Health Reimbursement Arrangement (HRA) Plan for Pre-Medicare Salaried Retirees Who Were Hired or Rehired PRIOR to June 1, 2001

Summary Plan Description
Effective: January 1, 2023

This document is your Summary Plan Description for the Salaried Health Reimbursement Arrangement (HRA) Plan for Pre-Medicare Retirees (the Plan) for purposes of the Employee Retirement Income Security Act of 1974.

Contents

Introduction

This Summary Plan Description (SPD) describes the pre-Medicare Retiree Health Reimbursement Account (HRA) available to you and your family if you're an eligible pre-Medicare Retiree of Ford Motor Company ("Ford" or the "Company"). This SPD describes plan provisions as of January 1, 2023. It replaces any prior SPD you may have received for this benefit. The HRA Plan replaces pre-Medicare retiree medical, prescription drug, dental, vision and legal benefits formerly provided by Ford. Via Benefits Insurance Services (Via Benefits) is the administrator of Ford's pre-Medicare HRA.

Your SPD contains valuable information about:

- Who is eligible
- How the HRA works
- Qualified expenses
- How to request reimbursement

Keep this SPD so you can refer to it whenever you have a question about your benefit.

The following information is intended to be a summary of your benefits and does not include all plan or policy provisions, limitations and exclusions. Ford intends to continue its benefit plans indefinitely but reserves the right to amend, suspend or terminate the Plan in whole or in part at any time. If there is a conflict between this SPD and the official Plan documents, the Plan documents will control.

Pre-Medicare Health Reimbursement Arrangement Plan Overview

Ford's contribution to your health coverage will be provided in the form of a Health Reimbursement Arrangement (HRA). You can use your HRA funds to get reimbursed for the cost of medical and dental coverage through Via Benefits Insurance Services, from a local broker or through a federal or state-based marketplace. Keep in mind that Via Benefits will be your HRA administrator regardless from whom you purchase coverage.

Ford provides an HRA with credits that vary depending on whether you, you and your spouse and/or you and your eligible dependent children are covered by the HRA, as described in the "How the Pre-Medicare HRA Works" section.

Note: The annual contribution amount is capped, which means it does not increase from year to year; it also does not roll over to the next calendar year if you don't use it.

Benefits of the HRA include helping to pay for medical and dental premiums.

Eligibility

The Company provides access to the pre-Medicare HRA to eligible pre-Medicare retirees and their dependents, as described in the "Who Is Eligible" section of this SPD.

Via Benefits

Via Benefits administers your HRA. For your convenience and a seamless experience, Via Benefits also offers a health insurance marketplace and resources that can help you explore your health care options and prices. Plus, you'll have the support you need from licensed benefit representatives who are specially trained to help you make the best health plan decisions for you.

Licensed benefit advisors are available Monday through Friday from 8 a.m. to 7 p.m., Eastern time.

Via Benefits is available to provide you and/or your eligible spouse with personalized assistance to:

- Answer questions to help you better understand your HRA.
- Help you understand plan options if you enroll with Via Benefits.

Choose the Individual Family Plan (IFP) that best fits your needs during the IFP enrollment period. Contact Via Benefits at 1-833-363-3673 or online at **marketplace.viabenefits.com/ford**. **Note:** Via Benefits does not offer enrollment options outside of the U.S. or in Puerto Rico. Retirees should refer directly to Puerto Rico health plan carriers for enrollment assistance.

If You Have Questions

If you have any questions about your HRA, you can contact:

Via Benefits Insurance Services (Via Benefits)
10975 South Sterling View Drive
South Jordan, UT 84905
Phone: 1-833-363-3673 (FORD) (TTY: 711)

How the Pre-Medicare HRA Works

Here is how the pre-Medicare HRA works:

- The Company establishes a notional account called an HRA and allocates a specified amount to the account (called "HRA Credits") for reimbursement of eligible medical and dental premiums.

  The credits vary depending on whether you, you and your spouse and/or you and your eligible dependent children are covered by the HRA:

  - $6,000 per year ($500 month) for retiree/surviving spouse
  - $6,000 per year ($500 month) for eligible spouse
  - $3,400 per year ($283.33 month) for each eligible child

- You do not, and cannot, contribute to this account; nor do you have to pay for your HRA coverage.
- The annual HRA allocation is distributed monthly and will be prorated starting with the month you become eligible.
- The annual contribution amount is capped, which means it does not increase from year to year; it also does not roll over to the next calendar year if you don't use it.
- The pre-Medicare HRA does not coordinate benefits with any other group or individual health coverage, and can only reimburse you for eligible medical and dental premiums.
- You must opt in to your HRA either online at **marketplace.viabenefits.com/ford** or by contacting Via Benefits at 1-833-363-3673 (FORD) (TTY: 711) to access the funds in this account.

Tax Advantages of HRAs

- The Internal Revenue Service (IRS) treats the HRA as a group health plan. Therefore, you do not pay taxes (federal income taxes, Social Security/FICA taxes, etc.) on the money you receive as reimbursement for an eligible expense. However, you'll be taxed on any reimbursement you do not properly document and repay when requested to do so.
- When you save on taxes, your dollars go further to help you pay the cost of eligible health care expenses. If you have any questions about the effect on your taxes, contact your personal tax advisor.

Note: The Internal Revenue Service (IRS) does not treat the HRA allocation amounts for a domestic partner or child of a domestic partner as nontaxable. If you choose to cover a domestic partner and/or the child of a domestic partner under the Plan, the amount of any reimbursement for a domestic partner's and/or the child of a domestic partner's eligible expenses will be treated as imputed income and reported as taxable wages to the IRS. You will pay taxes (federal income taxes, Social Security/FICA taxes, etc.) on any reimbursements for a domestic partner's and/or the child of a domestic partner's eligible expenses.

