 67 x $700)	-112
Monthly Deferred Vested Benefit	$588

You would receive this amount in the example above depending on the surviving spouse options you choose (reductions could occur for pre-retirement surviving spouse coverage and/or survivor benefit option election).

Situations Affecting Your Retirement Plans—Contemporary Option

- Funding for Retiree Medical Benefits
- A Few Words About Taxes
- Assignment of Benefits
- Plan Maximums
- Top-Heavy Provisions
- The Pension Benefit Guaranty Corporation (PBGC)
- Mistaken or Excess Pension Payments

The Company's Pension Plan and Savings and Investment Plan are designed to provide you with retirement income. But there are situations that could affect your benefits. Some of these situations are listed here.

Funding for Retiree Medical Benefits

As a part of the pension trust, the Plan includes a funding mechanism that can be used by the company to help pay the cost of retiree medical benefits for an employee hired before April 1, 2000. For a description of medical benefits in retirement, see Medical Benefits in Retirement.

A Few Words About Taxes

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

Assignment of Benefits

Your benefits from the retirement plans 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, or your Savings and Investment Plan account, contact the John Deere Savings & Retirement Service Center by phone 1-800-354-3427 or http://qdro.fidelity.com. Also, you will need to notify Deere Direct when your divorce is final.

Plan Maximums
Both plans have maximum benefit limits that apply. See Pension Plan Benefit Limit. For the Savings and Investment Plan (Savings and Investment Contribution Limits), the IRS sets limits on the amount you and the company can contribute to your account each year. These limits generally apply to higher-paid employees. You'll be notified if they affect you.

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

The Pension Benefit Guaranty Corporation (PBGC)
The 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 survivors' pensions. However, the PBGC does not guarantee all types of pensions, and the amount of protection is subject to certain limitations.

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

Mistaken or Excess Pension Payments
As soon as administratively practicable, the Plan Administrator will recoup any mistaken or excess pension benefit from any and all future pension payments unless another arrangement is agreed upon.

Preserved John Deere Coffeyville Works Benefits (Part A)—Contemporary Option

If you were a John Deere Coffeyville Works employee before November 1, 1990, your pension benefit consists of two parts. The first part (Part A), is the benefit you earned under the previous John Deere Coffeyville Works Pension Plan for Salaried Employees. The second part (Part B), is the benefit you accrued under the current Plan, which takes into consideration your previous service with John Deere Coffeyville Works (and in some cases, your service with Cooper Industries as well). If this situation applies to you, you'll want to read this section carefully to understand how your Part A and Part B benefits will coordinate when you retire.

Part A Pension Benefit
If you worked for John Deere Coffeyville Works before November 1, 1990, you earned a pension benefit under the John Deere Coffeyville Works Pension Plan for Salaried Employees. This benefit was based on the final balance in an account established in your name. The company made periodic adjustments to your account until June 31, 1992. Presently, John Deere adds 4.5% per year to your account.

When you retire from John Deere, you will be eligible for both your Part A and B benefits. However, your Part B benefit will be reduced by the amount of your Part A benefit. Here's how it works:

- Your Part A benefit, determined by the balance in your account at your retirement, will be distributed according to the payment option you choose.
- Your Part B benefit will be calculated using all your years of credited service. This amount will then be offset by the amount of your Part A benefit. Your Part A benefit will be made based on the payment options. If your Part A benefit is greater than your Part B benefit, you will not receive a Part B benefit.

Ownership of Your Part A Account
You earn rights to your Part A account (called "vesting") over time. The following table shows how you vest in the benefits from the former Plan after July 1, 1986:

Vesting Service	Vesting Percentage
Less than 3 years	0%
3 but less than 4 years	33%
4 but less than 5 years	67%
5 years or more	100%

You also become 100% vested when you reach age 65 or if you die.

When You Can Retire
Generally, the same retirement conditions apply for your benefits under Part A that apply for the current Pension Plan. (See normal retirement and early retirement for more information.) In addition, if you're eligible for Part A benefits, you can retire as early as age 55, as long as you have at least 10 years of service.

When Your Account Is Distributed
The vested portion of your account may be distributed starting on the first day of the month after you retire or die. If you leave the company, payments from your account normally begin on the first day of the month after you reach age 65. However, you can elect to receive payment as early as age 55.

Benefit payments must begin no later than April 1 following the calendar year in which you reach age 73 unless you are actively employed.

Payment of Small Amounts

If you are eligible for a deferred vested benefit and the present value of your benefit is less than $7,000 but more than $1,000, you will be notified and asked to make an election to have your benefit paid in cash or rolled over to the financial institution of your choice.

If you do not make an election, the Plan will establish an Individual Retirement Account (IRA) in your name, based on the present value of your benefit. Present value amounts less than $1,000 will be paid to you as a lump sum in cash with 20% federal income tax withholding applied.

How Your Account Is Distributed

Payment Methods: If you're married, your standard form of payment is automatically a 50% joint and survivor annuity. If you're single, your standard method of payment is a single life annuity. However, you also have several other payment options from which to choose—depending on your age and personal situation. Here is a list of the payment options and a short description of how each option works:

- 50% Joint and Survivor Annuity—If you're married when you retire, your standard method of payment under Part A is a 50% joint and survivor annuity. This form pays you a reduced monthly pension benefit for your life. Then, when you die, 50% of that benefit is paid to your surviving spouse, continuing for his or her lifetime only. No benefit is payable to a beneficiary after your spouse's death.
- Single Life Annuity—If you're not married when you retire, your standard method of payment is a single life annuity. A single life annuity is a monthly pension benefit that remains the same throughout your lifetime. No benefit is payable to a beneficiary after your death.
- Lump-Sum Payment—If you choose this option, you receive the total value of your account in a single, lump-sum payment once you reach age 55. If you retire early under the former Plan—before age 55—and elect a lump-sum payment, it will be paid to you with credited interest when you reach age 55.
- 10-Year Certain Plus Life—If you choose this option, you're paid a reduced monthly benefit for life. If you die before 120 payments are made, the same monthly benefit will be paid to your beneficiary for the remainder of that 120-month period (the remainder of the 10 years).
- Joint and Survivor—If you choose this payment method, you're paid a reduced monthly benefit for life, with 50% or 100% (whichever you choose), paid after your death to your joint annuitant for his or her lifetime.
- Cash Refund Annuity—If you elect this annuity, you're paid a reduced monthly benefit for life, with the guarantee that if you die before you've received the total of your pension account at retirement, the remainder will be paid to your beneficiary in a lump sum.
- Joint and Survivor Annuity with Cash Refund—If you elect this payment option, you're paid a reduced monthly benefit for life, with 50% or 100% of that benefit (whichever you choose), paid after your death to your joint annuitant for his or her lifetime. The minimum amount paid to you and/or your joint annuitant will be your total account balance at retirement. If both you and your joint annuitant die before this amount is paid, the remainder will be paid in a lump sum to the beneficiary or the estate of the last one of you to die.
- Level Income Option—If your payments start before you become eligible for your Social Security benefit, you can choose this option to ensure your total benefits from Part A and from Social Security remain relatively level for your lifetime. Under this option, your Part A payments are increased before Social Security payments begin and reduced after these payments start. You can also choose to have the balance paid to your beneficiary in a lump sum if you die before your total account balance has been paid.
- Increasing Single Life Annuity—If you choose this option you are paid a reduced monthly pension at retirement. Each year your benefit amount is increased by the percentage rate specified in the Plan at the time you retired. This benefit is payable for your lifetime only. No payments are made to a beneficiary after your death.

If you choose not to receive your Part A benefits in your standard form, you can elect one of the other payment options. However, if you're married, and you wish to reject the 50% joint and survivor annuity, you and your spouse both must sign a written request for this rejection, witnessed by a notary public.

Direct Rollover

How your account is distributed is very important because of the tax implications associated with your choice. When you request a distribution, you will receive a "Special Tax Notice", which will explain your distribution options—and the corresponding tax implications in greater detail.

However, in general, if you receive a lump sum, you may elect to have all or any part of your distribution paid in a direct rollover, or paid to you as follows:

- If you request a direct rollover— all or part of your account (at your direction), will be made payable to another employer's eligible retirement plan or an Individual Retirement Account (IRA). The portion that's rolled over is not subject to any immediate taxation. Any portion not rolled over will be distributed to you and will be subject to a 20% federal tax withholding.
- If the distribution is made to you—your account may be paid to you in a single payment and is subject to 20% mandatory federal tax withholding. If you are not yet age 59 1/2 at the time of the distribution, an early distribution tax of 10% may also apply.

Naming a Beneficiary

Your beneficiary is the person you name to receive your Plan benefits if you die. Under current laws, if you're married, your spouse is automatically your beneficiary. If you want to name someone other than or in addition to your spouse, your spouse must consent to your choice by signing the Beneficiary Designation Form in front of a notary public. If you ever want to change your beneficiary, your spouse must approve the change in writing again.

The Pension Plan - Traditional Option

The Pension Plan—Traditional Option

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

Pension Plan Highlights—Traditional Option

Company-Funded

The Pension Plan—Traditional Option is 100% funded by the company. You do not need to contribute to the Plan. The Pension Plan—Traditional Option helps build steady retirement income for you after your career with the company ends.

Coverage/Eligibility Under the Plan

Generally, if you're an employee of Deere & Company or one of its subsidiaries or affiliates that adopts the Plan, you are covered under the Plan automatically, starting on your first day at work provided you were hired on or before October 31, 1996 and elected this Pension Plan option in 1996. For employees of the Turf Division, the effective date is July 16, 1996. Leased workers are not eligible to participate.

Pension Benefits

Your pension benefits are determined according to formulas. (See Basic Pension Benefit Calculations—Traditional Option for basic formulas.) Additional benefits may also be payable.

When You Can Receive Benefits

Your pension benefit is vested once you have at least five years of service credit. Normal Retirement begins at age 65. However, the Plan also includes provisions for Early Retirement, and Deferred Vested Retirement under the Traditional Option.

How You Receive Benefits

The Plan offers several payment methods.

Cost—Traditional Option

Plan Cost

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

Basic Pension Benefit Calculations—Traditional Option

Basic Pension Benefit Components

Your basic pension benefit is calculated using your final average monthly salary and your service credit. In addition, if you worked in certain foundry jobs, a third element—your additional foundry service credit—may also be used to determine your pension benefit.

The Basic Pension Benefit
Generally, if you retire on or after November 1, 2003, your monthly basic pension benefit at normal retirement age is shown below.

Formula:

Formula Benefit Multiplier (1.5 %)

x Final Average Monthly Salary

x Your Years of Service Credit

= Basic Monthly Formula Pension Benefit

OR

Minimum

Minimum Benefit Multiplier ($48.75)

x Years of Service (up to 70% of your final monthly salary)

Additional Foundry Service Credit
If you're eligible for additional foundry service credit and you retire on or after November 1, 2003, your basic pension benefit will be increased $48.75 a month for every year of additional foundry service credit you have.

Maximum Benefits
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 Supplementary Pension Benefit Plan. This Plan is an unfunded, nonqualified plan with the payment of benefits made from the general assets of the company. You'll be notified if these limits affect you.

When You Retire
Depending on when you retire from the company, the Plan pays benefits for early retirement, normal retirement, and retirement after age 65. These benefits are adjusted depending on the surviving spouse benefit option you choose. See Payment Methods—Surviving Spouse Options for more details.

Normal Retirement—Traditional Option

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

How Your Normal Retirement Benefit Is Calculated
Your normal retirement benefit, even if you work past age 65, is calculated as a basic pension benefit, using your final average monthly salary and your years of service credit on the date you retire.

When Normal Retirement Benefits Are Paid
Your monthly normal retirement benefit payments start on the first day of the month after your retirement date and are payable the first work day of each month.

Early Retirement—Traditional Option

Early Retirement—Retiring Before Age 65
You may choose early retirement if:

- You are at least age 60 and you have at least 10 years of service credit
- You are not yet age 60 but your age plus your years of service credit equal at least 80
- You have 30 or more years of service credit

How Your Early Retirement Benefit is Calculated
Your early retirement benefit is calculated as a basic pension benefit, using your final average monthly salary and your years of service credit on the date you retire. Your benefit may be reduced, however, depending on when you retire and how your benefit is calculated. See Basic Pension Benefit Calculation—Traditional Option. To determine if a reduction applies, your benefit is calculated as a formula and a minimum benefit (as follows). You receive the greater benefit.

Formula: If benefits start before age 60, they are reduced 1/3% for each month payments start earlier than age 60. There is no age reduction for payments starting on or after age 60.

Minimum: If benefits start before age 62, they are reduced 1/3% for each month payments start earlier than age 62. However, if you have at least 30 years of service credit when you retire, your minimum benefit will be determined again without an age reduction when you reach eligibility for an 80% benefit under Social Security (or begin drawing a Social Security benefit, if earlier).

In this case, you will receive your original reduced formula benefit or your determined again minimum benefit—whichever is larger. There are no age reductions for payments starting on or after age 62.

When Early Retirement Benefits Are Paid
Your early retirement benefits start on the first day of the month after you retire and are payable the first work day of each month.

Supplemental Allowance

The Supplemental Allowance is designed to increase your retirement income temporarily, until you reach eligibility for an 80% benefit under Social Security (or begin drawing a Social Security benefit, if earlier). If you retire before eligibility for an 80% benefit under Social Security, you may be eligible for a Supplemental Allowance.

Supplemental Allowance Amount

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

- If you have 30 or more years of service credit and your benefit is less than $2,800, your allowance is the difference between your monthly early retirement benefit amount and $2,800.
- If you have fewer than 30 years of service credit, you determine the total benefit by dividing $2,800 by 30 and multiplying the result times your years of service credit. A 1% reduction applies to your total benefit for each month you begin receiving benefits before age 60. The difference, if any, between your total benefit and your reduced basic pension benefit equals your Supplemental Allowance.
- The maximum combined monthly pension benefit and Supplemental Allowance cannot exceed 70% of your final monthly salary. If you are a commissioned employee, it is your final monthly salary plus the average of commissions paid in the last 12 months. Also, the Supplemental Allowance is not payable if you elect the Social Security Offset Payment Option (described in Payment Methods).

Receiving Pension Benefits—Traditional Option

How You Receive Plan Payments

Your pension benefits are paid according to the payment form you elect at the time of your retirement:

- If you're single, you receive a single life annuity.
- If you're married, you may elect to provide a 55% or 75% surviving spouse benefit. If you choose to waive the surviving spouse coverage for the portion of your service on and after July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance), your spouse must consent to your choice by signing the consent form in the presence of a notary public.

Payment Methods:

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

55% Surviving Spouse Benefit Option. This payment method provides payments for your life and continues payments to your surviving spouse after your death. The surviving spouse payment will be 55% of what you receive in retirement. With this payment form, you agree to a reduction in your retirement benefits (in addition to any reduction in early or deferred vested benefits).

75% Surviving Spouse Benefit Option. This payment method provides payments for your life and continues payments to your surviving spouse after your death. The surviving spouse payment will be 75% of what you receive in retirement. With this payment form, you agree to a reduction in your retirement benefits (in addition to any reduction in early or deferred vested benefits).

For the benefit based on service credit earned before July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance), no reduction applies, unless your spouse is more than 10 years younger than you. In this case, your monthly benefit is reduced by 1/2% for each full year in excess of 10 years that your spouse is younger than you.

After your death, your surviving spouse's benefit is equal to 55% of this reduced amount. If you choose to waive the young spouse reduction for credit earned before July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance), your spouse must consent to your choice by signing the consent form in the presence of a notary public. If this coverage is waived, your surviving spouse will receive no benefit for service credit prior to July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance).

There are three options available to you for figuring your benefit and your surviving spouse's benefit:

Single Life Annuity Option provides you with an unreduced basic monthly pension benefit for all your years of service credit. If you die, your surviving spouse will receive 55% of the benefit you earned for service credited before 1 July 1993 (1 January 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance).

55% Surviving Spouse Benefit Option provides you with a reduced basic monthly pension benefit. The reduction applies to the portion of your pension benefit earned on and after July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance). If you die, your surviving spouse will receive 55% of your reduced total pension benefit.

75% Surviving Spouse Benefit Option provides you with a reduced basic monthly pension benefit. An additional reduction applies to the benefit value calculated in the 55% Option. If you die, your surviving spouse will receive 75% of your reduced total pension benefit.

See the Surviving Spouse Benefit reduction examples for further explanations.

Social Security Offset Payment Option. If you retire before you are eligible to receive Social Security benefits (generally age 62), you can choose this payment option. Under this option, you receive higher benefits from the Plan until you reach age 62 and lower benefits from the Plan after age 62. This way, the pension benefit you receive before age 62 is approximately equal to the combined total of your pension benefit and Social Security benefit after reaching age 62 if you choose to apply for Social Security at that time. The reduction for surviving spouse benefits also applies to this option.

When Your Benefits Are Paid

The date you begin receiving benefits depends on the type of retirement you choose. See Normal Retirement, Early Retirement, and Deferred Vested Pension for more information. However, payments must begin no later than the April 1 following the calendar year in which you reach age 73, unless you are still actively working for the Company.

To Receive Pension Benefits

You may not apply earlier than 180 days and no later than 60 days prior to the date of your intended retirement. Call the John Deere Savings & Retirement Service Center at 1-800-354-3427. You can call between 7:30 a.m. and 11:00 p.m. Central Time, Monday through Friday. Or, you may visit the benefit portal at www.netbenefits.com. This site provides modeling tools and you can even start your pension payment online, without the help of a retirement specialist. Please remember to notify your supervisor of your retirement plans.

If you use vacation to extend your retirement date, you must complete the Retirement Election Form at Your WORLD at Deere>Recognition, Rewards, and Meaningful Work>Your Retirement and email it to RetirementBenefits@JohnDeere.com, no later than 60 days before your last day in the office.