Online Account Access

The Via Benefits website (**marketplace.viabenefits.com/ford**) provides 24-hour access to your HRA, including account balance information. Here are some of the things you can do on the website:

- Ask a question
- Speak to an expert
- Submit eligible expenses for reimbursement
- Add direct deposit and update your address
- Review your HRA funding dashboard
- Browse your health care coverage options

In addition, you can submit reimbursement requests using the Via Benefits Accounts mobile app. To get started, search for “Via Benefits Accounts” in the App Store or Google Play, and download it to your smartphone or tablet.

Definitions

Terms to Know

Certain words that you'll see in this SPD have specific meanings. These definitions should make the HRA Plan easier to understand.

Enrolled in Coverage

This means that the eligible retiree enrolls in a health plan on the Via Benefits marketplace, by using a broker or enrolling with the health plan directly.

Participating Subsidiaries

Participating subsidiaries include:

- Ford Motor Credit Company LLC
- American Road Services Company
- Ford Motor Land Development Corporation
- Ford International Business Development, Incorporated
- Ford Global Technologies, LLC
- Livio, Inc**.**

Plan Year

The plan year is the same as the calendar year, January 1 to December 31.

Pre-Medicare HRA Participation

This means that the eligible retiree opts in to their HRA and receives a monthly allocation in their HRA account.

Who Is Eligible

Retirees

You are eligible if both of the following criteria are met:

- Your most recent Ford Service Date is prior to June 1, 2001; and
- You are eligible to receive a Regular Early, Special Early, Disability or Normal pension benefit under the General Retirement Plan. Deferred Vested pension benefits are not eligible for the pre-Medicare HRA.

Dependents

Only dependents who are eligible prior to the employee's retirement date are deemed eligible for the pre-Medicare HRA.

An eligible dependent includes your:

- **Spouse (including common-law spouse)**

  The individual to whom you are legally married under the laws of the state or foreign jurisdiction where the marriage took place.

  - Your spouse is eligible to participate in the pre-Medicare HRA if he or she meets both of the following criteria:
    - You were married to your spouse prior to your retirement date or before June 1, 2003.
    - You are enrolled in the HRA and have enrolled your spouse as a dependent.

  Note: A spouse by a common-law marriage will be eligible to participate in the pre-Medicare HRA only to the extent such a relationship is recognized by the laws of the state in which you are enrolled, and you must meet the requirements for documentation of marital status under common law as may be necessary by law and required by the Company.

- **Domestic Partner**

  For participants with a retirement date after May 1, 2023, your domestic partner is eligible to participate in the pre-Medicare HRA if they were eligible for health care coverage prior to your retirement.

  Domestic Partnership: A committed relationship between two adults, regardless of sex, in which the partners:

  - Are age 18 or older and legally competent to enter a contract;
  - Are each other's sole domestic partner and intend to remain so indefinitely;

- Have maintained a common residence for at least six months and will continue to do so;
- Have joint living expenses and care for each other's wellbeing;
- Are not married, in another domestic partnership, or in a civil union to anyone else (if previously married, a legal divorce or annulment has been obtained, or the spouse is deceased); and
- Are not related in a way that would prohibit legal marriage.

- **Surviving Spouse**
  - A surviving spouse is the person who was married to a retiree (or an employee eligible to be a retiree who has not yet retired):
    - On the date of retirement (or death in the case of an employee eligible to be a retiree); or
    - Before June 1, 2003, if married after date of retirement; and
    - Who remained continuously married to the employee/retiree until the date of death

- **Surviving Domestic Partner (Surviving DP)**
  - A surviving DP is the person who was in a committed relationship with a retiree (or an employee eligible to be a retiree who has not yet retired):
    - After May 1, 2023; and
    - Who remained continuously committed to the employee/retiree until the retiree's date of death.

- **Company couples** — If you and your spouse are both Ford retirees and eligible for the pre-Medicare retiree HRA, you will be set up under one HRA account. The account is set up under the participant who retired first from the Company. The applicable HRA funds will be deposited into one HRA account.
  - **Hourly and Salaried** — Spouses who are hourly retirees are eligible for coverage if he or she meets the eligibility criteria for coverage as a spouse.

- **Split Contracts (Pre-Medicare HRA and Medicare HRA)** — Households where the retiree is eligible for an HRA type that differs from the HRA type the dependent(s) is eligible for. For example:

  - Retiree is eligible for the Medicare HRA but the spouse and dependent child are eligible for the pre-Medicare HRA. In order for the spouse and child to be enrolled in the pre-Medicare HRA, the retiree must be enrolled in the Medicare HRA and elect to cover the spouse and child as dependents.

  - Because the types of expenses that are eligible for reimbursement under the pre-Medicare HRA and the Medicare HRA differ, separate accounts will be established for the retiree and his or her dependents.

- **Sponsored Dependent** — As of January 1, 2013, you or your surviving spouse may no longer cover a sponsored dependent.

- **Children** — which include:

  - Natural child(ren) or legally adopted child(ren) under age 26 (a legally adopted child includes a child for whom adoption papers have been filed and who is living with the adopting parents during the period of probation).

  - Foster child under age 26, placed with you by an authorized placement agency.

  - Child under age 26 for whom you are responsible under a court order, such as a Qualified Medical Child Support Order (QMCSO) — see “Children by Legal Guardianship” and “Qualified Medical Child Support Orders” sections below.

  - Domestic partner’s child(ren) under age 26. For participants with a retirement date after May 1, 2023, the natural, legally adopted or foster children of your domestic partner are eligible for pre-Medicare HRA coverage if they were eligible for health care coverage prior to your retirement.

  - Eligible surviving domestic partner’s child(ren) under age 26. See “Children of Your Eligible Surviving Domestic Partner” for more information.

  - Stepchild(ren) under age 26.

  - Any of the above child(ren) of any age if he or she is determined to be a totally and permanently disabled child, as defined in the “Totally and Permanently Disabled Children” section (see below).

Dependents cannot participate in both the pre-Medicare HRA and Medicare HRA for the same coverage period. Dependent children of Medicare-eligible retirees and spouses/domestic partners/surviving spouses cannot participate in the pre-Medicare HRA unless either the retiree or the spouse/domestic partner/surviving spouse is participating in the pre-Medicare HRA. The term “dependent” excludes any child age 26 and over who is not determined to be totally and permanently disabled by the Plan.

Important note:

It is your responsibility to ensure that the dependents you choose to cover in the pre-Medicare HRA meet the Plan's eligibility requirements. You'll be required to provide documentation for any dependent participating in the HRA Plan, verifying that your dependent(s) satisfies the Plan's eligibility requirements. Dependents who are not approved will be removed from your HRA Plan and cannot be reinstated until a subsequent Open Enrollment period or within 60 days following a qualified change in status that allows you to add dependents to your HRA. When requesting to add dependent(s) back to your HRA who were previously removed because their eligibility could not be verified, you will be required to provide documentation verifying their eligibility before their participation will be approved.

The decision to deny participation in or remove dependents from your HRA Plan is based on the information you provided (or did not provide) and Ford Plan provisions. If you disagree with the decision, you are entitled to have the decision reviewed by initiating a claim with the Dependent Verification Services (DVS) Claims and Appeals Management (CAM) team. To initiate a claim, please call the Dependent Verification Center at 1-800-248-4444. Select "Healthcare," then "Dependent Verification."

- **Children by Legal Guardianship** — A child(ren) covered by legal guardianship is eligible to participate in the pre-Medicare HRA plan if he or she was eligible for coverage as a dependent on your health care plan on your retirement effective date and you are currently enrolled in the pre-Medicare HRA.

  You must have responsibility to provide health care coverage for the minor child, and your child must not have reached the end of the calendar month in which age 18 is attained.

  The minor child must be unmarried and reside with you and be a member of your household. You, the Ford retiree, must claim the minor child as a tax dependent for federal income tax purposes.

- **Qualified Medical Child Support Order** — Participation in this Plan for children will be provided if required under a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order issued by a court or authorized agency that provides for medical child support in the event of divorce or other family law action.

  All medical child support orders served on the Plan must be received and approved by the Plan Sponsor before any action will be taken. Send your QMCSO to:

  National Employee Services Center
  Qualified Order Center
  P.O. Box 1590
  Lincolnshire, IL 60069-1590
  Fax: 1-847-442-0899

  You can also upload your QMCSO online by visiting **www.qocenter.com**. Click the link in the bottom right corner and follow the steps detailed there to complete the request.

  Note: A QMCSO can only be obtained for your natural child or legally adopted child.

- **Children of Your Eligible Surviving Domestic Partner** — Children of your eligible surviving DP may be eligible to participate in this Plan if they were eligible for coverage prior to your retirement and you retired on or after June 1, 2023. A child of your surviving DP is eligible for coverage if he or she meets all of the following requirements:

  - Is related to your surviving DP by birth or legal adoption
  - Is under age 26
  - Resided as a member in your household prior to your death (a child away at school is not considered a member of your household if he or she did not principally reside with you immediately before living at school, or does not reside with you when not at school)
  - Is unmarried

  Note: Children of eligible surviving DPs cannot be added after the retiree's date of death.

- **Totally and Permanently Disabled Children** — Your child is eligible to participate in this Plan if you are eligible for coverage at the time you retire, and he or she is determined to be totally and permanently disabled by the Plan before reaching age 26, when coverage otherwise would have ended.

  "Totally and permanently disabled" means having any medically determinable physical or mental condition that prevents the child from engaging in substantial gainful activity and that can be expected to result in death or be of long-continued or indefinite duration.

  The applicable age limits do not apply to a child (as defined by the Affordable Care Act) who, while covered by the Plan, becomes totally and permanently disabled before reaching age 26 and is determined to be eligible by the Plan, when coverage would otherwise end.

  The pre-Medicare HRA will not be reinstated for a child who first becomes totally and permanently disabled after the end of the month in which he or she reaches age 26 or who was eligible and enrolled for coverage as a totally and permanently disabled child, recovers and after coverage has ended, again has a total and permanent disability.

  To continue to cover a totally and permanently disabled child after the end of the month in which the dependent turns age 26, you must remain eligible for coverage and the dependent must also continue to meet all the following requirements:

  - Resides as a member in your household
  - Qualifies for a dependency exemption under the Internal Revenue Code (the Code) for federal income tax purposes. The dependent may be eligible for coverage if he or she earns less than $10,000 per year from regular employment, is considered dependent under Section 152 of the Code for federal income tax purposes and meets all other eligibility requirements of the Plan.
  - Is unmarried

Approximately 90 days prior to the child's 26th birthday, the NESC will send you a notice advising the child will be removed from your pre-Medicare HRA effective the first of the month following the 26th birthday. To request continuation as a totally and permanently disabled child, you must contact the NESC and request the application form. Completed application forms must be submitted prior to the child's 26th birthday. A letter will be sent to you advising whether the application was approved.

You may be required to provide documentation in the future to verify continued eligibility.

Note: Totally and permanently disabled children over the age of 26 who are covered under your Ford-sponsored medical coverage at the time you retire will be required to enroll in their own health plan on the marketplace, but will still be provided HRA funding at the child amount.

Dependent Coverage after Your Death

If you are eligible for the pre-Medicare HRA at the time of your death, your surviving spouse/domestic partner and dependent children may be eligible to continue pre-Medicare HRA participation.

It is your surviving spouse's/surviving DP's responsibility to report your death to Via Benefits or the NESC.

Only dependents participating in the pre-Medicare HRA at the time of your death are eligible to continue the pre-Medicare HRA after you die, if they continue to meet the eligibility requirements.

If your surviving spouse subsequently remarries or your surviving domestic partner has a new relationship, the new spouse/domestic partner is not eligible to participate in the pre-Medicare HRA. Participation in the pre-Medicare HRA for your dependent children continues only if your surviving spouse/domestic partner is a participant in the pre-Medicare HRA.