Death After Retirement—Traditional Option

If you die after you retire, the Plan includes protection for your surviving spouse. Surviving spouse benefits, if any, are paid only to your spouse. The Pension Plan does not provide benefit payments to a beneficiary other than your surviving spouse.

Who's Eligible?

Your spouse is eligible for surviving spouse benefits if you were married to him or her at retirement. You can waive the spousal coverage earned on or after July 1, 1993 (January 1, 1994, for employees of John Deere Financial Services, John Deere Health and John Deere Insurance), with your spouse's consent, if he or she signs the consent form in the presence of a notary public. If you marry during retirement, you must have been married at least one year immediately prior to your death. You may submit your application by contacting the John Deere Savings & Retirement Service Center at 1-800-354-3427.

Benefits Payable to Your Surviving Spouse

If this coverage is in effect for you on the date of your death, your surviving spouse will receive monthly benefits based upon your election at retirement, or under the 55% Surviving Spouse Benefit Option (described under Payment Methods), if a spouse waiver is not on file and you have been married at least one year.

Special Temporary, Supplemental Allowance, or other special benefits are not payable to a surviving spouse. However, if your Plan benefit is subject to redetermination, the surviving spouse's benefit will be based on the benefits that would have been payable to you after age 62 (or eligibility for an 80% benefit under Social Security).

Cost of Coverage

There is a charge for surviving spouse coverage on the portion of your benefit earned on and after July 1, 1993 (January 1, 1994 for employees of John Deere Financial Services, John Deere Health and John Deere Insurance). You pay the cost through a reduction in your benefit. See the examples of the 55% and 75% Surviving Spouse Reduction.

When Benefits Are Paid

Benefits to your spouse will start on the first day of the month following your death and are payable the first work day of every month.

Death Before Retirement—Traditional Option

Who's Eligible?

If you die before you retire, your surviving spouse is eligible for surviving spouse benefits as long as you were vested under the Plan (you have at least five years of service credit) and you were married at least one year prior to your death.

Benefits Payable to Your Surviving Spouse

Your surviving spouse will receive monthly benefits equal to 55% of the benefit you would have received if you had lived to your earliest retirement age and retired.

The company pays the full cost of this coverage. However, the surviving spouse benefit will be reduced if your spouse is more than 10 years younger than you. See Payment Methods.

When Benefits Are Paid

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

Disability Retirement—Traditional Option

If you were permanently and totally disabled prior to November 1, 1998 under the Disability Retirement provisions of the John Deere Pension Plan for Salaried Employees, you will continue to be administered under the provisions stated in the Retirement section of the 1998 Summary Plan Description.

Deferred Vested Pension—Traditional Option: If You Leave Before Retirement

When you have at least five years of service credit (not including additional foundry service credit), you're considered to be "vested" under the Plan. This means that you have 100% ownership rights to your accrued pension benefit, which is payable in the future.

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

How Your Deferred Vested Pension Is Calculated

Your deferred vested pension benefit is calculated using the service credit, the final average monthly salary, and the Plan provisions in effect on the date you left the company. The benefit is calculated as a Traditional basic pension benefit.

When Deferred Vested Benefits Are Paid

The company will notify you when you are eligible to begin deferred vested pension benefits. For benefits to begin, you must apply. You may not apply earlier than 180 days and no later than 60 days prior to the date of your intended retirement. Call the John Deere Savings & Retirement Service Center at 1-800-354-3427. You can call between 7:00 a.m. and 11:00 p.m. Central Time, Monday through Friday. Or, you may visit the benefit portal at www.netbenefits.com. This site provides modeling tools and you can even start your pension payment online, without the help of a retirement specialist.

You may choose to start payments at any time after your earliest eligibility to retire (at age 65 with five years of service, age 60 with 10 years of service, or when your age and service credit equal 80 points, but no later than April 1 following the calendar year in which you reach age 73.

Benefits are payable starting on the first day of the month of your request, provided you're eligible to receive benefits at that time. Choosing your benefit start date is important, because reductions apply for early payments:

- If you choose to start payments on or after the date you reach age 65, no reductions apply.
- If you choose to start payments before age 65, benefits are reduced by 1/2% for each month they start before age 65.

How Deferred Vested Benefits Are Paid

If you are eligible for a deferred vested benefit and the present value of your benefit is less than $7,000 but more than $1,000, you will be notified and asked to make an election to have your benefit paid in cash or rolled over to the financial institution of your choice.

If you do not make an election, the Plan will establish an Individual Retirement Account (IRA) in your name, based on the present value of your benefit. Present value amounts less than $1,000 will be paid to you as a lump sum unless an alternate election is submitted. You will be notified if this payment affects you. Otherwise, benefits are paid under one of the options previously described, except the Social Security Offset Payment Option is not available.

Deferred Vested Surviving Spouse Benefit

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

Benefits Payable

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

Your surviving spouse may begin receiving benefits, as of the date you would have first been eligible to receive a deferred vested pension. Your spouse may not apply earlier than 180 days and no later than 60 days prior to the date of your intended retirement. Your spouse should call the John Deere Savings & Retirement Service Center at 1-800-354-3427. They can call between 7:00 a.m. and 11:00 p.m. Central Time, Monday through Friday. Or, he/she may visit the benefit portal at www.netbenefits.com. This site provides modeling tools and they can even start their pension payment online, without the help of a retirement specialist.

Cost of Coverage

There is a charge for pre-retirement surviving spouse coverage. You pay the cost through a reduction in your pension benefit. The amount of the reduction depends on your age and how long the coverage is in effect. This coverage is automatic unless both you and your spouse reject it in the presence of a notary public. The chart below shows the monthly cost as a percentage reduction in your benefits.

Deferred Vested Benefit—Surviving Spouse Coverage

If You Are This Age	Your Pension Will Be Reduced By This Percentage for Each Year of Coverage:
Under 35	0.0%
35-44	0.1%
45-54	0.3%
55 and older	0.8%

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

Making Your Election

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

Pension Benefit Examples—Traditional Option

Basic Pension Benefit Example—Traditional Option

Assume your final average monthly salary is $3,500. You have 30 years of service credit.

Formula Benefit	
Formula Benefit Multiplier (1.5%)	.015
Final Average Monthly Earnings	x $3,500
Your Years of Service Credit	x 30
Basic Monthly Formula Pension	$1,575

Minimum Benefit	
Minimum Benefit Multiplier (1.5%)	$48.75
Your Years of Service Credit	x 30
Monthly Minimum Pension Benefit (up to 70% of your final monthly salary)	$1,462.50

The formula calculation produces the larger amount. Therefore, in this example, your monthly basic pension benefit at normal retirement age would be $1,575, depending on the survivor benefit option you choose (see Payment Methods).

Early Retirement Benefit Example—Traditional Option

Assume you retire at age 58, with 30 years of service credit, and basic pension benefits of $1,500 each month. You would like to begin receiving early retirement benefits immediately.

Formula (reduced before age 60)	
Basic Monthly Formula Pension	$1,500
Reduction Before Age 60 (1/3% x 24 months x $1,500)	-120
Early Retirement Monthly Formula Benefit	$1,380

Minimum (reduced before age 62)	
Minimum Benefit (48.75 x 30)	$1,462.50
Reduction Before Age 62 (1/3% x 48 months x $1,462.50)	-234
Early Retirement Monthly Minimum Benefit	$1,228.60

You would receive the larger amount—in this example, $1,380 each month—depending on the surviving spouse benefit option you choose (see Payment Methods).

Supplemental Allowance Example—Traditional Option

Assume your early retirement benefit is $1,380 each month. You retire (and begin receiving benefits), at age 58, with 30 years of service credit. Your Supplemental Allowance would be calculated as follows:

Supplemental Allowance	$2,800
Early Retirement Formula Benefit	-1.380
Supplemental Allowance	$1,420

So, until you reach eligibility for an 80% benefit under Social Security (or begin drawing Social Security, if earlier), your monthly benefit would be equal to $2,800 (your early retirement benefit plus your Supplemental Allowance), up to 70% of your final monthly salary.

Surviving Spouse Benefit Examples—Traditional Option

Assume that you retire on June 30, 2004 from John Deere Harvester Works with 30 years of service credit. Your basic monthly pension benefit is $1,500—with $1,000 accrued before July 1, 1993, and $500 accrued on or after July 1, 1993.

Surviving Spouse Benefits - Option 1	
Your Basic Unreduced Monthly Pension Benefit	$1,500
Accrued Pension Benefit Before July 1, 1993	$1,000
Surviving Spouse Benefit Multiplier (55%)	x .55
Surviving Spouse Monthly Pension Benefit	$550

55% Surviving Spouse Benefits - Option 2	
Accrued Pension Benefit On or After July 1, 1993	$500
55% Surviving Spouse Reduction Factor (Based on Your Age, Your Spouse's Age, and the Plan Year Interest Rate and Mortality Tables in Effect at the Time of Your Annuity Start Date)	x .9010
Accrued Pension Benefit Before July 1, 1993	+1,000
Your Reduced Basic Monthly Pension Benefit	$1,450.50

Your Spouse's Benefit	
Surviving Spouse Benefit Factor (55%)	x .55
Surviving Spouse Monthly Pension Benefit	$797.78

75% Surviving Spouse Benefits - Option 3	
Your Reduced Basic Monthly Pension Benefit Under Option 2	$1,450.50
75% Surviving Spouse Reduction Factor (Based on Your Age, Your Spouse's Age, and the Plan Year Interest Rate and Mortality Tables in Effect at the Time of Your Annuity Start Date)	x .9856
Your Reduced Basic Monthly Pension Benefit	$1,429.61

Your Spouse's Benefit	
Surviving Spouse Benefit Factor (75%)	x .75
Surviving Spouse Monthly Pension Benefit	$1,072.21

Deferred Vested Benefit Example—Traditional Option

Assume you left the company at age 40, with 15 years of service credit. Your basic accrued pension benefit, based on your service credit and final average monthly salary when you left, is $700 a month. You decide to begin receiving benefits at age 63. Therefore, your deferred vested benefit would be:

Unreduced Pension Benefit	$700
Reduction (1/2% x 24 months before age 65 x $700)	-84
Monthly Deferred Vested Benefit	$616

You would receive this amount in the example above depending on the surviving spouse options you choose (reductions could occur for pre-retirement surviving spouse coverage and/or survivor benefit option election).

Situations Affecting Your Retirement Plans—Traditional Option

The company's Pension Plan and Savings and Investment Plan are designed to provide you with retirement income. But there are situations that could affect your benefits. Some of these situations are listed here.

Funding for Retiree Medical Benefits

As a part of the pension trust, the Plan includes a funding mechanism that can be used by the company to help pay the cost of retiree medical benefits. For a description of medical benefits in retirement, see Medical Benefits in Retirement.

A Few Words About Taxes

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

Assignment of Benefits

Your benefits from the retirement plans 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, or your Savings and Investment Plan account, contact the John Deere Savings & Retirement Service Center by phone 1-800-354-3427 or http://qdro.fidelity.com. Also, you will need to notify Deere Direct when your divorce is final.

Plan Maximums

Both plans have maximum-benefit limits that apply. See Pension Plan Benefit Limit. For the Savings and Investment Plan (Savings and Investment Plan Contribution Limits), the IRS sets limits on the amount you and the company can contribute to your account each year. These limits generally apply to higher-paid employees. You'll be notified if they affect you.

Top-Heavy Provisions

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

The Pension Benefit Guaranty Corporation (PBGC)

The 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 survivors' and disability pensions. However, the PBGC does not guarantee all types of pensions, and the amount of protection is subject to certain limitations.

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

Mistaken or Excess Pension Payments

As soon as administratively practicable, the Plan Administrator will recoup any mistaken or excess pension benefit from any and all future pension payments unless another arrangement is agreed upon.

Preserved John Deere Coffeyville Works Benefits (Part A)–Traditional Option

If you were a John Deere Coffeyville Works employee before November 1, 1990, your pension benefit consists of two parts. The first part (Part A) is the benefit you earned under the previous John Deere Coffeyville Works Pension Plan for Salaried Employees. The second part (Part B) is the benefit you accrued under the current Plan, which takes into consideration your previous service with John Deere Coffeyville Works (and in some cases, your service with Cooper Industries as well).

If this situation applies to you, you'll want to read this section carefully to understand how your Part A and Part B benefits will coordinate when you retire.

Part A Pension Benefit

If you worked for John Deere Coffeyville Works before November 1, 1990, you earned a pension benefit under the John Deere Coffeyville Works Pension Plan for Salaried Employees. This benefit was based on the final balance in an account established in your name. The company made periodic adjustments to your account until 31 June 1992. Presently, Deere adds 4.5% per year to your account.

When you retire from Deere, you will be eligible for both your Part A and B benefits. However, your Part B benefit will be reduced by the amount of your Part A benefit. Here's how it works:

- Your Part A benefit, determined by the balance in your account at your retirement, will be distributed according to the payment option you choose.
- Your Part B benefit will be calculated using all your years of credited service. This amount will then be offset by the amount of your Part A benefit. Your Part A benefit will be made based on the payment options. If your Part A benefit is greater than your Part B benefit, you will not receive a Part B benefit.

Ownership of Your Part A Account

You earn rights to your Part A account (called "vesting") over time. The following table shows how you vest in the benefits from the former Plan after July 1, 1986:

Vesting Service	Vesting Percentage
Less than 3 years	0%
3 but less than 4 years	33%
4 but less than 5 years	67%
5 years or more	100%

You also become 100% vested when you reach age 65 or if you die.

When You Can Retire

Generally, the same retirement conditions apply for your benefits under Part A that apply for the current Pension Plan. (See normal retirement and early retirement for more information.) In addition, if you're eligible for Part A benefits, you can retire as early as age 55, as long as you have at least 10 years of service.

When Your Account Is Distributed

The vested portion of your account may be distributed starting on the first day of the month after you retire or die. If you leave the company, payments from your account normally begin on the first day of the month after you reach age 65. However, you can elect to receive payment as early as age 55.

Benefit payments must begin no later than April 1 following the calendar year in which you reach age 73 unless you are actively employed.

Payment of Small Amounts

If you are eligible for a deferred vested benefit and the present value of your benefit is less than $7,000 but more than $1,000, you will be notified and asked to make an election to have your benefit paid in cash or rolled over to the financial institution of your choice.

If you do not make an election, the Plan will establish an Individual Retirement Account (IRA) in your name, based on the present value of your benefit. Present value amounts less than $1,000 will be paid to you as a lump sum in cash with 20% federal income tax withholding applied.

How Your Account Is Distributed

Payment Methods: If you're married, your standard form of payment is automatically a 50% joint and survivor annuity. If you're single, your standard method of payment is a single life annuity. However, you also have several other payment options from which to choose—depending on your age and personal situation. Here is a list of the payment options and a short description of how each option works:

- 50% Joint and Survivor Annuity: If you're married when you retire, your standard method of payment under Part A is a 50% joint and survivor annuity. This form pays you a reduced monthly pension benefit for your life. Then, when you die, 50% of that benefit is paid to your surviving spouse, continuing for his or her lifetime only. No benefit is payable to a beneficiary after your spouse's death.
- Single Life Annuity: If you're not married when you retire, your standard method of payment is a single life annuity. A single life annuity is a monthly pension benefit that remains the same throughout your lifetime. No benefit is payable to a beneficiary after your death.
- Lump-Sum Payment: If you choose this option, you receive the total value of your account in a single, lump-sum payment once you reach age 55. If you retire early under the former Plan—before age 55—and elect a lump-sum payment, it will be paid to you with credited interest when you reach age 55.
- 10-Year Certain Plus Life: If you choose this option, you're paid a reduced monthly benefit for life. If you die before 120 payments are made, the same monthly benefit will be paid to your beneficiary for the remainder of that 120-month period (the remainder of the 10 years).
- Joint and Survivor: If you choose this payment method, you're paid a reduced monthly benefit for life, with 50% or 100% (whichever you choose), paid after your death to your joint annuitant for his or her lifetime.
- Cash Refund Annuity: If you elect this annuity, you're paid a reduced monthly benefit for life, with the guarantee that if you die before you've received the total of your pension account at retirement, the remainder will be paid to your beneficiary in a lump sum.

- Joint and Survivor Annuity with Cash Refund: If you elect this payment option, you're paid a reduced monthly benefit for life, with 50% or 100% of that benefit (whichever you choose), paid after your death to your joint annuitant for his or her lifetime. The minimum amount paid to you and/or your joint annuitant will be your total account balance at retirement. If both you and your joint annuitant die before this amount is paid, the remainder will be paid in a lump sum to the beneficiary or the estate of the last one of you to die.
- Level Income Option: If your payments start before you become eligible for your Social Security benefit, you can choose this option to ensure your total benefits from Part A and from Social Security remain relatively level for your lifetime. Under this option, your Part A payments are increased before Social Security payments begin and reduced after these payments start. You can also choose to have the balance paid to your beneficiary in a lump sum if you die before your total account balance has been paid.
- Increasing Single Life Annuity: If you choose this option you are paid a reduced monthly pension at retirement. Each year your benefit amount is increased by the percentage rate specified in the Plan at the time you retired. This benefit is payable for your lifetime only. No payments are made to a beneficiary after your death.

If you choose not to receive your Part A benefits in your standard form, you can elect one of the other payment options. However, if you're married, and you wish to reject the 50% joint and survivor annuity, you and your spouse both must sign a written request for this rejection, witnessed by a notary public.

Direct Rollover

How your account is distributed is very important because of the tax implications associated with your choice. When you request a distribution, you will receive a "Special Tax Notice", which will explain your distribution options—and the corresponding tax implications in greater detail.

However, in general, if you receive a lump sum, you may elect to have all or any part of a lump sum distribution paid in a direct rollover, or paid to you as follows:

- If you request a direct rollover: all or part of your account (at your direction), will be made payable to another employer's eligible retirement plan or an Individual Retirement Account (IRA). The portion that's rolled over is not subject to any immediate taxation. Any portion not rolled over will be distributed to you and will be subject to a 20% federal tax withholding.
- If the distribution is made to you: your account may be paid to you in a single payment and is subject to 20% mandatory federal tax withholding.

Naming a Beneficiary

Your beneficiary is the person you name to receive your Plan benefits if you die. Under current laws, if you're married, your spouse is automatically your beneficiary. If you want to name someone other than or in addition to your spouse, your spouse must consent to your choice by signing the Beneficiary Designation Form in front of a Human Resources representative or notary public. If you ever want to change your beneficiary, your spouse must approve the change in writing again.

When You Retire

Depending on when you retire from the company, the Plan pays benefits for early retirement, normal retirement, and retirement after age 65. These benefits are adjusted depending on the surviving spouse benefit option you choose.

See Payment Methods—Surviving Spouse Options for more details.

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.

Important: If you believe you are entitled to a benefit that you have not received or if you disagree with any determination made by the Plan Administrator regarding your benefit (such as the amount of your benefit or how it is calculated), you may submit a claim for benefits under the Plan. However, the time period during which you can submit a claim for benefits (including the time period to bring suit after exhausting the Plan's claims and appeals procedures), is limited. If you fail to make a timely claim for benefits or you fail to timely appeal a denied claim, you may lose your right to those benefits.

For important information regarding the process for submitting a claim for benefits and the deadlines for submitting such a claim, including the deadline for filing a claim in court, please see the section of this booklet titled "Claims that are not Group Health or Disability Claims."

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.

Under certain circumstances, your benefits may be lost, reduced or suspended. These circumstances include the following: All or a portion of your benefits are directed to be paid to your spouse, former spouse or child pursuant to a qualified domestic relations order.

1. Your benefits are (a) subject to a Federal tax levy, or (b) used to offset amounts that certain judgments or settlement agreements require you to pay to the Plan.
2. You do not provide the Company with your most recent address and you cannot be located.
3. You fail to make proper application for benefits or fail to provide necessary information.
4. The Plan is terminated before sufficient assets have been accumulated to pay all benefits. (In this case you may be protected, in full or in part, by the Pension Benefit Guaranty Corporation as described below)
5. The Plan is amended to reduce accrued benefits. (This may be done only with the permission of the federal government to avoid severe economic hardship to the Company. The Company has no present intention to take such action, but is required by law to inform you of the possibility.)
6. Under the joint and survivor annuity, your benefits are reduced to permit payments to your beneficiary after your death.
7. You stop receiving interest credits because you begin receiving your Plan benefit.
8. You leave the Company prior to becoming vested and incur five consecutive Breaks-in-Service resulting in the forfeiture of your unvested benefits.
9. In addition, Federal law may limit the benefits payable to highly compensated employees. You will be notified if this situation applies to you.
10. If you are one of the 25 highest allocated partners, based on your allocation for the current or any prior Plan Year, you may not be permitted to receive your benefits in the form of a lump sum unless the Plan(s) meets certain funding or financial requirements. You will be notified if this restriction applies to you.
11. If you believe you are entitled to a benefit that you have not received or if you disagree with any determination made by the Plan Administrator regarding your benefit (such as the amount of your benefit or how it is calculated), you may submit a claim for benefits under the Plan. However, the time period during which you can submit a claim for benefits (including the time period to bring suit after exhausting the Plan's claims and appeals procedures), is limited. If you fail to make a timely claim for benefits or you fail to timely appeal a denied claim, you may lose your right to those benefits.

For important information regarding the process for submitting a claim for benefits and the deadlines for submitting such a claim, including the deadline for filing a claim in court, please see the section of this booklet titled "Claims that are not Group Health or Disability Claims."

The Savings and Investment Plan—Contemporary Option

The Savings and Investment Plan—Contemporary Option

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 (SIP).

The Savings and Investment Plan—Contemporary Option is an easy way to supplement the retirement income you'll receive from the Pension Plan and Social Security. Generally, if you're an employee paid on the U.S. payroll and hired after 1996, you may participate in the Contemporary Plan. The Plan encourages you to save by providing you with a company match based on company profits, and allowing you to defer your taxes through pre-tax contributions and/or participate on an after-tax basis through Roth contributions.

Highlights—Contemporary Option

Tax Advantages

The money contributed to the Plan on your behalf, including the matching contributions from the company, is deposited in your account on a pre-tax basis, Roth after-tax basis or a combination of both. Taxes are delayed on your pre-tax dollars until distributed from the Plan. Beginning in the spring of 2007, a Roth after-tax component was added to the 401(k) Plan. Roth after-tax deferrals that satisfy certain requirements are distributed tax-free, along with earnings on those deferrals.

Your Plan Account

You can save from 1% to 75% of your eligible earnings, as limited by the IRS, in the Plan, on a pre-tax and/or Roth after-tax basis. John Deere will match a portion of your pre-tax and/or Roth after-tax contributions. All company matching contributions are made on a pre-tax basis.

Your contributions and the Company matching contributions are credited to an account in your name. If you are age 50 or older as of December 31 of the calendar year, you are eligible to make catch-up contributions. The catch-up amount will be based upon your election as described above and will begin once you have reached the current year's IRS maximum.

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.

Eligibility and Enrollment—Contemporary Option

Who's Eligible?

You're eligible to participate if you're an employee of Deere & Company or of an affiliate or subsidiary that adopts the Plan, and paid through the U.S. payroll system. Some salaried employees working for foreign branches or subsidiaries may also be eligible. For more information on eligibility, contact Fidelity Investments. You are eligible to participate in the Contemporary Plan if you were hired after October 31, 1996 or if you elected the Contemporary option in 1996. For employees of the former Commercial and Consumer Equipment Division the effective date is July 16, 1996. Leased Workers are not eligible to participate.

Uniformed Services Employment and Reemployment Rights Act of 1994

An employee who left employment with the company and immediately entered the service of the "Uniformed Services of the United States" will be considered as continuing to have been employed by the company; will be given an opportunity for "make-up contributions" in order to receive matching contributions; and service in the Uniformed Services of the United States will be credited towards service credit up to a maximum of 40 hours for each week for a maximum time period of five years, provided the employee has reemployment rights under applicable law and does become reemployed by the company under the provisions of that law.

Once re-employed by the Company, an eligible employee who wishes to make-up missed contributions and receive the Company match on those contributions must make his or her missed contributions to the Plan during the period (following re-employment), that is no longer than three times his or her period of uniformed services, up to a maximum of five years following re-employment. Contact Deere Direct for additional information.

If an employee dies on or after January 1, 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.

Enrolling in the Plan

The Savings and Investment Plan is voluntary. You need to enroll before you can make deferrals. To enroll, call the John Deere Savings & Retirement Service Center at Fidelity Investments (1-800-354-3427), hereafter referred to as the Service Center, or you may enroll by logging on to Fidelity NetBenefits at www.netbenefits.com, hereafter referred to as NetBenefits. Your participation will be effective the next pay period after you place your call.

The Savings and Investment Plan is voluntary. You need to enroll before you can make deferrals. To enroll, call the John Deere Savings & Retirement Service Center at Fidelity Investments (1-800-354-3427) here after referred to as the Service Center, or you may enroll by logging on to Fidelity NetBenefits at www.netbenefits.com, here after referred to as NetBenefits. Your participation will be effective the next pay period after you place your call.

Employee's hired on and after December 31, 2016 will be automatically enrolled in the Plan with a 6% deferral contribution that will begin on or about 30 days following the entry of employee enrollment information to Fidelity's system . Also, employees not enrolled in the Plan at this time or enrolled with a deferral contribution less than 6%, will be enrolled at 6%. Within 30 days, you may elect a different percentage or opt out of the Plan.

If you decide not to participate when first eligible, you can enroll at any later time. Your participation will be effective with the next applicable payroll period after your enrollment is received by the Service Center.

Naming a Beneficiary

Your beneficiary is the person you name to receive your Plan benefits if you die. Under current laws, if you're married, your Spouse is automatically your beneficiary. If you want to name someone other than or in addition to your Spouse, your Spouse must consent to your choice. Contact Fidelity Investments to add or change your beneficiary.

If you ever want to change your beneficiary, your Spouse must again approve the change. Contact Fidelity Investments to add or change your beneficiary.

Contributions—Contemporary Option

The Savings and Investment Plan—Contemporary Option is designed around different types of contributions being made to each participant's account. Under the Plan, there are several types of contributions. Some of these are: your matched deferral, your unmatched deferral; your company matching contribution; Roth deferrals, catch-up deferrals and rollover contributions.

Your Contributions

If you participate in the Savings and Investment Plan (SIP), you can contribute from 1% to 75% of your eligible earnings, as limited by the IRS, in whole percentages. This includes Short-Term Incentive bonuses, incentive pay, and commissions. The Long Term Incentive Cash bonus is not considered eligible earnings for purposes of this Plan.

If you are age 50 or older as of December 31 of the calendar year, you are eligible to make catch-up contributions. The catch-up amount will be based upon your election as described above, and will begin once you have reached the current year's IRS maximum. Log on to www.netbenefits.com or call the Service Center at 1-800-354-3427 for

additional contribution and catch-up information.

Your SIP deferrals can be made on a pre-tax basis, a Roth after-tax basis or a combination of both. The deferrals are deducted from your paycheck and are deposited in your account at the end of the payroll period in which the deferral was made.

Effective January 1, 2005, you may elect to participate in the Automatic Increase Program (AIP). This program automatically increases your deferral by 1% each March 1. Of course, you are still able to make changes to your deferral percentage whenever you wish. Log on to NetBenefits or call the Service Center, if you would like to participate in the AIP. Employees hired on or after September 1, 2006, will be enrolled automatically in AIP.

Effective April 2011, all future contributions for which you have not made an investment election are defaulted to the target date fund closest to your 65th birth date. To change the default, contact the Savings Plan Service Center.

The contributions you can make:

- Your matched contributions: These are pre-tax and Roth after-tax contributions you make that are eligible for the company match. Your matched contributions are on the first 6% of your eligible earnings that you defer.
- Your unmatched contributions: These pre-tax and Roth after-tax contributions are also credited to your account, but they are not eligible for the company match. Your unmatched contributions are those that exceed the first 6% of your eligible earnings (as limited by the IRS).

Pre-tax Contributions

The Savings and Investment Plan lets you defer taxes by making pre-tax contributions.

Here's how:

Normally, when you deposit money in a bank account or other savings vehicle, you have already paid taxes on those amounts. Under the SIP, however, your savings are deducted before taxes are applied—then the balance of your salary is taxed. Your savings aren't counted as part of your taxable income for federal and most state and local income taxes until you receive a distribution of your account. Social Security taxes are deducted on all your wages, even your pre-tax contributions.

Pre-tax contributions mean:

- Your Savings and Investment Plan contributions are not taxed immediately; and
- You pay less tax on your wages

After-tax Contributions

With the introduction of the Roth in March 2007, you are now able to contribute employee contributions on an after-tax basis. You should check with your accountant or tax advisor to determine if Roth after-tax contributions are right for you.

After-tax contributions mean:

- Your Savings and Investment Plan contributions are taxed immediately
- Upon distribution, no income taxes will be owed as long as you have been making Roth contributions to the Plan for at least five years and the distribution is made on or after you reach age 59-1/2, after your death or on account of your disability.

Changing or Stopping Your Contributions

You can increase, decrease, or discontinue your contributions any pay period by calling the Service Center at 1-800-354-3427, or by logging on to Fidelity NetBenefits (www.netbenefits.com), any time. Your change will be effective the next payroll period after your change is received. If you stop contributing, you can re-enroll by calling the Service Center or by logging on to www.netbenefits.com.

Company Match—Contemporary Option

The company match is a fixed rate on employee deferrals up to 6% of eligible earnings.

The company will match 10% of an employee's eligible earnings on the first 6% of an employee's contribution. The match will be tiered at 300% for the first 2% contributed and 100% for the next 4% contributed.

- Employee deferrals above 6% of eligible earnings are not eligible for the match.
- Effective for each pay period processed after July 20, 2014, a calculation will be performed to determine if a matching contribution is due. The calculation will take into account your year-to-date deferrals divided by the year-to-date eligible compensation to determine a year-to-date deferral rate. The year-to-date deferral rate shall be applied against the matching level provided by your employer to determine the required year-to-date matching contribution amount by the conclusion of the pay period, subject to IRS limits.
- If you were employed by more than one employer that has adopted the Plan in any calendar year, the matching contribution provided shall be based upon the matching level of the highest matching employer.
- Effective 1 January 2023, an additional 4% will be made for employees hired on or after 1 January 2023 or elected to participate in the Grow Together option in 2023. The contribution will be based on plan eligible earnings and will be immediately vested.

Vesting of the Company Match

You are always 100% vested in your pre-tax and Roth after-tax contributions to the Savings and Investment Plan (SIP). Your company matching contributions are 100% vested and non-forfeitable once you have three years of Service Credit with the Company. Prior service credit with John Deere is used in determining total Service Credit.

Rollover Contributions—Contemporary Option

If, before joining the company, you participated in a qualified savings plan (401(k), 457 or 403(b) plan), you may be able to roll over pre-tax contributions, Roth after-tax contributions and earnings from your former plan into the Savings and Investment Plan. A rollover must be made within 60 days after you receive payment from the former plan.

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

- SIP offers a more varied selection of funds;
- You want to be able to access funds in the prior plan through a loan from the SIP; or
- Your previous employer requires distribution and you wish to continue to defer taxes on amounts (including earnings), previously deferred.

When you roll over money to the Plan, a separate source is set up for your rollover contribution. You are not considered a plan participant until you start contributing to the Plan through salary deferrals. You are not eligible for company-matching contributions until you contribute pre-tax or Roth after-tax deferrals to the Plan.

Effective November 1, 2014, if you are no longer employed by the company and receive a lump sum distribution from the John Deere Pension Plan for Salaried Employees, you may roll that distribution into the Savings and Investment Plan.

Contact the Service Center at 1-800-354-3427, to find out whether a rollover is possible in your situation.

A note of caution: If you participated or continue to participate in another qualified plan, your combined contributions to the Plan and the other qualified plan cannot exceed the current calendar year IRS maximum. It is your responsibility to keep Deere Direct advised of any and all deferrals outside of the SIP. If you exceed the IRS maximum, you will have to file an amended tax return.

Contribution Limits — Contemporary Option

Limits: The Savings and Investment Plan is highly regulated and subject to Internal Revenue Code (IRC) provisions and regulations. Specific regulatory limits apply to the Savings and Investment Plan. One limit restricts your combined pre-tax and Roth after-tax deferrals each calendar year ($23,000 in 2024). The limit on catch-up contributions for 2024 is $7,500. Total covered compensation is $330,000 in 2024.

John Deere Defined Contribution Restoration Plan (DCRP): The Savings and Investment Plan is designed to match up to the first 6% of employee deferrals. Because of the collective IRC limits, however, a small segment of employees may not be able to defer 6% to the Savings and Investment Plan and may be eligible for the DCRP. This account is different from the Savings and Investment Plan in several ways.

For instance, the Plan is a non-qualified plan. Further, the money is not held in a trust fund, it is recorded on the books of the company as a credit to the employee. Fidelity is the record keeper for the DCRP. Employees eligible for this plan will be personally notified.

Investment Choices — Contemporary Option

You decide how your contributions are 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 1-800-354-3427 or log on to NetBenefits® (www.netbenefits.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 of fer 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 G
- BTC LifePath® 2025 G
- BTC LifePath® 2030 G
- BTC LifePath® 2035 G
- BTC LifePath® 2040 G
- BTC LifePath® 2045 G
- BTC LifePath® 2050 G
- BTC LifePath® 2055 G
- BTC LifePath® 2060 G
- BTC LifePath® 2065 G

CHOICE 2

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

- S & P 500 Stock Index, Class F
- Small/Mid Stock Index, Class F
- International Stock Index, Class F
- U.S. TIPS Bond Index, Class F
- U.S. Bond Index, Class F
- Commodity Index, Class F
- Real Estate Index, Class F

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

CHOICE 3

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

- Fidelity® Growth Company Commingled Pool Class #3
- Boston Partners Large Cap Value Fund Share Class E
- QMA US Small Cap Core Equity Fund CL 4
- International Equity Fund
- U.S. Equity Fund
- Allspring Emerging Markets
- CIT-Allspring Enhanced Core Bond E2

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

You have the right to direct the Plan trustee concerning shareholder rights, such as the right to vote or tender, for shares attributable to the units of Deere & Company Common Stock Fund credited to your account. The trustee will hold your decision with respect to the exercise of shareholder rights in confidence, except to the extent required by law.

In addition, the Company will not review information concerning any individual participant's purchase, holding or sale of Deere & Company Common Stock Fund, unless required to fulfill its fiduciary obligations, or by applicable law. The Company does not have access to your decisions with respect to exercise of your rights as a shareholder.

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 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

When you contact Fidelity through NetBenefits or call the Service Center, you indicate what percentage of your contributions you want to go into each investment option, using whole percentages. If you fail to make a fund election, your contributions will be invested in the LifePath Target Date Fund closest to your 65th birth date. You may change this default at any time you choose.

Company-matching contributions are invested in the same funds as those you select for your own contributions. Any income earned by each fund is reinvested in that fund.

Investment Fund Changes

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

Change future investments. If you do this, you maintain your investment mix for your current account balances, but change the mix for future contributions. Effective March 18, 2011, all future contributions for which you do not make a fund election are invested in a LifePath Target Date fund closest to your 65th birth date. To change this default, call the Service Center or log on to NetBenefits.

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 Short Term Investment Fund W. or to BrokerageLink®. These options compete with the Blended Interest Fund and are subject to a 3-month equity wash. Call the Savings Center for more information.