Plan Participation

Opt In

Ford will establish a pre-Medicare HRA when you retire if you meet the eligibility requirements.

You must opt in to your HRA either online at **marketplace.viabenefits.com/ford** or by contacting Via Benefits at 1-833-363-3673 (FORD) (TTY: 711) to access the funds in this account. All eligible dependents will need to opt in to get access to the HRA funding.

You can use your pre-Medicare HRA to be reimbursed for medical and dental plan premiums for coverage purchased with Via Benefits, a local broker or through a federal or state-based marketplace.

If you are eligible for, but waived the pre-Medicare HRA, you must contact the NESC during the month prior to becoming Medicare eligible to have your Medicare HRA eligibility confirmed. Credits are made to your Medicare HRA account after your eligibility is verified by the NESC. Credits to your HRA will not be provided retroactively. HRA benefits will begin on the first of the month following opt-in.

Marketplace Health Insurance Coverage

Ford provides access to Via Benefits, one of the industry's leading health insurance marketplaces to help you make informed and confident decisions about your health care plan options in retirement. You should visit the Via Benefits Marketplace at **marketplace.viabenefits.com/ford** to understand the enrollment process and potential plan options available to you and your family.

Note: You can enroll in coverage with Via Benefits, a local broker or through a federal or state-based marketplace. Keep in mind though that Via Benefits will still administer your HRA, including the reimbursement process for eligible expenses.

It is important you enroll prior to your retirement effective date to avoid a lapse in coverage. For example, if you are enrolled in active health care coverage and retiring effective April 1, you should contact Via Benefits at least 60 days prior to your retirement date to enroll in retiree coverage effective April 1. If you miss your Special Enrollment Period (SEP) as a result of your retirement, you must wait until the next Open Enrollment period to enroll in coverage on the marketplace.

Note: You may qualify for a Special Enrollment Period (SEP) if you or anyone in your household lost qualifying health coverage in the past 60 days or expects to lose coverage in the next 60 days. The 60-day SEP will begin the day your group active coverage ends. During your SEP, if you enroll by the end of the month prior to your retirement, your new plan will be effective the first day of the following month. Otherwise, coverage begins on the first day of the month following your enrollment within the 60-day SEP window after loss of coverage. If you miss the SEP you cannot enroll in coverage until the next Open Enrollment Period.

You can only change or cancel your coverage during the marketplace Open Enrollment Period held annually (generally November 1 through December 15), unless you have a Qualifying Life Event (QLE). Here are a few events that might qualify you for a 60-day Special Enrollment Period (SEP):

- Your marital status changes
- You lose your medical plan due to an insurance carrier terminating your plan
- You move outside the area covered by your medical plan
- You have or adopt a child

Participation for dependents takes effect on the effective date of your participation. Coverage for a newly enrolled eligible dependent (a dependent who was eligible, but not enrolled, as of your retirement date) is effective on the date he or she is enrolled, as long as you notify Ford by calling the NESC within 60 days of enrolling the dependent.

When Pre-Medicare HRA Participation Ends

For a retiree:

- You no longer meet the eligibility requirements as designated by this SPD; for example, you reach age 65 or become Medicare eligible.
- The Plan terminates or is amended to end participation .
- You die.

For an eligible spouse, surviving spouse, common-law spouse, domestic partner or eligible surviving DP:

- The date of his or her death.
- The date of a final decree of divorce.
- The end of the domestic partnership.
- The date your marriage is annulled.
- The last day of the month following the month in which you die unless your spouse/ domestic partner qualifies as a surviving spouse/surviving DP under the Plan.
- The date your spouse, domestic partner or eligible surviving DP no longer meets any other eligibility requirements of the Plan; for example, he or she reaches age 65 or becomes Medicare eligible.

Once you and your eligible spouse/domestic partner both become Medicare eligible because of age or disability, all dependent children (including totally and permanently disabled) will no longer be eligible for the Ford pre-Medicare HRA, and no credits are provided for them in the Medicare HRA Plan. Prior to reaching age 65 or Medicare eligibility, there are other events that could cause termination for your dependents' eligibility, as noted below.

Pre-Medicare HRA participation terminates for your eligible dependent child(ren) on the date of the event in the following occurrences (see below for termination dates for totally and permanently disabled children and children of eligible surviving DPs):

- Your relationship to a stepchild ends due to the termination of the marriage.
- The foster child relationship ends.
- The child dies.
- The qualified legal requirement to provide health care coverage has terminated or he or she no longer meets Plan requirements.
- A retiree, surviving spouse, spouse or eligible surviving DP is no longer covered by the Plan (including those whose coverage ends as a result of their eligibility for Medicare due to age or disability).

- You or your spouse, or the order of a court of competent jurisdiction, terminates the legal obligation for total or partial support for a child who met the criteria for placement for adoption under the Omnibus Budget Reconciliation Act of 1993 (OBRA93).

- The child no longer meets any other eligibility requirements of the Plan.

Your totally and permanently disabled child loses eligibility for coverage on the earliest date to occur of the following, provided the child is age 26 or older:

- He or she is no longer determined by the Plan to be totally and permanently disabled.

- He or she gets legally married.

- He or she ceases to be dependent upon you or your spouse for federal income tax purposes and/or earns more than $10,000 per year from regular employment.

- He or she no longer resides in the same household as you.

- The court order, divorce decree or other QMCSO ordering you to provide health care coverage has expired. **Note:** You can continue to cover the child, without a lapse in HRA participation, by contacting the NESC.

- You or your spouse/domestic partner, or the order of a court of competent jurisdiction, terminates the legal obligation for total or partial support for a child who met the criteria for placement for adoption under OBRA93.

- He or she dies.

- He or she no longer meets any other eligibility requirements of the Plan.

Your child under legal guardianship will lose eligibility for coverage:

- The date your coverage ends.

- The date the legal guardianship ends, is otherwise terminated or the order to provide medical coverage is terminated.

- The end of the calendar month in which the child turns 18 years old.