To change your investments, including transferring or redirecting future contributions, call the Service Center at 1-800-354-3427 or log on to Net Benefits. The changes you request will be effective at the end of that business day if you call before 3 p.m. Central Time (or the next business day, if your call is received after 3 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. Online 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 Savings and Investment Plan is intended to qualify as a 404(c) plan under Federal law. This means you will be given information about the investment options and about setting and achieving investment objectives, so that you can make sound investment decisions. Because you exercise control over the assets in your account and make investment decisions from a broad range of investment alternatives, plan fiduciaries will not be liable for any losses resulting from your control and investment decisions.

Loans — Contemporary Option

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

When you borrow money from the Plan, you are essentially borrowing from yourself. You even pay yourself interest. Your account balance is used as collateral for securing the amount of your loan. As soon as practicable, a loan origination fee of $5 and a loan maintenance fee of $2.50 each quarter 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?

You're eligible to take a loan from the Plan if you are an active, inactive or retired employee.

Applying for a Loan

To apply for a loan, call the Service Center at 1-800-354-3427 at Fidelity or log on to www.netbenefits.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 regular loan (6, 12, 18, 24, 30, 36, 42, 48, or 54 months, or 10 years for a mortgage loan), provided that your wages are sufficient to cover your loan amount. Your first repayment will occur the last payroll period following the month of application.

The 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. When you pay off your loan, you must wait 30 days before taking out a new loan.

Prepaying the Loan

Effective November 10, 2008, partial loan repayments are allowed. Call the Service Center at 1-800-354-3427 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.

Since your loan repayments are deducted from each paycheck, it's difficult to miss or default on repayments. However, if you are on unpaid leave, or if your wages aren't enough to cover the repayment amount, you may miss or default on repayments. You are required to keep your loan current so call the Service Center 1-800-354-3427 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, your loan will be defaulted and taxes and/or penalties will be due.

If You Leave the Company

If you terminate employment with the Company and its affiliates and subsidiaries for any reason with an outstanding loan balance and choose not to continue to repay the loan, the outstanding amount of your loan will be reported as a taxable distribution. You may make loan repayments through ACH. Contact the Service Center to obtain details.

Effective November 10, 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.

Early Withdrawals

To meet the objective of providing you with a substantial personal investment, the company encourages you to leave your account untouched for retirement - to grow in value for your future benefit. However, the company realizes you may need some of

your savings when certain situations arise. Taking a withdrawal from your account gives you limited access to your savings while you're an active employee.

Age 59 ½ In-Service Withdrawal

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

Hardship Withdrawals

You may also take a withdrawal from the Plan as an active Employee if you incur a hardship. A hardship means that you have an immediate financial need that cannot be met from any other resources, including a loan from the Plan. You must provide proof of the hardship to the record keeper, and to the IRS in the case of an audit.

When Hardship Withdrawals Can Be Made

Withdrawals of your pre-tax and Roth after tax contributions (not company match), from the Savings and Investment Plan may be made once in a 12-month period for:

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

How Hardship Withdrawals/Loans Are Withdrawn from Investment Funds

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

Taxes on Hardship Withdrawals

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

Distributions – Contemporary Option

You're always 100% vested in your pre-tax and Roth after-tax contributions to the Savings and Investment Plan account. Your company matching contributions are 100% vested if you have three years of credited company service. This means you have full ownership rights to your whole account. Your account may be distributed:

- When you terminate employment with the Company and its affiliates and subsidiaries for any reason, including retirement*
- If you die
- If the Plan is terminated
- Effective October 18, 2014, if you are a retired or terminated participant with a vested account balance of $1,000 or less, your account will be distributed to you in full. You will be notified by Fidelity Investments and provided your options prior to the distribution occurring.

**When you terminate employment with the Company and its affiliates and subsidiaries, you can generally choose when you want to receive payment of your account, subject to restrictions imposed by the Plan or the Internal Revenue Code (as discussed below).*

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

If your employment with the Company and its affiliates and subsidiaries terminates, you must contact the Service Center at Fidelity Investments to request one or more 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
- A specific period of time during which a reduced amount will be paid out and at the end of which your account balance will be zero
- A fixed percentage paid out every month until your account balance reaches zero

– Life Expectancy in which an amount will be paid out monthly based on your estimated life until your account balance reaches zero.
– A Minimum Required Distribution (MRD): This type of distribution is required by the Internal Revenue Code and is based on actuarial calculations. If you are an active Employee who reaches age 73 no MRD distribution will be made. If your employment with the Company and its affiliates and subsidiaries is terminated, once you reach 73, an annual MRD is required. You will be notified by Fidelity regarding the distribution.
– Unscheduled Distribution: A distribution any month. The amount you elect cannot be less than $1,000 or more frequent than once each month. Call the Service Center at 1-800-354-3427 for more information

Assignment of Benefits

Your benefits from the Savings and Investment 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 Savings and Investment Plan benefits, contact the Service Center at 1-800-354-3427.

Participants and beneficiaries may obtain, at no cost, a copy of the Plan'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 website and not materially altered - $300/each
– Manual review of one defined contribution plan mentioned in an order that was not generated on the QDRO website or was generated on the website, but materially altered - $1,200/each
– Manual review of a combination of any two or more defined contribution plans mentioned in an order - $1,800

Taxes

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

Here are a few general guidelines to help you understand how payments are usually taxed. This information is based on current laws and is subject to change. 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 possibly post-tax contributions with the implementation of the Roth, 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 Plan before you are 59½ years old. The tax is in addition to your regular income taxes on the payment. However, this tax does not apply in some cases. For example, it doesn't apply if you die, become disabled, or terminate employment, 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 your distribution is from Roth after-tax contributions, no income taxes will be owed at the time of distribution, if you satisfy the requirements discussed above.

If You Die

If you die before receiving your Plan 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 Plan's hierarchy. Contact Fidelity Investments 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 (and on Roth after-tax contributions and earnings if the requirements summarized above are not satisfied). Effective January 1, 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 Fidelity Investments.

Beneficiary Information — Contemporary 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. Contact the John Deere Savings & Retirement Service Center to add or change your beneficiary.

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

Situations Affecting Your Retirement Plans — Contemporary Option

The company's Pension Plan and Savings and Investment Plan are designed to provide you with retirement income. But there are situations that could affect your benefits. Some of these situations are listed here.

Funding for Retiree Medical Benefits

As a part of the pension trust, the Plan includes a funding mechanism that can be used by the company to help pay the cost of retiree medical benefits for an employee hired before April 1, 2000. For a description of medical benefits in retirement, see Medical Benefits in Retirement.

A Few Words About Taxes

Your benefit payments from this plan are subject to federal and certain state and local 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.

Top-Heavy Provisions

As required by law, alternate Plan provisions go into effect if the Plan becomes "top heavy." A plan is top heavy if more than 60% of accumulated benefits or 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 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 survivors' pensions. However, the PBGC does not guarantee all types of pensions, and the amount of protection is subject to certain limitations.

The Savings and Investment Plan is a "defined contribution" plan, which means the value of your account depends on the amount of contributions made and on gains and losses. Your SIP account is not insured by the PBGC.

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.

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.

The Savings and Investment Plan — Traditional Option

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.

The Savings and Investment Plan (SIP)—Traditional Option is an easy way to supplement the retirement income you may receive from the Pension Plan and Social Security. Generally, if you're an employee paid on the U.S. payroll, and you elected the Traditional Option in 1996, you may participate in the Traditional Plan. Enrollment in the Traditional plan after 1996 is prohibited.

You are eligible to participate in the Traditional Plan if you were hired before November 1, 1996, or if you elected this option in 1996. For employees of the former Commercial and Consumer Equipment Division, the effective date is July 16, 1996. Leased Workers are not eligible to participate. If you were not an employee on these dates, refer to the Contemporary Option. The Plan encourages you to save by providing you with a company match based on company profits, and allows you to defer pre-tax deferrals, after-tax deferrals or a combination of both.

Highlights — Traditional Option

Tax Advantages

The money contributed to the Plan on your behalf, including the matching contributions from the company, is deposited in your account on a pre-tax basis, Roth after-tax basis or a combination of both. Taxes are delayed on your pre-tax dollars until distributed from the Plan. Beginning in the spring of 2007, a Roth after-tax component was added to the Plan. Roth after-tax deferrals that satisfy certain requirements are distributed tax-free, along with earnings on those deferrals.

Your Plan Account

You can save from 1% to 75% of your eligible earnings, as limited by the IRS, in the Plan, on a pre-tax and/or Roth after-tax basis. The Company will match a portion of your contributions on a pre-tax basis. Your contributions and the company matching contributions are credited to an account in your name.

If you are age 50 or older as of December 31 of the calendar year, you are eligible to make catch-up contributions. The catch-up amount will be based upon your election as described above and will begin once you have reached the current year's IRS maximum.

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 paid directly to you or your beneficiary may be rolled over to an IRA or other qualified plan.

Eligibility and Enrollment — Traditional Option

Who's Eligible?

You're eligible to participate if you're an employee of Deere & Company or of an affiliate or subsidiary that adopts the Plan, and paid through the U.S. payroll system. Some salaried employees working for foreign branches or subsidiaries may also be eligible. For more information on eligibility, contact Deere Direct. You are eligible to participate in the Traditional Plan if you were hired before November 1, 1996, or if you elected this option in 1996. For employees of the former Commercial and Consumer Equipment Division, the effective date is July 16, 1996. Leased Workers are not eligible to participate.

Uniformed Services Employment and Reemployment Rights Act of 1994

An employee who left employment with the Company and immediately entered the service of the "Uniformed Services of the United States" will be considered as continuing to have been employed by the company; will be given an opportunity for "make-up contributions" in order to receive matching contributions; and service in the Uniformed Services of the United States will be credited towards service credit up to a maximum of 40 hours for each week for a maximum time period of five years, provided the employee has reemployment rights under applicable law and does become reemployed by the company under the provisions of that law.

Once re-employed by the Company, an eligible Employee who wishes to make-up missed contributions and receive the Company match on those contributions must make his or her missed contributions to the SIP during the period (following re-employment), that is no longer than three times his or her period of uniformed services, up to a maximum of five years following reemployment.

If an employee dies on or after January 1, 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.

Enrolling in the Plan

You cannot enroll in the Traditional Plan option. If your hire date is after October 31, 1996, or July 16, 1996, for former Commercial and Consumer Equipment Division employees, please see "Enrolling in the Plan" under Contemporary Option.

Naming a Beneficiary

Your beneficiary is the person you name to receive your Plan benefits if you die. Under current laws, if you're married, your Spouse is automatically your beneficiary. If you want to name someone other than or in addition to your Spouse, your Spouse must consent to your choice. Contact John Deere Savings & Retirement Service Center to add or change your beneficiary. If you ever want to change your beneficiary, your Spouse must again approve the change.

Contributions — Traditional Option

The Savings and Investment Plan — Traditional Option is designed around different types of contributions being made to each participant's account. Under the Plan, there are several types of contributions. Some of these are your matched deferral, your unmatched deferral; your company matching contribution, Roth deferrals, catch-up deferrals and rollover contributions.

Your Contributions

If you participate in the Savings and Investment Plan, you can contribute from 1% to 75% of your eligible earnings, as limited by the IRS, in whole percentages. This includes incentive pay and commissions. Not included as eligible earnings are incentive bonuses, Short-Term Incentive bonuses or Long Term Incentive Cash bonuses. If you are age 50 or older as of December 31 of the calendar year, you are eligible to make catch-up contributions.

The catch-up amount will be based upon your election as described above and will begin once you have reached the current year's IRS maximum. Log on to www.netbenefits.com or call the Service Center at 1-800-354-3427 for additional contribution and catch-up information.

Your SIP contributions can be made on a pre-tax basis, a Roth after-tax basis, or a combination of both. The deferrals are deducted from your paycheck and are deposited in your account at the end of the payroll period in which the deferral was made.

Effective January 1, 2005, you may elect to participate in the Automatic Increase Program (AIP). This program automatically increases your deferral by 1% each March 1. Of course, you are still able to make changes to your deferral percentage whenever you wish. Log onto NetBenefits or call the Service Center if you would like to participate in the AIP.

Effective April 2011, all future contributions for which you have not made an investment election are defaulted to the target date fund closest to your 65th birthdate. To change this default, contact the Savings Plan Service Center.
The contributions you can make:

- Your matched contributions. These are pre-tax and Roth after-tax contributions you make that are eligible for the company match. Your matched contributions are on the first 6% of your eligible earnings that you defer.
- Your unmatched contributions. These pre-tax and Roth after-tax contributions are also credited to your account, but they are not eligible for the company match. Your unmatched contributions are those that exceed the first 6% of your eligible earnings (as limited by the IRS).

Pre-tax Contributions

The Savings and Investment Plan lets you defer taxes by making pre-tax contributions. Here's how:

Normally, when you deposit money in a bank account or other savings vehicle, you have already paid taxes on those amounts. Under the SIP, however, your savings are deducted before taxes are applied—then the balance of your salary is taxed. Your savings aren't counted as part of your taxable income for federal and most state and local income taxes until you receive a distribution of your account. Social Security taxes are deducted on all your wages, even your pre-tax contributions.

Pre-tax contributions mean:
- Your Savings and Investment Plan contributions are not taxed immediately
- You pay less taxes on your wages

After-Tax Contributions

With the introduction of the Roth in March 2007, you are able to contribute employee contributions on an after-tax basis. You should check with your accountant or tax advisor to determine if Roth after-tax contributions are right for you.

After-tax contributions mean:
- Your Savings and Investment Plan contributions are taxed immediately and
- Upon distribution, no income taxes will be owed, as long as you have been making Roth contributions to the SIP for at least five years and the distribution is made on or after you reach age 59-1/2, after your death or on account of your disability.

Changing or Stopping Your Contributions

You can increase, decrease, or discontinue your contributions any pay period by calling the Service Center at 1-800-354-3427 or by logging on to NetBenefits www.netbenefits.com, any time. Your change will be effective the next payroll period after your change is received. If you stop contributing, you can re-enroll by calling the Service Center or by logging on to www.netbenefits.com.

Company Match — Traditional Option

The company match is a fixed rate on employee deferrals up to 6% of eligible earnings.

The company will match 10% of an employee's eligible earnings on the first 6% of an employee's contribution. The match will be tiered at 300% for the first 2% contributed and 100% for the next 4% contributed.

- Employee deferrals above 6% of eligible earnings are not eligible for the match.
- Effective for each pay period processed after July 20, 2014, a calculation will be performed to determine if a matching contribution is due. The calculation will take into account your year-to-date deferrals divided by the year-to-date eligible compensation to determine a year-to-date deferral rate. The year-to-date deferral rate shall be applied against the matching level provided by the eligible employee's employer to determine the required year-to-date matching contribution amount by the conclusion of the pay period, subject to IRS limits.
- If you were employed by more than one employer that has adopted the Plan in any calendar year, the matching contribution provided shall be based upon the matching level of the highest matching employer.

Vesting of the Company Match

You are always 100% vested in your contributions to the SIP and your company match contributions are always 100% vested and nonforfeitable.

Rollover Contributions — Traditional Option

If, before joining the company, you participated in a qualified savings plan (401(k), 457 or 403b plan), you may be able to roll over pre-tax contributions, Roth after-tax contributions, and earnings from your former plan into the Savings and Investment Plan. A rollover must be made within 60 days after you receive payment from the former plan.

You may want to take distribution from a previous employer because:
- SIP offers a more varied selection of funds
- You want to be able to access funds in the prior plan through a loan from the SIP
- Your previous employer requires distribution and you wish to continue to defer taxes on amounts (including earnings), previously deferred

When you roll over money to the Plan, a separate source is set up for your rollover contribution. You are not considered a plan participant until you start contributing to the Plan through salary deferrals. You are not eligible for company-matching contributions until you contribute pre-tax or Roth after-tax deferrals to the Plan.

Effective 1 November 2014, if you are no longer employed by the company and receive a lump sum distribution from the John Deere Pension Plan for Salaried Employees, you may roll that distribution into the Savings and Investment Plan.

Contact the Service Center at 1-800-354-3427, to find out whether a rollover is possible in your situation.

A note of caution: If you participated or continue to participate in another qualified plan, your combined contributions to the Plan and other qualified plans cannot exceed the current calendar year IRS maximum. It is your responsibility to keep Deere Direct advised of any and all deferrals outside of the Plan. If you exceed the IRS maximum, you will have to file an amended tax return.

Contribution Limits — Traditional Option

Limits: The Savings and Investment Plan is highly regulated and subject to Internal Revenue Code (IRC) provisions and regulations. Specific regulatory limits apply to the Savings and Investment Plan as well as other company benefit plans which provide pre-tax advantages. Employee participation in these plans, when combined, can have a compounding effect on some of the IRC limits. One limit restricts your combined pre-tax and Roth after-tax deferrals each calendar year ($23,000 in 2024). The limit on catch-up contributions for 2024 is $7,500. Total covered compensation is $330,000 in 2024.

Investment Choices — Traditional Option

You decide how your contributions are 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 1-800-354-3427 or log on to NetBenefits (www.netbenefits.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 of fer 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 G
- BTC LifePath® 2025 G
- BTC LifePath® 2030 G
- BTC LifePath® 2035 G
- BTC LifePath® 2040 G
- BTC LifePath® 2045 G
- BTC LifePath® 2050 G
- BTC LifePath® 2055 G
- BTC LifePath® 2060 G
- BTC LifePath® 2065 G

CHOICE 2

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

- S & P 500 Stock Index, Class F
- Small/Mid Stock Index, Class F
- International Stock Index, Class F
- U.S. TIPS Bond Index, Class F
- U.S. Bond Index, Class F
- Commodity Index, Class F
- Real Estate Index, Class F

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

CHOICE 3

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

- Fidelity® Growth Company Commingled Pool Class #3
- Boston Partners Large Cap Value Fund Share Class E
- QMA US Small Cap Core Equity Fund CL 4
- International Equity Fund
- U.S. Equity Fund
- Allspring Emerging Markets
- CIT-Allspring Enhanced Core Bond E2

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

You have the right to direct the SIP trustee concerning shareholder rights, such as the right to vote or tender, for shares attributable to the units of Deere & Company Common Stock Fund credited to your account.

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

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 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

When you contact Fidelity through NetBenefits or call the Service Center, you indicate

what percentage of your contributions you want to go into each investment option, using whole percentages.

Company-matching contributions are invested in the same funds as those you select for your own contributions. Any income earned by each fund is reinvested in that fund.

Investment Fund Changes

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

Change future investments: If you do this, you maintain your investment mix for your current account balances, but change the mix for future contributions. Effective March 18, 2011, all future contributions for which you do not make a fund election are invested in the LifePath Target Date fund closest to your 65th birth date. To change this default, call the Service Center or log on to NetBenefits.

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 Short Term Investment Fund W. or to BrokerageLink®. These options compete with the Blended Interest Fund and are subject to a 3-month equity wash. Call the Service Center for more information.

To change your investments, including transferring or redirecting future contributions, call the Service Center at 1-800-354-3427 or log on to Net Benefits at www.netbenefits.com. The changes you request will be effective at the end of that business day if you call before 3 p.m. Central Time (or the next business day, if your call is received after 3 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. Online 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.

Loans — Traditional Option

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

When you borrow money from the Plan, you are essentially borrowing from yourself. You even pay yourself interest. Your account balance is used as collateral for securing the amount of your loan. As soon as practicable, a loan origination fee of $5 and a loan maintenance fee of $2.50 each quarter 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?

You're eligible to take a loan from the Plan if you are an active, inactive or retired employee.

Applying for a Loan

To apply for a loan, call the Service Center at 1-800-354-3427 at Fidelity or log on to www.netbenefits.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), provided that your wages are sufficient to cover your loan amount. Your first repayment will occur the last payroll period following the month of application.

The 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. When you pay off your loan, you must wait 30 days before taking out a new loan.

Prepaying the Loan

Effective November 10, 2008, you may make partial loan repayments. Call the Service Center at 1-800-354-3427 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.

Since your loan repayments are deducted from each paycheck, it's difficult to miss or default on repayments. However, if you are on unpaid leave, or if your wages aren't enough to cover the repayment amount, you may miss or default on repayments. You are required to keep your loan current so call the Service Center at 1-800-354-3427 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.

If You Leave the Company

If you terminate employment with the Company and its affiliates and subsidiaries for any reason with an outstanding loan balance and choose not to continue to repay the loan, the outstanding amount of your loan will be reported as a taxable distribution. You may make loan repayments through ACH.

Contact the Service Center to obtain details. Effective November 10, 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.

Early Withdrawals

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

Age 59½ In-Service Withdrawal

If you are an active employee and have reached age 59½, you may elect to take distribution of your vested account balance. Call the Service Center for more information at 1-800-354-3427.

Hardship Withdrawals

You may also take a withdrawal from the SIP as an active Employee if you incur a hardship. A hardship means that you have an immediate financial need that cannot be met from any other resources, including a loan from the Plan. You must provide proof of the hardship to the record keeper, and to the IRS in the case of an audit.

When Hardship Withdrawals Can Be Made

Withdrawals of your pre-tax and Roth after-tax contributions (not company match), from the Savings and Investment Plan may be made once in a 12-month period for:

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

How Hardship Withdrawals/Loans Are Withdrawn from Investment Funds

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

Taxes on Hardship Withdrawals

Financial hardship withdrawals are subject to ordinary income tax. If you take a hardship withdrawal before age 59½, you also may owe a 10% early payment penalty on the amount of your withdrawal. Be sure to check with a tax advisor before taking a hardship withdrawal.

Distributions — Traditional Option

You're always 100% vested in your pre-tax and Roth after-tax contributions to the Savings and Investment Plan account. Your company matching contributions are also

100% vested. This means you have full ownership rights to your whole account. Your account may be distributed:

- When you terminate employment with the Company and its affiliates and subsidiaries for any reason, including retirement
- If you die
- If the Plan is terminated
- Effective October 18, 2014, if you are a retired or terminated participant with a vested account balance of $1,000 or less, your account will be distributed to you in full. You will be notified by Fidelity Investments and provided your options prior to distribution occurring.

** When you terminate employment with the Company and its affiliates and subsidiaries, you can generally choose when you want to receive payment of your account, subject to restrictions imposed by the SIP or the Internal Revenue Code (as discussed below).*

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

If your employment with the Company and its affiliates and subsidiaries terminates, you must contact the Service Center at Fidelity Investments to request one or more 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
- A specific period of time during which a reduced amount will be paid out and at the end of which your account balance will be zero
- A fixed percentage paid out every month until your account balance reaches zero
- Life Expectancy in which an amount will be paid out over your estimated life until your account balance reaches zero
- A Minimum Required Distribution (MRD): This type of distribution is required by the Internal Revenue Code and is based on actuarial calculations. If you are an active Employee who reaches age 73 no MRD distribution will be made. If your employment with the Company and its affiliates and subsidiaries is terminated, once you reach 73, an annual MRD is required. You will be notified by Fidelity regarding the distribution.
- Unscheduled Distribution: A distribution any month. The amount you elect cannot be less than $1,000 or more frequent than once each month. Call the Service Center at 1-800-354-3427 for more information.

Assignment of Benefits

Your benefits from the Savings and Investment 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 Savings and Investment Plan benefits, contact the Service Center 1-800-354-3427.

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 website and not materially altered - $300 each.
- Manual review of one defined contribution plan mentioned in an order that was not generated on the QDRO Web site or was generated on the website, but materially altered - $1,200 each.
- Manual review of a combination of any two or more defined contribution plans mentioned in an order - $1,800.

Taxes

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

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

General Tax Treatments

Since your account balance is made up of pre-tax contributions and possibly post-tax contributions with the implementation of the Roth, 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 Plan before you are 59½ years old. The tax is in addition to your regular income taxes on the payment. However, this tax does not apply in some cases. For example, it doesn't apply if you die, become disabled, or terminate employment, 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 your distribution is from Roth after-tax contributions, no income taxes will be owed at the time of distribution, if you satisfy the requirements discussed above.

If You Die

If you die before receiving your Plan 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 Plan's hierarchy. Contact Fidelity Investments 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 (and on Roth after-tax contributions and earnings if the requirements summarized above are not satisfied). Effective January 1, 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 Fidelity Investments.

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. Contact Fidelity Investments to add or change your beneficiary.

If you ever want to change your beneficiary, your Spouse must again approve the change. To name your beneficiary, contact Fidelity Investments.

Situations Affecting Your Retirement Plans

Your benefit Plan and Savings and Investment Plan are designed to provide you with retirement income. But there are situations that could affect your benefits. Some of these situations are listed here.

Funding for Retiree Medical Benefits

As a part of the pension trust, the Plan includes a funding mechanism that can be used by the company to help pay the cost of retiree medical benefits for an employee hired before April 1, 2000. For a description of medical benefits in retirement, see Medical Benefits in Retirement.

A Few Words About Taxes

Your benefit payments from this plan are subject to federal and certain state and local 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.

Top-Heavy Provisions

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

The Pension Benefit Guaranty Corporation (PBGC)

The 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 survivors' pensions. However, the PBGC does not guarantee

all types of pensions, and the amount of protection is subject to certain limitations.

The Savings and Investment Plan is a "defined contribution" plan, which means the value of your account depends on the amount of contributions made and on gains and losses. Your SIP account is not insured by the PBGC.

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.

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.

My Stock Purchase Plan Quick Links

Stock Purchase Plan

Company Ownership

Participating in the Stock Purchase Plan means you are a shareholder of Deere & Company. Stock ownership gives you a direct stake in the future success of the Company.

Whether you make a small or large investment in the company, the Stock Purchase Plan helps simplify the process and makes stock ownership easy.

Participating in the Plan

If you're an active employee of the company, you may elect to participate in the Plan by enrolling through Fidelity Investments.

Your Plan Account

When you participate, you may contribute from 1% to 15% of your salary through after-tax payroll deductions. Your contributions are used to buy Deere & Company common stock, which is credited to an account for you.

Know the Risks and the Benefits

Owning stock isn't for everyone. There are both benefits and risks. Before you invest, read this chapter and the stock prospectus carefully.

Participation

Eligibility and Cost

Who's Eligible?

You're eligible to participate in the Stock Purchase Plan if you are an active salaried employee residing within the United States and paid on the U.S. payroll of Deere & Company or of an affiliate or subsidiary that adopts the Plan.

Deciding Whether to Participate

Participation in the Stock Purchase Plan is completely voluntary. Before you enroll, you need to consider the benefits and risks of stock ownership.

Stock gives you a partial-ownership interest in Deere & Company, and a financial stake in our company. However, stock ownership involves some risk. The value of the stock can go up—but it can also go down.

You should consider buying stock in the company only after thinking about your total financial situation. Before deciding whether or how much to invest, it's important to consider, among other things:

- Your total income
- Your expenses
- Your level of savings

– What might happen if you have an investment loss
– Other investments you may have

Enrolling in the Plan
To enroll in the Plan, contact Fidelity Investments. Your participation is effective the next pay period after you contact Fidelity Investments.

Plan Cost
The company pays the administrative costs of the Plan, including broker commissions for stock purchases. However, you are responsible for paying any delivery and/or selling expenses.

When Your Participation Ends
You stop participating in the Plan if:

– You request to end your participation by contacting Fidelity Investments
– Your employment ends for any reason
– You no longer reside within the United States
– You become disabled
– You die

Contributions
The Stock Purchase Plan uses your contributions to purchase stock for your account.

Your Contributions
If you decide to participate in the Stock Purchase Plan, you can contribute from 1% to 15% of your annual salary. Your contributions are taken after taxes are applied. Contributions are deducted from each paycheck.

Changing or Stopping Your Contributions
You can increase, decrease, or stop your contributions to the Stock Purchase Plan any time by contacting Fidelity Investments. Your change will go into effect the next payroll period after you contact Fidelity Investments.

Stock Transactions

Buying Stock
Each pay period, Deere forwards your contributions to the broker. The broker then purchases whole shares of stock on behalf of each participant, and credits the stock to each participant's account.

Proof of Ownership
The stock bought by the broker is credited to your account. However, the shares are held in the broker's name until you request otherwise. There are two ways you can prove ownership of the stock in your account:

– You can request stock certificates from the broker at any time. When you request certificates, the stock is transferred to your name.
– The quarterly statements you receive from the broker are evidence of your ownership.
– When you request certificates, you're responsible for paying the broker's charge for delivery and certification. There is a charge per certificate. You can receive a certificate only for whole shares of stock in your account.

Stock Price
The price for each share is the average price of all purchases made for the Plan on the day the shares are purchased.

Working with Your Broker
When you elect to participate, you establish a normal broker/client relationship working with Fidelity at 1-800-354-3427. The company is completely uninvolved in this relationship, except to the extent that the company wires money and pays administrative fees and broker commission for stock purchases.

If you conduct stock transactions other than with Deere & Company stock, these transactions are outside the Plan. You are responsible for paying all associated fees for these transactions.

John Deere reserves the right to change, suspend, or end any relationship with a brokerage firm at any time. If this happens, your Stock Purchase Plan account would be transferred to a new broker. You'll be notified if the broker changes.

Account Statements
The broker will provide you with quarterly statements of your account. The statement will list any transactions made on your behalf. These statements serve as evidence of your ownership of shares until certificates are issued. It is your responsibility to keep all your statements. The company does not maintain records and the broker may charge a fee for lost statements.

Staying Informed
Stock prices often fluctuate. So, while your quarterly reports give you a good summary of your stock value each quarter, they don't give you a detailed look at what happened during the quarter.

It's important for you to manage your Stock Purchase Plan account. Deere & Company stock is publicly traded on the New York Stock Exchange. You can monitor market prices and fluctuations by reading the stock reports in your newspaper (listed as "Deere").

Stockholder Reports and Voting Rights

As a participant in the Stock Purchase Plan, you will receive annual reports, quarterly reports, proxy statements, and other materials the company sends to its stockholders. These materials are provided to you at no charge.

As a company shareholder, you have the same voting rights as any other shareholder. You will be informed of any meetings and you may vote by proxy.

Selling Stock

You may sell the full and/or fractional shares in your account at any time. Selling shares doesn't affect your Plan participation in any way.

To sell shares notify Fidelity at 1-800-354-3427 of your intent. When the shares are sold, the broker will mail you a check from the sale, minus commission and fees.

Taxes and Plan Status

The Stock Purchase Plan is not intended to qualify for special tax treatment under Section 423 of the Internal Revenue Code of 1986, as amended. Nor is it intended to qualify for tax exemption under Section 401(a) of the Internal Revenue Code. It is also not subject to any of the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

This information is designed to give you a summary of the general federal income tax effects of purchasing stock through the Stock Purchase Plan and selling this stock later. Different tax consequences may result from different circumstances (for example, if you give your stock to another person).

Tax laws are complicated and subject to change. State and local taxes also may apply, and the rules governing such taxes may vary from federal income tax rules. If you're not a U.S. taxpayer, the tax effects of your participation in the Plan will be determined by the taxing jurisdiction or jurisdictions to which you are subject.

You purchase the stock with money that's already been taxed, so you owe no additional taxes when your stock is purchased. You will owe taxes on any dividends, or any other income produced by the stock. Also, when you sell or otherwise dispose of stock purchased through the Stock Purchase Plan, any appreciation will be taxed as capital gains on your federal income tax return.

Your actual income tax consequences depend upon your individual circumstances. You should always consult with a qualified tax advisor about your own unique case.

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 Administration Information section.

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 SPD, 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.

My Work-Life Programs Quick Links

Work-Life Programs

When You Need Some Time Off

Your Holidays and Time Off Plan provides two kinds of time off with pay. For certain family and medical situations, you may take an unpaid family leave.

Time Off for Rest and Relaxation

You have time off for holidays and vacation based on your continuous employment. You may be able to buy vacation days.

Holidays

The company provides time off with pay as follows:

New Year's Day
Martin Luther King Jr. Birthday
Good Friday
Memorial Day
Independence Day
Labor Day
Veterans Day
Thanksgiving Day
Friday After Thanksgiving Day
Christmas Eve Day
Christmas Day
New Year's Eve Day

In some years, an extra paid holiday is provided. Check the online holiday schedule for floating holidays.

In addition, at some locations, the company discontinues operations on the three workdays between Christmas and New Year's Holidays. You will be paid your regular rate of pay for these days. If you are required to work at locations where operations are discontinued for these three Christmas shutdown days, you will be given a corresponding amount of time off at a later date during the same fiscal year.

At John Deere Financial Services the three work days between Christmas and New Year's Holidays are not paid holidays, but the company provides three Personal Elected Holidays (PEH) during each full calendar year for full-time employees.

For new hires, the number of days in the year hired will be prorated based on the date of hire.

Holiday Pay

- Exempt employees: You will receive your regular pay on holidays.
- Nonexempt employees: You receive regular straight-time pay plus the appropriate shift premium if you are a second- or third-shift employee. If you are required to work on a holiday, you will be paid double time for hours worked, in addition to your regular pay.

Vacation

You accrue vacation days based on your years of continuous employment with the Company. You are eligible for vacation days on the anniversary of your starting date with the company in your last period of continuous employment. See the vacation schedule for more details.

The 12-month period starting on your anniversary date is called your anniversary year.

This vacation policy does not apply to designated Regular Part-Time Students, Seasonal, or Temporary employees.

Scheduling Vacation Time

Scheduling a vacation should be discussed with your immediate supervisor. Every attempt will be made to schedule vacation in accordance with your interests, but your supervisor is responsible for making sure that vacations don't interfere with daily operations of your unit. If a number of employees request the same period of time off, the employees with the longest service will have first consideration.

In special circumstances, you may be allowed to take your regular vacation just before the end of your anniversary year and to take your next year's vacation just after your next anniversary year begins. However, unused vacation time cannot be carried over into your next anniversary year unless you are eligible to defer vacation. (See "Special Features" below.)

Special Features

Three special features of the John Deere Vacation Policy are the opportunities to buy, defer or retrieve vacation days. Your eligibility to buy, defer or retrieve vacation days depends on the number of days of vacation you earned at the start of your anniversary year.

A few general guidelines apply:

- Vacation can be scheduled in full or less than one day increments.
- The number of days you earn, plus the number of days you can buy cannot exceed 25 days.
- When you buy, defer or retrieve vacation days, they must be in whole day increments.
- When you buy vacation, the price is based on your pay in the first full pay period after your election is recorded.

Buying Vacation

Here are the guidelines for buying one to five vacation days:

- The vacation days you buy, combined with your earned vacation, cannot be more than 25 days.
- You may only purchase one to five days of vacation per anniversary year but only once at any time during that year.
- Your cost for buying vacation days is deducted from your remaining paychecks in your anniversary year in equal amounts. The deductions are taken on an after-tax basis.
- If you elect to purchase vacation days, you must use those days or lose them. The purchased vacation days cannot be sold. Vacation days must be purchased in whole day increments.

Deferred Vacation

You may elect to defer vacation days if you have 25 or more days of vacation at the start of your anniversary year.

Here are the guidelines:

- You must take (or lose), your first 15 days of vacation during your anniversary year.
- You may elect to defer from one to 10 whole days of vacation any time during your anniversary year, but only once during that year.
- Your accumulated deferred vacation may not exceed 130 days if hired prior to July 1, 1993. Employees hired on or after July 1, 1993, can defer up to a maximum of 50 vacation days.

Retrieving Deferred Vacation

Once a year, you may retrieve from one (1) to 10 deferred vacation days during an anniversary year.