- The date the child no longer meets any other eligibility requirements of the Plan.

Your eligible surviving DP's child's eligibility for coverage ends on the earliest to occur of the following date:

- He or she ceases to be dependent upon you or your domestic partner for federal income tax purposes.

- He or she no longer resides in the same household as you.

- He or she gets legally married.

- The qualified legal requirement to provide health care coverage has terminated or the qualified legal requirement to provide health care coverage no longer meets Plan requirements.
- The last day in the calendar year in which he or she attains age 26.
- You or your eligible surviving DP, or the order of a court of competent jurisdiction, terminates the legal obligation for total or partial support for a child who met the criteria for placement for adoption under OBRA93.
- The last of a retiree, surviving spouse, spouse or eligible surviving DP is no longer covered by the Plan (including those whose coverage ends as a result of their eligibility for Medicare due to age or disability).
- He or she no longer meets any other eligibility requirements of the Plan.

Coverage for QMCSO child(ren) ends on the date:

- Your coverage ends.
- The child(ren) graduates from high school or attains age 18, whichever occurs later, but in no instance after age 19 and six months.
- The qualified legal requirement to provide health care coverage has terminated or the qualified legal requirement to provide health care coverage no longer meets the Plan requirements.
- The child(ren) no longer meets any other eligibility requirements of the Plan.

Once You Become Medicare Eligible

When you reach age 65 or become Medicare eligible, you will no longer be covered by this Plan. You will be eligible for the Medicare HRA Plan if you were eligible for this Plan.

If you or your spouse/domestic partner becomes Medicare eligible during the year, the Medicare HRA will go into effect on the first day of the month you/he/she becomes Medicare eligible and eligibility is verified. The amount credited to your Medicare HRA account will be pro-rated.

For example: You reach age 65 on July 31:

- June 30, Pre-Medicare HRA participation ends.
- July 1, Medicare coverage begins.
- July 1, HRA account is credited with $900*

Note: After the retiree and spouse/domestic partner become Medicare eligible, dependents are no longer covered by the pre-Medicare HRA, and Medicare-eligible retirees do not receive Medicare HRA credits for them.

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* $1,800 / 12 months = $150 per month x 6 months remaining in the year (July through December) = $900

Via Benefits will send a welcome kit approximately 90 – 120 days before you and your eligible spouse's/domestic partner's 65th birthday. The personalized kit includes your HRA funding amount, as well as step-by-step directions on how to prepare, review and enroll in plan(s) as you approach Medicare eligibility.

See your Medicare HRA SPD for details on that plan.

If You Die

When you die, the pre-Medicare HRA contribution ends at the end of the month the death occurred. The account remains available for reimbursement of eligible expenses incurred prior to the date of death, for 12 months. The length of time it remains available varies:

- Retiree and eligible spouse/domestic partner: Your HRA account remains open and continues to receive credits annually (only for the survivor) until the survivor also dies. HRA allocations for the participant who died cease. Pre-death eligible expenses for the participant who died first may be submitted for 12 months. Expenses that were already submitted prior to participant's death and are in pending status will be reimbursed from available funds until the surviving spouse/domestic partner dies. Once the survivor dies, the estate will have access to the HRA account for 12 months, for pre-death eligible health care expenses before being forfeited.

- Single retiree/surviving spouse/surviving domestic partner: The estate will have access to the HRA account for 12 months for pre-death health care expenses before being forfeited.

Pre-Medicare HRA Credits

The details of the pre-Medicare HRA credits are:

- The credits will vary depending on whether you, you and your spouse/domestic partner and/or you and your eligible dependent children are covered by the HRA:

  - $6,000 per year ($500 month) for retiree/surviving spouse/surviving DP

  - $6,000 per year ($500 month) for eligible spouse/domestic partner

  - $3,400 per year ($283.33 month) for each eligible child

- The HRA allocation is distributed monthly and will be prorated starting with the month you become eligible.

- If you were not enrolled in coverage prior to retirement and you decide to opt in to your HRA, you need to call Via Benefits. HRA benefits will begin on the first of the month following opt in.

- The annual contribution amount is capped, which means it does not increase from year to year; it also does not roll over to the next calendar year if you don't use it.

Special Rules

- You may not contribute to your HRA; all contributions are made by the Company.
- You may only request reimbursement for medical and dental plan premiums paid for while you are a participant.
- The administrator and its designees are authorized to act on written, electronic or telephone instructions for enrollment or other changes or information provided by participants; such instructions must be true and accurate to the best of the participant's knowledge as of the time the instructions or information is provided.
- The Company, and any persons involved with administering the Plan on its behalf, is not liable for any cost, expense, liability or loss arising out of any telephone instructions or information provided by a participant.
- The participant must promptly repay all amounts the Plan has paid for services rendered to ineligible persons or benefits to which the participant is not entitled. Written notice of the occurrence of an overpayment and the amount owed will be sent to the participant's last address of record. If a participant fails to make timely repayment within 30 days after receiving written notice of the overpayment, unless appealed within the timeframe set forth in the claims procedure, in which case, within 30 days of a final determination upon appeal, the Company, as permitted by applicable law, may:
  - Suspend or terminate participation under the Plan, or
  - Offset any amount owed to the Plan by the participant against future benefits payable under the Plan.

If You Have a Health Savings Account (HSA)

You can contribute and use an HSA and the HRA at the same time, until you become Medicare eligible, if you enroll in an HSA-qualified High Deductible Health Plan (HDHP) and you do not have any disqualifying medical coverage.

HSA and HRA benefits should be used for different expenses (i.e., HRA reimbursements for medical and dental premiums and HSA payments to cover your out-of-pocket health care costs).

Reimbursements from the Pre-Medicare HRA

Via Benefits is the administrator for the pre-Medicare HRA Plan. You will request reimbursement for qualified health care premiums (medical and dental premiums only) from Via Benefits.