Here are the guidelines for retrieving your deferred vacation:

- Retrieved vacation days must be in whole-day increments and consist of days which were deferred in a previous anniversary year.
- If you are unable to take any vacation days that you retrieve, you can defer them again to your vacation bank during your anniversary year.
- Deferring previously retrieved days does not affect your eligibility to defer other days in your current anniversary year; however, you are still limited to a total of 130 or 50 accumulated deferred vacation days, depending on your date of hire.

If You Take a Leave of Absence

If you are on a formal leave of absence, your vacation time in the anniversary year following your return from the leave will be reduced by 1/24 for each full pay period you were on leave. However, the number of days will never be reduced to less than five. You should contact Deere Direct for details regarding a reduction of vacation time due to a formal leave of absence.

Part-time Employment Employees participating in the Part-time Employment Program (PEP) earned vacation pro-rata based on scheduled work percentage. An employee will earn vacation days for the next anniversary year based on the scheduled work percentage this anniversary year.

Vacation accrual for subsequent qualification years shall be determined for PEP employees on the same basis as regular full-time employees.

Buy, defer, and retrieve rules apply on the same basis as regular full-time employees. These elections must be made in whole day increments based on scheduled work percentage.

Employees moving from full-time employment to PEP may take all earned vacation into PEP. If in PEP, the employee is scheduled to work 40% schedule, vacation available is number of days carried into PEP at 40% pay. Remaining 60% of days carried into PEP can be sold or deferred per the vacation policy at any time in the anniversary year, or at the end of the anniversary year, the remaining days will be paid by the company. If the employee returns to full-time employment before the end of the anniversary year, the unused days can be used or deferred per the vacation policy.

If You Leave the Company

If your employment ends for any reason, you (or your beneficiary), will receive pay for any unused vacation days. In addition, you (or your beneficiary), will be eligible for a pro-rata vacation payment of 1/24 of your regular anniversary year vacation for each pay period between your last anniversary date and the date you retire, leave the company, or die.

If you go on long-term disability, your period of salary continuance (prior to your long-term disability), will be considered as active employment. Once you begin receiving long-term disability payments, you will not accrue additional vacation time.

10 - A&T Sales/Marketing

17 - Construction

18 - JD Power Systems

28 - JD Construction Equipment - Overseas

2V - Waratah - Atlanta

79 - John Deere Financial

9A - John Deere Financial - Madison

90 - WWHQ

A8 - JD Seeding Valley City

DW - Davenport Works

DY - Parts

E - Ottumwa

FF - Kernersville

GX - Greeneville (John Deere Power Products)

H - Harvester/Seeding

JL - JD Paton

LV - Augusta

M - Horicon

MI - SEEC

N - Des Moines Works

NA - JD ISG - Torrance

PC - JD ISG - Urbandale

PH - John Deere Electronic Solutions - Fargo

R - Waterloo Works

RE - Production Engineering Center, Waterloo

RF - Waterloo Foundry

RG - Waterloo Engine

SE - John Deere Reman Springfield

T - Dubuque Works

T8 - Thibodaux

TC - Turf Care

YK - John Deere Performance Upgrade

YZ - John Deere Coffeyville

Deere & Company U.S. Units With Vacation Benefits

Years of Continued Service as of Last Anniversary Date	Salary Hired prior to July 1, 1993 (Not available to Unit Transfers or LV)*	Salary Hired after July 1, 1993 For the following units: 10, 17, 18, 28, 2V, 79, 9A, 90, A8, AN, DW, DY, E, FF, GX, H, JL, LV, M, MI, N, NA, PC, PH, R, RE, RF, RG, SB, SE, T, T8 TC, YK, YZ
2 months	10	10
1	10	10
2	15	10
3	18	13
4	18	13
5	18	15
6	19	16
7	20	17
8	21	18
9	22	19
10	23	20
11	23	20
12	24	21
13	24	21
14	25	22
15	25	22
16	26	23
17	26	23
18-19	27	24
20-21	28	25
22-23	29	25
24-25	30	25
26-27	31	25
28-29	32	25
30-36	33	25
37-38	34	25
39-40	35	25
41-42	36	25
43-44	37	25
45 and up	38	25

UNIT CODES

10 - A8 - JD Seeding Valley City

GX - Greeneville (John Deere Power Products)

JL - JD Paton

LV - Augusta

PH - John Deere Electronic Solutions - Fargo

SE - John Deere Reman Springfield

TC - Turf Care

Note: Employees in the John Deere Part Time Employment Program (PEP) will accrue PTO on a prorated basis based on the PEP contractual work percentage multiplied by the appropriate PTO earned hour's amount from the table above.
For example: A full-time employee with less than five years of service, in PTO Option #1, who is paid semi-monthly begins working part time for 30 hours (75%) per week. The employee's PTO accrual rate would be .75 multiplied by 5.0000 PTO hours per pay period, which equals 3.7500 PTO hours earned per pay period.

**Generally applies to employees hired prior to July 1, 1993 at certain units*

Paid Time Off (PTO)

Paid Time Off applies to salary employees of Greeneville and John Deere Paton. Certain Part-time, Temporary, and Seasonal employees are not eligible for PTO.

Greenville Vacation and PTO
January 1, 2024

Employees Hired Prior to January 1, 2017				
GX PTO	GX Vacation	GX Vacation &PTO	GX Vacation (hired on or after Jan 1, 2017)**	
			Years of Service	Core Days
3	4	7	0-6 months	5
3	9	12	1	10
3	11	14	2	10
4	12	17	3	13
5	12	17	4	13
5	13	18	5	15
5	14	19	6	16
5	15	20	7	17
5	15	20	8	18
5	16	21	9	19
5	17	22	10	20
5	18	23	11	20
5	19	24	12	21
5	19	24	13	21
5	20	25	14	22
5	20	25	15	22
5	21	26	16	23
5	21	26	17	23
5	21	26	18	24
5	22	27	19	24
			20	25

* GX Vacation - Pre 10/2014 hire must work 1,560 (75%) straight-time hours in prior year. Below that level will be prorated on a 2,080 basis

40 Hours of vacation used each year for shutdown

Paid Time Off (PTO)

John Deere Paton

Hours Worked August 1, 2023 - August 1, 2024	PTO Hours
1401 and Over	25
1000 - 1400	10
0 - 999	0

Can be used in 2 hour increments or greater

Hours remaining August 1, 2024 are paid out

Scheduling Paid Time Off (PTO)
Scheduling time off should be discussed with your immediate supervisor. Every attempt will be made to schedule paid time off in accordance with your interests, but your supervisor is responsible for making sure that absences don't interfere with daily operations of your unit. If a number of employees request the same period of time off, the employees with the longest service will have first consideration.

PTO Guidelines:
- PTO is earned each worked pay period based on your scheduled work percentage and is not available for use until the next pay period.
- PTO can be used for short-term disabilities including illnesses and accidents during the 14 consecutive calendar day waiting period (7 consecutive calendar day waiting period for wage employees at JD Paton and wage employees at JD Reman).
- Any PTO accrual over the maximum hours, determined by each individual Unit's schedule is forfeited.
- PTO is to be used for approved absences, vacations, personal days, and sick leave. Holidays are provided to all and are not part of PTO.
- You cannot buy PTO hours.
- Some units will allow you to sell PTO hours under certain circumstances.
- You may use PTO in increments (hours or days), approved by your Unit.

If You Take a Leave of Absence
If you are on a formal leave of absence, no further accrual of paid time off will occur. You should contact Deere Direct for more details regarding a formal leave of absence.

Part-time Employment
You will earn PTO hours based on your scheduled hours worked percentage and pro-rata to the PTO schedule.

If You Leave the Company
If your employment ends for any reason, you (or your beneficiary), will receive pay for any unused PTO hours.

If you go on long-term disability, your period of short-term disability (prior to your long-term disability), will be considered as active employment. Once you begin receiving long-term disability payments, you will not accrue additional PTO hours.

Taking a Family and Medical Leave

Eligibility
You are eligible for a leave of absence under the Family and Medical Leave Act of 1993, as amended ("FMLA"), if you are a full-time or part-time employee who has worked for Deere & Company for at least 12 months and who worked at least 1,250 hours during the year prior to the start of an FMLA leave.

You may take up to 12 work weeks of FMLA leave in a rolling 12-month period for one of the reasons listed below.

In addition, you may be able to take up to 26 work weeks in a single 12-month period to care for a covered member of the Armed Forces with a serious injury or illness. Please contact John Deere Disability and Leave Services for more information about this type of FMLA leave.

Reasons for an FMLA Leave
You may take an FMLA leave for one or more of the following reasons:

- For the birth or adoption of a child, or for foster care; or
- To care for a family member with a serious health condition. A "family member" for purposes of an FMLA leave includes your child, spouse, or parent (or an individual who acted as your parent when you were a child).
- An individual can be considered the same as your child for purposes of an FMLA leave if you act as a parent for that individual and have day-to-day responsibility for caring for that individual; for example, the individual may include your grandchild or the child of your domestic partner; or
- Your own serious health condition, if you are unable to perform the functions of your position (the leave is coordinated with the Company's Salary Continuance and Personal & Compelling policies); or
- For a qualifying military exigency (defined below).

What Is a "Serious Health Condition"?
A "serious health condition" for purposes of an FMLA leave involves inpatient care in a hospital, hospice, or residential medical-care facility, or continuing treatment by a health-care provider.

If inpatient care is not required, a serious health condition must involve continuing treatment or supervision by a health care provider where:

- The condition requires an absence of more than three days from work, school, or other regular daily activities; or
- The condition is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three days; or
- The treatment is for prenatal care.

"Continuing treatment" requires that your ill family member be treated by (or under orders of), a health-care provider two or more times for the injury or illness or that the person be under continuing supervision for a chronic condition or disability that cannot be cured.

For FMLA leaves, an eligible health-care provider could be a doctor of medicine, an osteopathic doctor, a podiatrist, a dentist, a clinical psychologist, an optometrist, a chiropractor (for certain conditions), a nurse practitioner or nurse midwife, or certain Christian Scientist practitioners.

What is a Qualifying Military Exigency?

A qualifying military exigency is an urgent need arising out of the fact that your family member is on active military duty or has been notified of an impending call or order to active duty in support of military operations. Qualifying military exigencies include:

- Leave to deal with issues arising from a covered military member's short-notice deployment
- Military events and related activities, such as official ceremonies, programs, or events sponsored by the military
- Family support for assistance programs and informational briefings that are related to the active duty or call to active duty status of a covered military member
- Qualifying childcare and school activities arising from the active duty or call to active duty status of a covered military member
- Attending counseling provided by someone other than a health care provider, the need for which arises from the active duty or call to active duty status of a covered military member
- Rest and recuperation leave of up to five days to spend time with a covered military member who is on short-term, temporary, rest and recuperation leave during the period of deployment
- Attending certain post-deployment activities within 90 days of the termination of the covered military member's duty
- Additional activities that arise out of the covered military member's active duty or call to active duty status

When Leave May Be Taken

FMLA leave for birth or adoption (including foster-care placement), must end within 12 months of the birth, adoption, or placement.

FMLA leave for a family member's serious health condition may be taken:

- In one period
- On an intermittent or reduced-schedule leave, if medically necessary. "Intermittent" means you would take your FMLA leave in blocks of time. An intermittent leave might be medically necessary, for example, if your family member is undergoing chemotherapy treatment. A "reduced" schedule means your normal daily hours would be reduced. This might be medically necessary, for example, if your spouse is recovering from surgery and requires care.
- You may also take an intermittent FMLA leave for the birth, placement for adoption, or foster care of a child. In these cases, however, you will need Company approval.

If you need to take an intermittent or reduced schedule FMLA leave, the Company may transfer you temporarily to an alternate position, provided the position has equivalent pay and benefits and better accommodates your schedule.

If You and Your Spouse Work for Deere

If you and your spouse both work for Deere, you are both entitled to take an FMLA leave for the same reason. The reason for the FMLA leave determines the length of leave you are entitled to:

- Combined total (between you and your spouse), of 12 weeks—for the birth or placement for adoption or foster care of a child, or to care for a parent who has a serious health condition
- Separate 12 weeks for each of you—to care for a child or spouse who has a serious health condition or for your own serious health condition

Using Paid Time for an FMLA Leave

Generally, an FMLA leave is unpaid. However, some of the reasons for which you could take FMLA leave are also qualifying events for other Company plans, which pay you during the period of absence.

For example, if you are absent for your own maternity, the period of recovery following the birth of the child is considered a disability. You would be paid during this period of absence through the salary continuance program. However, the period you are paid will also reduce the period of unpaid FMLA leave you could take.

If you have an excused personal and compelling absence to care for a family member, it can be considered part of the 12-week FMLA leave period.

Continuation of Benefits

During an approved FMLA leave, you continue to accrue service credit as long as you are credited with at least 500 hours worked during the anniversary year in which the FMLA leave occurs and you return to employment following the FMLA leave.

FMLA leave does not affect your vesting in the Pension Plan or Savings and Investment Plan. Your contributions to the Savings and Investment Plan and Stock Purchase Plan are suspended, unless your salary is being continued.

When you take an FMLA leave, your health care benefits (the Medical Plan, Dental Plan and Limited Purpose Health Care Flexible Spending Account), continue.

If your FMLA leave is six weeks or less, your pre-tax contributions are placed in arrears. If your FMLA leave is longer than six weeks, you may pay your contribution through direct billing from the John Deere Benefits Center.

You may drop your health care coverage during your period of FMLA leave. When you return to active employment, the coverage you had before the FMLA leave will resume.

Vacation eligibility is reduced in the next anniversary year based on the number of weeks you were on FMLA leave. If you inform the Company that you do not intend to return to work or if you do not return to work when your FMLA leave ends, your benefits will end. If you fail to return to work without a satisfactory reason at the expiration of the FMLA leave, you will be obligated to reimburse the Company the full

cost of premiums paid for the continuation of health care coverage. You may elect to continue your health care benefits, as described in Administrative Information.

Returning to Work

When you return from an FMLA leave, you will be restored to your job or to an "equivalent" job. An equivalent job has the same pay, benefits, and other employment terms and conditions.

Key Employees

Certain highly-paid key employees may not be reinstated to their jobs after an FMLA leave, if reinstatement would cause substantial and grievous economic injury to the Company. In order for the Company to deny reinstatement, the Company must:

- Notify the employee of his or her status as a "key" employee when FMLA leave is requested
- Notify the employee as soon as the Company decides to deny job restoration, and explain the reasons for this decision
- Offer the employee a reasonable opportunity to return to work from FMLA leave after giving this notice

A "key" employee is a salaried eligible employee who is among the highest paid 10% of employees within 75 miles of the work site.

Certification Requirements

Contact John Deere Disability and Leave Services to request a FMLA leave. When you request an FMLA leave, you may be required to provide:

- 30 days advance notice when an FMLA leave is foreseeable
- Medical certification supporting the need for an FMLA leave due to a serious health condition affecting a family member
- Second or third medical opinions and periodic recertification, at the Company's expense
- Periodic reports during your FMLA leave regarding your status and your intent to return to work
- When an FMLA leave is needed to care for a family member, you must attempt to schedule treatment so it will not unduly disrupt the Company's operations

Your Right to an FMLA Leave

Under recent government rules and regulations, the Company may not interfere with, restrain, or deny you the opportunity to exercise your right to take an FMLA leave. Also, you cannot be discharged or discriminated against for inquiring about or requesting an FMLA leave. For more information on FMLA leaves, contact John Deere Disability and Leave Services.

If You Want to Continue Your Education

A mutual benefit is received by you and by the Company when you choose to upgrade your professional skills or acquire critical new business competencies through additional formal education. The Tuition Assistance Plan will reimburse you up to 100% for tuition and eligible fees for accredited college or university courses.

Additional education may help you meet the changing demands of your current position and help you prepare for potential future jobs. The company benefits from your additional skills and competencies as well.

Continuing education covered by this plan will have a direct relationship to the development of knowledge and competencies required by the Company. The ultimate result must align with company business objectives. For example, the Plan does not cover courses directed to a degree in physical education. However, the Plan does cover a physical education course required to complete a Bachelor's degree in a field related to our business, such as Accounting.

The Tuition Assistance Plan will reimburse you for tuition and certain fees for approved courses.

Eligibility

Full-time, part-time employees (PEP), and part-time students at U.S. units are eligible to participate in the Tuition Assistance Plan for approved courses starting on or after date of hire unless listed as exclusions in the policy statement.

Intern employees, are immediately eligible for the Plan on the date of hire. Summer courses starting in the year of hire/return, and completed during year of the internship period, are eligible.

Employees on educational or other leave of absence are not eligible, nor are Intern employees while on leave of absence.

Approved Schools and Courses

Credit for regular, extension, correspondence, and e-learning courses offered by accredited and approved colleges and universities are covered if required for an approved degree plan. Not approved for Tuition Assistance Plan coverage are business seminars, workshops, and professional or technical certification programs. These types of programs are considered as "cost of doing business" and are paid directly by the Department or Business Unit.

Administration

Upon completion and submittal of documentation, 100% payment of tuition and eligible fees, up to the annual cap, is made to the employee. Successful completion of a course is a grade of C- or better. Contact the John Deere Benefits Center at 844-689-7833 or log on to the benefit portal at www.yourbenefitsresources.com/deere for more information.

Taxability of Tuition Payments
Graduate and Undergraduate level coursework is excluded from taxation up to $5,250 per year.

What's Not Covered by the Tuition Assistance Plan?
Some services and supplies are not covered by the Tuition Assistance Plan. Excluded expenses include, but are not limited to:

- Meals and lodging
- Computer use, parking, late payment fees
- Examination fees
- Transportation costs
- Cost of tuition that is reimbursed through scholarships, grants, GI Benefits, etc.

Annual Tuition Payment Caps
Annual Tuition Payment Caps apply to all participants. The annual cap is $7,500 for undergraduate degrees and $15,000 for advanced degrees. For information on your cap, contact John Deere Benefits Center at 844-689-7833.

If You Want to Purchase John Deere Consumer Equipment
You may buy certain John Deere consumer equipment and receive a discount at time of purchase.

Eligibility
Active employees, retirees, and surviving spouses of any U.S. or Canadian unit of Deere & Company (as well as any subsidiary or affiliate of the Company that has adopted the Plan), are eligible participants for this discount.

What Products Are Eligible for a Discount

You may receive a purchase discount on any John Deere consumer equipment listed on the John Deere Employee Purchase Plan guidelines. These rules apply:

- Only new products purchased are eligible.
- Only products/model years listed in the guidelines are eligible.
- The products must be purchased new from a John Deere dealer.
- Products must be for the purchaser's personal household use or personal farm.
- Products must not be traded or resold within six months of purchase.

How to Get the Discount Voucher
Go to www.Deere.com/EPP to apply for an EPP voucher via John Deere Rewards before visiting a John Deere dealer. For more information on the EPP program go to the Life Balance and Flex @Work page of Your World at Deere from JD Online.

Employee Purchase and Supplier Discount Programs
Access additional details On Your World at Deere under Life Balance and Flex @ Work.

- Vehicle Purchase Programs
  - General Motors, Ford, BMW, FCA Chrysler
- Cell Phone Discounts
  - Verizon and AT&T
- Stihl Equipment Rebate Program
- Hotel Discount Programs
  - Doubletree, Hilton, IHG, Drury, Choice Hotels, Best Western
- Computers and Equipment Purchase Programs
  - Hewlitt Packard, Dell, and Microsoft Office
- Car Rental
  - Enterprise/National, Hertz
- Office Depot / Office Max Office Products
- Liberty Safe Rebate Program
- Mi-T-M Rebate Program
- Dry Cleaning Services at certain locations
- John Deere Store Employee Discount

Voluntary Discount Benefits
- Identity Theft Protection
  - Discounted rates through LifeLock
  - Access information on to the benefit portal at www.yourbenefitsresources.com/deere on the Other Benefits tab
- Discounted Pet Insurance Pet insurance is available as a voluntary benefit through FIGO.
  - This benefit is being offered at a 10% discount for active employees.
  - You can obtain more information and enroll in coverage by going to the Other Benefits page from the benefit portal at www.yourbenefitsresources.com/deere.
  - You may enroll in coverage and make changes at any time. Employees will be responsible for the full premium through a direct billing process established at the time of enrollment.

Adoption and Surrogacy Reimbursement
To support you and your growing family, John Deere offers adoption and surrogacy reimbursement of qualified expenses up to a lifetime maximum of $30,000.

This does not include the adoption of a child or grandchild of a spouse or domestic partner. This benefit applies to all full-time salary employees (Excl. Part-Time Employment Program employees, Interns, Inpats, and PT Students).

Parental Leave

The Company provides time off to care for, and bond with, a child after a birth or adoption. Up to eight weeks of parental leave will be paid to eligible employees based on work percentage. The leave can be taken at one time, or in full week increments, for up to one year after a birth or adoption. Parental leave will run concurrently with the Family Medical Leave Act. Contact John Deere Disability and Leave Services to request Paid Parental Leave by calling 855-232-0815. Select the appropriate option if you need to talk to the John Deere Benefit Coordinator regarding the benefit or a claim issue. Part-time Students, interns, and Inpats are not eligible for this benefit.

Paid Caregiver Leave

The company provides two weeks per calendar year of paid time off from job duties to care for a family member (spouse, domestic partner, children, parents, siblings, and father in-law or mother-in-law) who has a serious health condition.

Fitness Reimbursement

With this benefit, employees receive up to $150 annually for maintaining a healthy lifestyle. The following types of expenses are eligible for reimbursement: fitness center membership, online fitness program or subscriptions, fitness classes, registration fees for running events, personal trainer fees, at-home exercise equipment, and activity trackers. Expenses are reimbursable only for the year they are incurred and can be submitted on the benefit portal at www.yourbenefitsresources/deere by accessing the reimbursement page from the menu on the home page. You have until March 31 of the following year to submit your expenses. Part-Time Students and Inpats are not eligible for this benefit.

Emotional Wellbeing Solutions your Employee Assistance Program (EAP)

The Emotional Wellbeing Solutions Employee Assistance Program will provide you and your family the help you need to get though life's challenging moments. The program provides up to eight free counseling visits per issue per year for everyone in your household. There is no charge to you or your dependents, and confidential support is available 24 hours a day, seven days a week. Call toll-free 888-533-7311 or visit liveandworkwell.com, using access code: DEERE. Part-Time Students are not eligible for this benefit.

Weight Watchers Subsidy

Weight Watchers will help you establish weight loss goals and a plan to achieve these goals. Visit weightwatchers.com/us/johndeere to enroll. The company will pay 50% of the Weight Watchers membership for employees who enroll in the program. This program is not available to your dependents, and the company subsidy will be taxable income in your paycheck. You will need to provide your RACF ID at the time you enroll to receive the company subsidy. Part-Time Students and Inpats are not eligible for this benefit.

My Resources

Contact List

Ask HR: ..... 1-844-901-4762 or access AskHR.Deere.com

Deere Direct: ..... 1-888-432-3373 or email DeereDirect@JohnDeere.com

John Deere Savings &
Retirement Service Center (Fidelity): ..... 1-800-354-3427 | NetBenefits.com

UnitedHealthcare: 1-888-JDEERE1 (1-888-533-3731)

John Deere Disability and Leave Services 1-855-232-0815

Securian Financial 1-877-494-1034

John Deere Benefit Center ..... 1-844-689-7833 | www.yourbenefitsresources.com/deere

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 you legal rights under a federal law called the Employee Retirement Income Security Act of 1974 as amended (ERISA).

An Important Note

This document summarizes the key features of plans, programs, and certain payroll policies available to salaried employees of Deere & Company. 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.

Plan Administration

Employer Identification Number

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

Employer

The employer whose employees are covered by these plans is:

Deere & Company
One John Deere Place
Moline, Illinois 61265-8098
(309) 765-8000

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 61265-8098
(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 plan options described in this summary plan description.

UnitedHealthcare
PO Box 740800
Atlanta, GA 30374-0800
1-888-JDEERE1 (1-888-533-3731)

The John Deere Benefits Center is the claims administrator for the Retiree Medical Credits described in this summary plan description.

Legal process may also be served on plan trustees, where applicable. See Additional Administrative Facts section for information regarding any plan trustee and principal place of business.

Plan Sponsor

The Plan Sponsor is Deere & Company.

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 Employee Benefits, One John Deere Place, Moline, Illinois 61265-8098.

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

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.

Claims Process

Deere & Company has delegated to UnitedHealthcare the Plan's Claims Administrator obligation 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 Claims 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 may call the Claims Administrator at the number on your ID card before requesting a formal appeal.

If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file appeal as described below. 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 Claims 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 time frames.

If you wish to appeal a denied pre-service request for benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination.

You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card
- the provider's name
- the date of medical service
- the reason you disagree with the denial
- any documentation or other written information to support your request

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare – Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for benefits that have been denied, you or your provider can call the Claims Administrator at the toll-free number on your ID card to request an appeal.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for benefits: a request for benefits provided in connection with Urgent Care services, as defined in Definitions
- Pre-Service request for benefits: a request for benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided
- Post-Service: a claim for reimbursement of the cost of non-Urgent Care that has already been provided

Urgent Care Claims

You will be notified of the claim decision no later than 72 hours after receipt of the claim, if you provide sufficient information to determine whether and to what extent benefits are payable under the Plan.

If additional information is needed to evaluate the claim, you will be notified within 24 hours after receipt of the claim regarding what information is needed to decide the claim.

You will have a reasonable amount of time, but not less than 48 hours, to provide the specified information. After you provide the additional information, you will be notified of the claim decision within 24 hours of receipt of this additional information

If the Claims Administrator denies your request for benefits, you must appeal an adverse benefit determination no later than 180 days after receiving the adverse benefit determination. The Claims Administrator must notify you of the appeal decision within 72 hours after receiving the appeal.

**You do not need to submit Urgent Care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an Urgent Care request for benefits.*

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

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for benefits and decided according to the time frames described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service time frames, whichever applies.

Pre-Service Claims

If the initial request for benefits is complete you will be notified of the claim decision within 15 calendar days after receipt of the claim.

If you or your authorized representative does 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 five days following the failure.

If your request for benefits is incomplete 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 receipt of the additional information (if the initial request for benefits is incomplete).

A "pre-service" claim is a claim for a benefit for which prior authorization or approval is required by the Plan.

Post-Service Claims

If the initial request for benefits is complete, you will be notified of the claim denial within 30 calendar days after receipt of the claim. If your request for Benefits is incomplete and additional information is needed to make a claim decision, you will be advised of the specific information needed 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 receipt of the additional information (if the initial claim is incomplete).

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
- In case of a claim denial involving urgent care, you will receive an explanation of the expedited review process
- If the Claims 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 Claims 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 Claims 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 Claims 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 Claims 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 three 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 48 hours of receipt of 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
- 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

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the External Review Program. This program only applies if the adverse benefit determination is based on:

- clinical reasons
- the exclusions for Experimental or Investigational Services or Unproven Services
- rescission of coverage (coverage that was cancelled or discontinued retroactively)
- as otherwise required by applicable law

This External Review Program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if the Claims Administrator fails to respond to your appeal in accordance with applicable regulations.

If the above conditions are satisfied, you may request an independent review of the adverse benefit determination. Neither you nor the Claims Administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by UnitedHealthcare and has no material affiliation or interest with the Claims Administrator or Deere & Company. UnitedHealthcare will choose the IRO based on a rotating list of appropriately accredited IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable time frames of the Claims Administrator's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records
- all other documents relied upon by the Claims Administrator in making a decision on the case
- all other information or evidence that you or your Physician has already submitted to the Claims Administrator

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and the Claims Administrator will include it with the documents forwarded to the IRO.

A decision will be made within applicable time frames. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and the Claims Administrator with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

Disability Claims (Including Disability Claims Under the Pension Plans)

If a Disability Claim Is Denied

If a disability claim is denied, the Plan Administrator or its delegate will notify you of the claim denial no later than 45 days after receiving the claim. The 45-day period may be extended for up to 30 days if the Plan Administrator or its delegate (1) determines the extension is necessary because of matters beyond the Plan's control, and (2) notifies you, before the end of the 45-day period, why the extension is needed and the expected decision date.

If the Plan Administrator or its delegate determines, before the end of the 30-day extension, that due to matters beyond the Plan's control a decision cannot be made within the extension period, the Plan Administrator or its delegate may extend the determination period for up to an additional 30 days. However, the Plan Administrator or its delegate must notify you why the extension is necessary and what the expected decision date is before the end of the first 30-day extension period.

The extension notice will explain (1) the standards on which benefit entitlement is based; (2) the unresolved issues that prevent a claim decision; and (3) any additional information needed. You will have at least 45 days to provide any additional information needed.

If your claim is denied in whole or in part, you will be notified of the claim decision. This notification will be provided in a culturally and linguistically appropriate manner (including oral language services and upon request a notice in any applicable non-English language, and will include:

- The specific reason(s) for denial
- Reference to the specific Plan provisions on which the denial is based
- A description of any additional material and/or information necessary for you to perfect the claim and an explanation of why that information is necessary
- A description of the Plan's review procedures, the applicable time limits for such procedures, and your rights to bring a civil action under ERISA Section 502(a) following an appeal denial
- If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request; and
- Either the specific internal rules, guidelines, protocol standards or other similar criteria of the Plan relied upon in making the adverse determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
- A discussion of the decision including an explanation of the basis for disagreeing with or not following:
  - The views that you presented to the Plan presented by health care professionals treating you and vocational professionals who evaluated you,
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
  - A disability determination made on your behalf by the Social Security Administration, presented by you to the Plan.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals

You or your authorized representative may appeal a denied claim within 180 days after receipt of a claim denial notice.

During the 180-day period, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim, and you may request copies free of charge. You may submit written comments, documents, records, and other information relating to the claim to the Plan Administrator or its delegate.

Review of your appeal shall take into account all comments, documents, records, and other information, without regard to whether such information was submitted or considered in the initial claim decision. The review of your claim denial will not defer to the initial determination made by the Plan Administrator or its delegate. The individual who will review your appeal will be independent from the individual who reviewed your claim.

If your appeal involves a medical judgment, the Plan Administrator or its delegate will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be an individual who was neither consulted in connection with the claim decision nor the subordinate of any such individual.

Before an adverse determination on appeal is issued, the Plan Administrator or its delegate will provide you free of charge with any new or additional evidence considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you.

Before an adverse determination on appeal is issued based on a new or additional rationale, the Plan Administrator or its delegate will provide you free of charge with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you.

If your appeal is denied, the Plan Administrator or its delegate will provide written notification of its decision to you. The Plan Administrator or its delegate will notify you within 45 days after the appeal is received by the Plan Administrator or its delegate (or within 90 days if the Plan Administrator or its delegate determines special circumstances require an extension of time for considering the appeal, and if written notice of such extension and circumstances is given to you within the initial 45 day period).

If your appeal is denied, you will receive a notification in a culturally and linguistically appropriate manner (including oral language services and upon request a notice in any applicable non-English language) that includes:

- The specific reason(s) for the decision
- Reference to the specific Plan provision(s) on which the decision 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) and a description of any contractual limitations period applicable to your right to bring such action, including the calendar date on which such contractual limitations period expires for the claim
- If the adverse benefit determination was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms on the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request ; and
- Either the specific internal rules, guidelines, protocol standards or other similar criteria of the Plan relied upon in making the adverse determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
- A discussion of the decision including an explanation of the basis for disagreeing with or not following:
  - The views that you presented to the Plan presented by health care professionals treating you and vocational professionals who evaluated you,
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
  - A disability determination made on your behalf by the Social Security Administration, presented by you to the Plan.

Contractual Limitations Period

You must exhaust the Plan's administrative claims and appeals procedures before bringing suit in either state or federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination. Any claim or suit must be filed within 24 months after, the earliest of (1) the date the first benefit payment was made or due; (2) the date the Plan Administrator or its delegate first denied your request; or (3) the first date you knew or should have known the principal facts on which your claim or action is based; provided, however, that, if you commence the Plan's claims and appeals procedure before the expiration of the 24 month period, the period for commencing the claim or action in court expires on the later of the end of the 24 month period and the date that is three months after you have exhausted the Plan's claims and appeals procedures. If you raise a claim or commence on action after expiration of the 24 month period (or, if applicable, expiration of the three period following exhaustion of the Plan's claims and appeals procedures), the claim or action will be time-barred.

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 their delegates 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.

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
- Request an opportunity to review all relevant documents relating to your claim
- 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 time-barred. 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.

Funding of Retiree Medical Benefits – VEBA

The Company has established a Voluntary Employees' Beneficiary Association (VEBA) as of 25 February 2004. This VEBA, as defined and regulated according to section 501(c) (9) of the Internal Revenue Code of 1986, serves as a vehicle for providing retiree medical benefits to retired salaried employees and to retired wage employees whose employment with the Company was not governed by collective bargaining agreements between the Company and employee representatives.

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.

Rights & Privacy Notice

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
  - 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.

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
- Bona fide medical research and education

Pension Benefit Statement

You have the right to ask for and receive an annual statement of your pension benefit. This statement must tell you whether or not you have a right to receive a pension benefit at normal retirement age (age 65). If you do have the right to a benefit, the statement must tell you what your benefit would be at age 65 if you stop working under the Plan now.

If you don't have a right to a pension, the statement will tell you how many more years you must work to earn the right to a pension.

Log onto the Retirement Service Center at www.netbenefits.com call the John Deere Pension Benefits Center at 800-354-3427 to receive your pension benefit statement. The Plan is only required to provide the statement once a year.

Pension Benefit Guaranty Corporation (PBGC)

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

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

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the Plan terminates; (3) benefits that are not vested

because you have not worked long enough for the Firm; (4) benefits for which you have not met all of the requirements at the time the Plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security), that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

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

For more information about the PBGC and the benefits it guarantees, ask the Benefit Administration Committee or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the Federal relay service toll-free at 1-800-377-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at http://www.pbgc.gov.

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 as amended (ERISA). Benefits not listed in the "Additional Administrative Facts" chart, such as the Stock Purchase Plan, Salary Continuance Plan, Dependent Care Flexible Spending Account, Dependent Care Flexible Spending Account, Vacations and Holiday Plan, John Deere Employee Purchase Plan for John Deere Consumer Equipment, and Tuition Assistance 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. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 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 an 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.

Health Information 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.

Protecting the privacy and confidentiality of your protected health information is very important to us. This Notice explains the privacy practices of the John Deere Health Benefit Plan and it should answer questions about how we handle your protected health information. "Protected health information" includes any individually identifiable health 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. In general, the John Deere Health Benefit Plan does not handle protected health information. Such information is handled by our third party administrator, UnitedHeathcare.

Permitted Uses and Disclosures of Your Health Information

To continue to provide quality health benefits and service to you, we may need to use and disclose certain information about you. For your convenience, the following information describes the ways that we may use and disclose your protected health information. For each category of disclosures, we will explain what is meant and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

1. Treatment: We may use or disclose protected health information about you for 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 may need to know health care information in plan files that might assist in treatment.

2. Payment Functions: We may use or disclose protected health information about you 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 might include information that identifies you, as well as your diagnosis, procedures and supplies used.

3. Health Care Operations: We may use and disclose protected health information about you to support functions necessary for insurance and other health care related activities. For example, such activities may include quality assurance activities, case management, receiving and responding to complaints, physician reviews, compliance programs, audits, business planning, development, management and general administration.