Via Benefits will send you a "Via Benefits Reimbursement Guide" with the information to manage your pre-Medicare HRA. The funding guide will include a claim reimbursement form that can be used to set up recurring premium reimbursements. You can expect to receive the Guide after you have opted in to your HRA. Via Benefits is available by phone to answer your questions. There is no cost to you to use Via Benefits.

Requesting Reimbursement

Pay your premiums for medical and dental coverage, and then complete a reimbursement request online, on the Via Benefits Accounts mobile app, or by mail or fax at:

Via Benefits
P.O. Box 981156
El Paso, TX 79998-1156
Fax: 1-866-886-0878

In order to be promptly reimbursed, it's important to include the correct supporting documentation with your reimbursement request. You may need to provide more than one document to confirm the premium expenses.

- Insurance carrier/COBRA (e.g., BCBS, BCN)
- Premium type (e.g., medical, dental)
- Premium amount (proof* of total amount you paid for premiums)
- Individual covered (e.g., your name and names of all covered dependents)
- Premium coverage period (e.g., January 1 – December 31, 2023; January 1 – January 31 for monthly premiums)

Recurring Premium Reimbursement

You can set up recurring premium reimbursement to reimburse yourself directly from your HRA for your monthly premiums. Submit a Recurring Reimbursement Request on the mobile app or Via Benefits' website, or mail a Reimbursement Request Form to Via Benefits.

Paired with direct deposit, you'll automatically receive reimbursement directly to your bank.

You'll need to set up a recurring reimbursement every plan (calendar) year and whenever your premium amount changes, to continue to receive reimbursement automatically.

* Proof of payment typically can be found on carrier website portals and also can be a bank statement detailing the premium charge, and/or confirmation of payment notification e-mail or mailed).

Your reimbursement request is considered filed when Via Benefits receives it. If the request for reimbursement is approved, you'll receive reimbursement as soon as reasonably possible after the determination.

Via Benefits determines the method or mode of reimbursement payments, including whether by direct deposit, written check, or otherwise.

Qualified and Incurred Health Care Expenses

Health care expenses are considered "qualified" if they are incurred by you or your dependents for medical and/or dental plan premiums.

Qualified expenses can only be reimbursed if the expense is not reimbursed or reimbursable through any other group health plan, other insurance, or any other accident or health plan. Examples of qualified expenses include premiums for medical and dental coverage purchased on the marketplace, through unsubsidized COBRA, from a broker or directly through a health insurance plan.

In no event will the following expenses be eligible for reimbursement:

- Any expense not defined in IRS Code §213(d) as an expense for medical care;
- Any expenses incurred for qualified long-term care services (as defined in IRS Code §106);
- Expenses incurred prior to the date coverage under this HRA becomes effective;
- Expenses incurred after participation ends;
- Expenses reimbursed by another plan or for which you plan to seek reimbursement under another plan;
- Out-of-pocket expenses; or
- Vision premiums.

Determining whether an expense is a qualified medical expense is at Via Benefits' sole discretion, on behalf of Ford as the Plan Sponsor.

Claims and Appeals Process

Standard Internal Claims Review and Appeal Process

The Plan has established the following claims review and appeal procedure for the pre-Medicare HRA benefit.

Via Benefits will review your claim as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of Via Benefits, Via Benefits may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time before the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to provide that information.

If your claim for reimbursement is approved, reimbursement will be made. If your claim is denied, in whole or in part, you'll receive an electronic or written notification from Via Benefits.

If your claim is denied, review the notice from Via Benefits carefully. It will contain:

- The specific reason(s) for the denial and the specific Plan provisions or other documentation on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of any additional material or information necessary for the reimbursement request to be completed and an explanation of why such material or information is necessary,
- A description of the Plan's external review procedures and a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; including your right to bring a civil action in federal court following a reimbursement requests denial on review;
- A description of any internal rule, guideline, protocol, or similar criteria used in the decision or a statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol or other similar criteria will be provided, free of charge, upon request;
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment, or similar exclusion or limit, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided upon request, free of charge;
- The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

First Level Appeal

If you do not agree with Via Benefits' decision, you can file a written appeal, which must be received within 180 days of the date you receive your denial notification.

Submit all information identified in the notice of denial as necessary to perfect your claim, and any additional information related to your claim, along with your appeal, such as: written comments, documents, records, a letter from your health care provider indicating medical necessity of the denied product or service, and any other information you feel will support your claim. This can include but is not limited to your Explanation of Unpaid Expenses, Explanation of Payment, or Notice of Adverse Determination.

To identify yourself include:

- Your name
- The covered participant's name
- The last four digits of your Social Security number
- Your date of birth, ID number, and phone number
- The service for which benefit coverage has been denied and the diagnosis code and treatment codes to which the service relates (together with the corresponding explanation for those codes)

Your appeal should be submitted in writing and mailed to:

Via Benefits
P.O. Box 981155
El Paso, TX 79998-1155
Fax: 1-866-886-0878

Your appeal will be reviewed by a person who was not involved with the initial claim denial and who is not a subordinate of any person who was. The review will be a fresh look at your claim and appeal without deference to the initial denial and will take into account all information submitted with your claim and/or appeal.

Via Benefits will notify you of the decision regarding your appeal in writing within 30 days of receipt of your written appeal.

You have the right to:

- Submit written comments, documents, records, and other information relating to the reimbursement claim for benefits.
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your reimbursement request for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your reimbursement request if it:
  - Was relied upon in making the benefit determination.

- Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record, or other information was relied upon in making the benefit determination.

- Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.

- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

- A review that takes into account all comments, documents, records and other information related to the reimbursement request that you submitted, regardless of whether the information was submitted or considered in the initial benefit determination.

If sufficient information is available to decide the appeal, Via Benefits will resolve your first level appeal within a reasonable period of time but not later than 30 business days from receipt of the first level appeal request. If more information is needed to make a decision on your appeal, Via Benefits will send a written request for the information after receipt of the appeal. If the additional information requested is not received within 30 business days of the appeal request, Via Benefits will conduct its review based upon the available information. The review will be completed within a reasonable period of time but not later than 30 business days from receipt of the appeal request.