4. Health Oversight Activities: We may disclose protected health 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. For example, we may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or conduct post-marketing surveillance.

5. Required by Law: As required by law, we may use and disclose your protected health information. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action. We may disclose your protected health information in the course of any administrative or judicial proceeding.

6. Public Health: As required by law, we may disclose your protected health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

7. Law Enforcement: We may disclose your protected health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes or to the appropriate correctional institution or law enforcement official, in the case of inmates that in custody.

8. Coroners, Medical Examiners and Funeral Directors: We may disclose your protected health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person or determine the cause of death.

9. Organ and Tissue Donation: We may disclose your protected health information to organizations involved in procuring, banking or transplanting organs and tissues, as necessary.

10. Public Safety: We may disclose your protected health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or

safety of a particular person or the general public.

11. National Security: We may disclose your protected health information for military, national security, prisoner and government benefits purposes.

12. Worker's Compensation: We may disclose your protected health information as necessary to comply with worker's compensation or similar laws.

13. Marketing: We may contact you to give you information about health-related benefits and services that may be of interest to you.

14. Disclosures to Plan Sponsors: We may disclose your protected health information to the sponsor of the Plan, for purposes of administering benefits under the Plan.

Disclosure:

- to family member or friend who is involved in participant's medical care or helps pay for care to extent participant agrees or fails to object when given opportunity
- to entity authorized by law or charter to assist in disaster relief efforts to extent necessary to assist in relief effort
- for research purposes pursuant to 45 CFR section 164.512(i)
- to Business Associates
- to government authority is belief that participant has been victim of abuse, neglect, domestic violence as required by law or if participant agrees

When Are We Not Permitted to Use or Disclose Your Health Information

Except as described in this Health Information Privacy Notice, we will not use or disclose your protected health information without written authorization from you. If you do authorize us to use or disclose your protected health information for another purpose, you may revoke your authorization in writing at any time.

If you revoke your authorization, we will no longer be able to use or disclose protected health information about you for the reasons covered in your written authorization. However, any disclosures made with your permission prior to your written revocation will remain in place.

Statement of Your Protected Health Information Rights

1. Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your protected health information. However, we are not required to agree to your request. If you would like to make a request for restrictions, you may do so by calling the customer service phone number listed on the back of your health care identification card.

2. Right to Request Confidential Communications: You have the right to receive your protected health information through a reasonable alternative means or at an alternative location if you feel that the disclosure of your protected health information could endanger you. To request confidential or alternative communications, call the customer service phone number listed on the back of your health care identification card. We are not required to agree to your request.

3. Right to Inspect and Copy: You have the right to inspect and copy protected health information about you, except for psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. To inspect and copy such information, call the customer service phone number listed on the back of your health care identification card or your health care provider.

4. Right to Request Amendment: You have a right to request that your protected health information be amended, if you believe it is incorrect or incomplete. We are not required to change your protected health information. If your request is denied, we will provide you with information about our denial. This information will include what you are entitled to do about the denial, including your right to submit a statement of disagreement. To request an amendment, you must call the customer service
phone number listed on the back of your health care identification card or your health care provider.

5. Right to Accounting of Disclosures: You have the right to receive a list or "accounting of disclosures" of your protected health information made by us, except that we do not have to account for disclosures made for purposes of payment functions or health care operations, or made to you. To request this accounting of disclosures, you must call the customer service phone number listed on the back of your health care identification card. You may request an accounting of disclosures for a period of up to six years. You may not include dates before April 14, 2005.

6. Right to Paper Copy: You have a right to receive a paper copy of this Health Information Privacy Notice at any time. To obtain a paper copy of this Notice, call Deere Direct at 1-888-432-3373. You may also obtain a copy of this Notice in the benefits directory at: http://jdo.deere.com/en-us/hr/benefits/Pages/Home.aspx.

Changes to this Notice of Privacy Practices

We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We reserve the right to amend this Health Information Privacy Notice at any time in the future and to make the new Notice provisions effective for all protected health information that is maintained. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, except as required by law, we are required to comply with the current version of this Notice.

Complaints

Complaints about this Health Information Privacy Notice or about how we handle your protected health information should be directed to Deere Direct at 1-888-432-3373. You may also direct inquiries or complaints to the Privacy Manager, Deere & Company, Office of Corporate Compliance, One John Deere Place, Moline IL 61265-8098; or e-mail PrivacyManager@JohnDeere.com.

The company will not retaliate against you in any way for filing a complaint. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the United States Department of Health and Human Services within 180 days of the unauthorized disclosure.

Further Information

You need not respond to this Notice. If you have questions about this notice, please call Deere Direct at 1-888-432-3373. This Notice is provided to employee and retiree participants for the benefit of themselves and their dependents.

Grandfather Health Plan Notice

The Company believes some of the medical benefit packages or options provided to employees by the Plan are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your medical benefits package or option may not include certain consumer protections of the Affordable Care Act that apply to other packages or options, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential health benefits. The Company communicates whether a medical benefit package is considered grandfathered annually prior to open enrollment.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at Deere & Company, One John Deere Place, Moline, IL 61265, 1-309-765-8000.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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 Flexible Benefits Plan: – Salary reduction for medical and dental options – Flexible spending account for health care expenses	541	Flex Benefits	Deere & Company One John Deere Place Moline, IL 61265	Employee. With your approval, the company reduces your salary for the contributions you make.	November 1 - October 31
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	Company makes contributions to a trust fund	Company makes contributions to a trust fund
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	Company and employee. The company pays its portion of the benefits on a self-insured basis except for the expat plan, which is an insured arrangement where the company pays an agreed-upon premium.	November 1 - October 31
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 400 Robert St. North, St. Paul, MN 55101	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.	November 1 - October 31
John Deere Pension Plan for Salaried Employees	001	Defined benefit	The Bank of New York Mellon 135 Santilli Highway Everett, MA 02149	Company makes contributions to a trust fund; payments are determined by actuaries in amounts judged sufficient to meet expected benefit obligations of the Plan.	November 1 - October 31
John Deere Savings and Investment Plan	003	Defined contribution	Fidelity Management Trust Company 82 Devonshire Street, ZR1 Boston, MA 02109	Company and employee	November 1 - October 31

Benefits Acronym List

- Accidental Death and Dismemberment (AD&D)
- Automated Clearing House (ACH)
- Automatic Increase Program (AIP)
- Children's Health Insurance Program (CHIP)
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Defined Contribution Restoration Plan (DCRP)
- Department of Labor (DOL)
- Employee Retirement Income Security Act of 1974 (ERISA)
- Explanation of Benefits (EOB)
- Family and Medical Leave Act of 1933 (FMLA)
- Health Savings Account (HSA)
- High Deductible Health Plan (HDHP)
- Individual Retirement Account (IRA)
- Internal Revenue Code (IRC)
- Long-Term Disability (LTD)
- Managed Care Organization (MCO)
- Minimum Required Distribution (MRD)
- Paid Time Off (PTO)
- Part-time Employment Program (PEP)
- Pension Benefit Guaranty Corporation (PBGC)
- Personal Elected Holidays (PEH)
- Personal No Pay (PNP)
- Qualified Domestic Relations Order (QDRO)
- Registered Nurse (RN)
- Savings and Investment Plan (SIP)
- Short-Term Disability (STD)
- Short-Term Incentive Plan (STI)
- Third Party Administrator (TPA)
- Unemployment Compensation Disability Law (UCD)
- Uniformed Services Employment and Reemployment Rights (USERRA)
- United Healthcare (UHC)
- Voluntary Employees' Beneficiary Association (VEBA)
- Women's Health and Cancer Rights Act of 1998 (WHCRA)

Glossary

A

Accrued benefit — Cash Balance
Your accrued Pension Plan benefit is the benefit you have earned, based on eligible earnings, pay and interest credits. This is also referred to as Total Cash Balance Account.

Accrued benefit — Contemporary Option
Your accrued Pension Plan benefit is the benefit you have earned, based on service credit and career average earnings at any given time.

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.

Additional foundry service credit
A special type of service credit you can earn if you worked in certain foundry jobs. In general, you receive a year of additional foundry service credit for every five years of service in a foundry. To qualify, you must have worked in one of the following positions at least 25 weeks in the anniversary year for which the service would be credited.

Your position must have:

- Been classified under an "A" occupational code, or you must have been in a direct supervisory position, supervising such employees;
- Been classified as a direct supervisor in melting, coremaking, molding, or cleaning-finishing occupational areas; or
- Required you to work at least 85% of your regular workday in one of the occupational areas listed above.

You will not receive additional foundry service credit if you worked either outside the foundry or in an enclosed area within the foundry.

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.

Anniversary date
The annual anniversary of the date you first report to work in your most recent period of employment with the company.

Anniversary year
The 12-month period starting on your anniversary date.

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.

Annual salary — Contemporary Option
See Career Average Earnings — Contemporary Option.

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

Average assets
This is the sum of the company's month-end asset balances with Federal Services on the equity basis for the period from October to October excluding November divided by twelve months.

B

Basis of coverage date
Your salary rate as of this date is used to determine your group and optional life insurance coverage. For group and optional life insurance, the basis of coverage date is your date of hire and each subsequent October 1. For optional life insurance, the basis of coverage date is October 1.

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

Career average earnings — Contemporary Option
The total of all eligible earnings divided by the number of months, in which those earnings were received from work for the company.

Eligible earnings are direct pay, short-term incentive bonuses, commissions and most other pay for work performed and paid time-off. It does not include long term incentive cash bonuses.

If you had at least five years of continuous employment as of 1 January 1997, your career average earnings will be the average of your earnings from the past five years and all your future earnings until you retire. Bonuses that you received from 1992 through 1996 will be totaled, then added into your career average earnings over the next five years at the rate of 1/120th per pay period while an eligible employee.

Christmas shutdown
The three workdays between Christmas and New Year's holiday. At some locations, the company discontinues operations during this time.

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%.

Covered Health Services
Those health services and supplies that are provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

Credit Course
A course taken for credit at a fully approved and accredited institution, college or university that is part of a curriculum that improves skills or results in acquisition of critical business competencies.

Continuous Employment
Your employment period starting on the date you last began work with any unit of Deere & Company, including its domestic and foreign subsidiaries.

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.

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

Dependent Care Flexible Savings Account
This is a tax effective way to pay for eligible Dependent Care expenses. If you choose to participate, you contribute pre-tax dollars to the account. You pay eligible expenses and then request reimbursement from your account.

Disability rate for COBRA
150% of the full continuation rate.

E

Eligible Earnings - Cash Balance
Eligible earnings are direct pay, short-term incentive bonuses, commissions and most other pay for work performed and paid time-off. It does not include long term incentive cash bonuses.

Employee
Individuals, including salaried workers employed by the company and paid on the U.S. payroll of the company. The term does not mean individuals who are employed through a temporary employment agency or a leasing company, who are on a personal services contract, or who are represented by a collective bargaining unit.

Employee Net Premiums
The amount withheld each pay period from employees pay for medical & dental benefits on a pre-tax basis.

Evidence of Insurability
A medical questionnaire to be completed by the employee to prove insurability for the employee and/or dependents when required by the Plan.

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.

Full Continuation Rate

The full price of medical and/or dental coverage plus a 2% administrative fee.

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 John Deere flexible benefits.

Health Savings Account (HSA)

The trust or account established by an Employee in accordance with the provisions of Internal Revenue Code section 223(d) for the reimbursement of qualified medical expenses.

High deductible health plan (HDHP)

A type of health plan defined under Internal Revenue Code section 223 and regulated by the Internal Revenue Service to allow its participants to contribute to a health savings account (HSA).

I

Interest Credits

Beginning of fiscal year Total Cash Balance Account multiplied by Interest Crediting Rate.

Interest Crediting Rate

Rate used to calculate Interest Credit. Rate is tied to 30-year Treasury yield.

L

Leased workers

A person who is not on the US base pay system of the company and who performs services pursuant to an agreement between the company and a leasing organization shall be considered a "leased worker" if such person performed the services on a substantially full-time basis and under the primary direction or control of the company.

Leased workers are not eligible to participate in any Deere & Company or any of its subsidiaries or affiliates Plan or benefit whether listed in this SPD or not, as long as the person continues to be a leased worker.

Limited Purpose Health Care Flexible Spending Account

This is a tax effective way to pay for out-of-pocket eligible covered and non-covered vision and dental expenses. If you choose to participate, you contribute pre-tax dollars to the account. You pay eligible expenses and then request reimbursement from your account to cover your costs. You are only participating if you are making contributions to your account. You can only claim reimbursement for expenses while you are participating by making contributions.

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.

Loss

For purposes of Accidental Death & Dismemberment insurance, the severance at or above the wrist or ankle, and/or the complete and irrevocable loss of sight.

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-credit Course

A course, workshop, program or seminar that is taken where no college or university credit is given. Non-credit courses should enhance an employee's professional skills or assist in the acquisition of critical business competencies. Courses in this category are considered as "cost of doing business" and are not covered by the Tuition Assistance Plan.

Non-formulary

Brand-name drugs which are not listed on the formulary list by the Plan or its TPA/MCO.

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).

Pay Credits
Pay Credit Rate multiplied by Eligible Earnings - Cash Balance.

Pay Credit Rate
Rate used to calculate Pay Credit. Current rate is 4%.

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)
- 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 TDSP is the 401(k) Benefits Committee, Deere & Company, One John Deere Place, Moline, Illinois 61265, (309) 765-8000.

The Plan Administrator for the John Deere Pension Plan for Wage Employees is the Pension Benefits Committee, Deere & Company, One John Deere Place, Moline, Illinois 61265, (309) 765-8000.

The Plan Administrator for the remaining plans is Deere & Company, One John Deere Place, Moline, IL 61265, (309) 765-8000.

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.

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

Pre-tax Dollars
You pay for medical and dental coverage with money that is deducted from your pay before federal, Social Security, Medicare, and state taxes (except in Pennsylvania), are taken out. Contributions to the flexible spending accounts are also made with pre-tax dollars. Paying with pre-tax dollars means you may pay less in taxes.

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.

Profit Percentage
The profit percentage applicable to any payroll period is measured as a return on average assets (ROA) determined by dividing the profits of the company by the average assets for the fiscal year. Some SBUs or Divisions use ROE.

Profits
This means, for any fiscal year of the company, the total net income of the company and all of its consolidated and unconsolidated subsidiaries, computed on a consolidated basis in conformity with generally accepted accounting principles, but before deducting salary and wage profit sharing payments and applicable federal, foreign, state and local income taxes, applicable bonus payments, contributions under the John Deere Savings and Investment Plan and the John Deere Stock Purchase Plan, extraordinary gains or losses, changes in accounting as defined by generally accepted accounting principles, and federal, foreign, state and local income taxes for those extraordinary gains or losses or changes.

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.

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.

Redetermination Date
The date used each year (January 1) to refigure optional life insurance premiums, based on your age as of that date and your salary rate as of the basis of coverage date.

Residential or Outpatient Substance Abuse Facility
A facility that provides detoxification and rehabilitation services for the treatment of substance abuse and has been approved by a Third Party Administrator (TPA). To be covered by the Health Benefit Plan, services for inpatient substance abuse must be provided at a hospital or an approved residential substance abuse facility.

Restoration
The repair and reconstruction of natural teeth, including fillings and crowns.

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.

Retiree Medical Credit or RMC
The amount or credit determined and contributed by the company to an eligible retiree's account for reimbursement of qualified medical expenses. Pursuant to a Health Reimbursement Arrangement solely established and contributed to by the employer, that meets Internal Revenue Service Notice 2002-45 and related Internal Revenue Service guidance.

S

Salary (Pension — Contemporary Option)
See Career Average Earnings — Contemporary Option.

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.

Service Credit
If you earn at least 500 hours worked in any anniversary year, you receive a year of Service Credit that's credited on your next anniversary date. Service Credit is used by the Pension Plan to determine the amount of your pension benefit (Traditional and Contemporary), and your eligibility for Plan benefits (Traditional, Contemporary and Cash Balance).

You do not receive Service Credit:

- When you earn less than 500 hours worked in any anniversary year
- After you retire
- When your employment with the Company and its affiliates and subsidiaries ends for any reason
- When you fail to return from a leave of absence
- After you die
- If you become totally and permanently disabled, after attaining five years of Service Credit following salary continuance, and receive Long-Term Disability benefits, you continue to earn Service Credit, which is credited to you at normal or early retirement. If you return to work, your Service Credit continues unbroken. You also receive credit for partial years of service (earned), after 1976 when you retire or terminate employment prior to the last day of your anniversary year. This is based on the ratio of the number of hours with which you were credited in the anniversary year over 2,080 hours.

Hours worked: In general, salaried employee hours are not counted using a timecard system. Therefore, we use equivalencies to count hours based on the payroll period applicable to salaried employees, who are paid on a semi-monthly basis. In general, semi-monthly paid employees receive 95 hours for each pay period they work at least one hour for the company.

A monthly equivalency of 190 hours is used for salaried employees to determine partial year benefit accrual for participants who retire or terminate employment prior to the end of their anniversary year.

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
Effective 1 January 2016, "Spouse" means 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

Tuition Assistance Plan
The company tuition payment or reimbursement policy for employees who choose to upgrade professional skills or acquire critical business competencies through enrolling in approved college or university credit courses for degree-related programs.

V

Vacation Deferral
The election to bank vacation until a later date, such as a future anniversary year, retirement, or termination of employment.

Vested — Cash Balance
Means you have 100% ownership rights to your accrued pension benefit. Your pension benefit is vested once you have at least three years of service credit or if you are employed by the company or any affiliate when you reach normal retirement age.

Vested — Contemporary 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 fully vested in your contributions made to the Savings and Investment Plan. The company matching contributions to the Savings and Investment Plan are fully vested when you have 3 years of service credit with the company.

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.

Y

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