Second Level Appeal

If you are not satisfied with the decision made on the first level appeal, you may request in writing, within 180 days of receipt of the notice of the decision, a second level appeal.

If you choose to appeal this claim again, Ford is the plan fiduciary and, as such, has the final decision.

A second level appeal may be initiated by you or your authorized representative (e.g. physician). To initiate a second-level appeal, you can provide all information from the first level of appeal and additional information or statements that you feel are relevant. You have the same rights with the second level appeal as you do with the first level appeal and all responses will follow the same time period.

Second Level Appeal Address:

Ford Motor Company Salaried Health Care Committee
P.O. Box 6214
Dearborn, Michigan 48121-6214

Notice of an adverse benefit determination on appeals will contain all of the following information:

- The specific reasons for the denial;

- The specific HRA Plan provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the Plan's standard, if any, used in denying the reimbursement request, and in the case of a final adverse determination, a discussion of the decision;

- A description of any additional material or information necessary for the reimbursement request to be completed and an explanation of why such material or information is necessary,

- A description of the Plan's external review procedures and a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; including your right to bring a civil action in federal court following a reimbursement requests denial on review;

- A description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, or a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request, free of charge;

- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment, or similar exclusion or limit, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided upon request, free of charge; and

- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

You'll receive notification of the outcome of the review in writing within 45 days after the appeal is received, unless special circumstances require an extension of time for processing.

If you are not satisfied with the response to your final appeal for health care or prescription drugs, you may bring a civil action in federal court under ERISA Section 502(a) no later than two (2) years after the date of the denial of your appeal and no later than six (6) months after the date of the last event for any other legal action. Any legal action brought against the Plan must be brought in the United States District Court for the Eastern District of Michigan.

External Review of Adverse Internal Appeals

Only Final Internal Adverse Benefit Determinations involving (a) "medical judgment" (excluding those that involve only contractual or legal interpretation without the use of medical judgment) as determined by the IRO or (b) rescissions of coverage (whether or not the rescission has any effect on any particular benefit at the time) are subject to external review.

Claims and Appeals Timelines and COVID-19

During the COVID-19 National Emergency and the COVID-19 Outbreak Period (as defined by federal law and regulations), the deadlines for you to file claims, appeals and external review requests with the Plan have been modified. The COVID-19 National Emergency ended on April 10, 2023 and the COVID-19 Outbreak Period ended on July 10, 2023.

If you received a claim denial letter that was dated prior to July 10, 2023, you have until 60 days after the earlier of (i) one year from the date you were eligible for the COVID relief or (ii) July 10, 2023 (the end of the Outbreak Period), to submit your appeal.

Now that the Outbreak Period has ended, the "normal" 60-day deadline has resumed.
For example, if you receive a claim denial letter dated September 1, 2023, you have until October 30, 2023 (60 days from September 1) to submit your appeal.

Requesting a Review —Timing

Claimants must request an external review from the Claims Processor who made the Adverse Determination of an Appeal within four months after the date of receipt of the benefits denial notice. However, if a Claims Processor fails to follow these claim and appeal procedures a Claimant may immediately request an external review. The external review shall be provided unless the IRO determines that the non-compliance did not cause, and was not likely to cause, prejudice or harm to the Claimant and the Claims Processor can demonstrate that violation was for good cause or due to matters beyond the control of the Claims Processor and occurred in the context of an ongoing exchange of information with the Claimant.

Preliminary Review

The Claims Processor will complete a preliminary review of an external review request within five business days after receiving the request. The preliminary review will determine whether:

- The Claimant is (or was) covered under the Plan when the health care item or service was requested; for retroactive reviews, the Claims Processor must determine whether the Claimant was covered under the Plan when the health care item or service was provided
- The benefit denial does not relate to the Claimant's failure to meet the Plan's eligibility requirements (except with respect to a rescission)
- The Claimant has exhausted the Plan's internal appeals process (unless the Claimant is not required to do so under the appeals regulations)
- The Claimant has provided all the information and forms needed to process the external review

The Claims Processor will provide the Claimant written notice of its preliminary review determination within one business day after completing its review. If the request is complete but not eligible for external review, the notice must state the reasons for the ineligibility and provide Employee Benefit Security Administration contact information (1-866-444-EBSA [3272]). If the request is incomplete, the notice must describe the information or materials needed to complete the request. A Claimant will be permitted to "perfect" (i.e., complete) the external review request within the four-month filing period or, if later, 48-hours after receipt of the notice.

Referral to Independent Review Organization (IRO)

The Claims Processor will assign an accredited independent review organization (IRO) to perform the external review. To ensure against bias and ensure independence, the Claims Processor has contracted (under contract terms meeting legal requirements designed to have the IRO be independent) with at least three IROs for assignments, and rotates claims assignments among the IROs.

Notice of Acceptance for External Review

The IRO will provide the Claimant with written notice of the request's eligibility and acceptance for external review. The notice must inform Claimants that they can submit additional information in writing to the IRO within 10 business days following receipt of the notice and that the IRO must consider such additional information in its external review. The IRO may also accept and consider additional information that is submitted after 10 business days, though it is not required to do so.

Plan Must Provide Documents and Information to IRO

Within five business days after the date the IRO is assigned, the plan's Claims Processor must provide the IRO the documents and any information considered in making the benefits denial. Failure to timely provide such documents and information is not cause for delaying the external review. If the plan's Claims Processor fails to timely provide the documents and information, the IRO may terminate the external review and decide to reverse the benefits denial. If the IRO does so, it must notify the Claimant and the Plan within one business day after making the decision.

Reconsideration by Plan's Claims Processor

On receiving any information submitted by the Claimant, the IRO must forward the information to the Claims Processor within one business day. The Claims Processor may then reconsider its benefits denial, though any reconsideration will not delay the external review. If the Claims Processor decides, on reconsideration, to reverse its benefits denial and provide coverage or payment, then the external review can be terminated. The Claims Processor must provide written notice to the Claimant and the IRO within one business day after making this decision. On receiving such a notice, the IRO must terminate its external review.

Standard of Review

The IRO will review all information and documents timely received. In reaching its decision, the IRO must make its own review of the claim, and is not bound by any decisions or conclusions reached by the Claims Processor under the internal claims and appeals process.

Other Documents Considered Under External Review

In addition to documents and information provided by the Claimant, the IRO will consider the following items in reaching its decision (to the extent the information or documents are available and the IRO considers them appropriate):

- The Claimant's medical records
- The recommendation of the attending health care professional
- Reports from appropriate health care professionals and other documents submitted by the Plan or insurer, Claimant, or the Claimant's treating provider
- The governing plan terms (to ensure that the IRO's decision is not inconsistent with the Plan's terms—unless the plan terms are contrary to governing law)
- Appropriate practice guidelines, which must include applicable evidence-based standards;
- Any applicable clinical review criteria developed and used by the Claims Processor (unless the criteria are inconsistent with the Plan terms or applicable law)
- The opinion of the IRO's clinical reviewer(s)

Final Decision

Within 45 days after the IRO receives the external review request, it must provide written notice of the final external review decision. This notice must be delivered to both the Claimant and the Claims Processor. This notice must include the following information:

- A general description of the reason for the external review request, including information sufficient to identify the claim; this information includes the date(s) of service, the provider, claim amount (if applicable), diagnosis and treatment codes (and their corresponding meanings) and the reason for the prior denial
- The date the IRO received the assignment to conduct the external review, and the date of the IRO's decision
- References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards relied on in making the decision
- A statement that the IRO's determination is binding, unless other remedies are available to the Plan or Claimant under state or federal law
- A statement that judicial review may be available to the Claimant
- The telephone number and other current contact information for any applicable office of health insurance consumer assistance or designated health insurance regulatory agency

Compliance with IRO Decision: If the IRO's decision is to reverse the denial, the Plan must immediately provide coverage or payment for the claim. This includes immediately authorizing or paying benefits.

Reversal of Plan's Decision

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of the appeal, Via Benefits will review relevant information that you will submit even if it is new information; and
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Limitations Period

No legal action for benefits under the Plan can be brought against the Plan until after the claims and appeal procedures have been exhausted. Unless the Employee Retirement Income and Security Act (ERISA) of 1974, as amended, specifically provides a different period of limitations, legal action under the Plan for benefits must be brought no later than two years after the claim arises. No other actions may be brought against the Plan more than six months after the claim arises.

Continuation of HRA Coverage Under COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your covered spouse, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose coverage under the Plan. It can also become available to your spouse who is covered under the Plan when he or she would otherwise lose such coverage.

What Is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of HRA Plan coverage when you would otherwise lose such coverage because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You and your covered spouse could become qualified beneficiaries if covered under the Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Under the Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described in the "Paying for COBRA Continuation Coverage" section.

COBRA Qualifying Events

If you are a covered retiree, you will become a qualified beneficiary if you lose coverage under the HRA Plan because the following qualifying event happens:

- The Company files for Chapter 11 bankruptcy and coverage under the HRA Plan is substantially eliminated within one year before or after the filing.

If you are the covered spouse of a retiree, you will become a qualified beneficiary if you lose coverage under the HRA Plan because any of the following qualifying events happens:

- You become divorced or legally separated from your spouse.
- The Company files for Chapter 11 bankruptcy and coverage under the HRA Plan is substantially eliminated within one year before or after the filing.

If you are the covered dependent child of a retiree, you will become a qualified beneficiary if you lose coverage under the HRA Plan because the following qualifying event happens:

- Loss of dependent status due to aging out at 26 years old.

For this purpose, "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event.

Giving Notice that a COBRA Qualifying Event Has Occurred

The pre-Medicare HRA Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Sponsor has been timely notified that a qualifying event has occurred. When the qualifying event is the employer's bankruptcy filing, the employer must notify the Plan Administrator of the qualifying events.

For all other qualifying events (divorce or legal separation), you are responsible to notify the Plan Sponsor in writing within 60 days after the later of: 1) the date of the qualifying event, or 2) the date the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. You must provide this notice in writing to the National Employee Service Center (NESC):

Regular mail:	**Express mail:**
Ford NESC Dept. 01700 P.O. Box 1599 Lincolnshire, IL 60069-1590	Ford NESC Dept. 01700 4 Overlook Point, Ste. 4OB Lincolnshire, IL 60069

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a "COBRA Continuation Coverage Election Notice") to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered retirees may elect COBRA continuation on behalf of their covered spouses, but covered retirees cannot reject COBRA continuation on behalf of their covered spouses.

If coverage under the HRA Plan is changed for retirees, the same changes will apply to individuals receiving COBRA continuation coverage.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of HRA coverage.

When the qualifying event is the death of the retiree or divorce, COBRA continuation coverage for the retiree's covered spouse (but not the retiree) under the pre-Medicare HRA Plan lasts for up to a total of 36 months from the date of the qualifying event.

When the qualifying event is the bankruptcy of the Company, the pre-Medicare HRA Plan for you and your covered spouse may be continued for the rest of your (the retiree's) life. After your death (including if you have already died when the bankruptcy proceeding begins), your surviving covered spouse may continue HRA Plan coverage for an additional 36 months after your death.

The table below provides a summary of the COBRA provisions outlined in this section.

	Maximum Continuation Period	
Qualifying Events That Result in Loss of Coverage	**Retiree**	**Spouse/Child**
Retiree dies	N/A	36 months*
Retiree and spouse or divorce	N/A	36 months
Loss of dependent status; dependent reaching age 26	N/A	36 months
The Company commences bankruptcy proceedings under Title 11 of the United States Code	Death	36 months

* 36-month period is counted from the date of retiree's death

Electing COBRA Continuation Coverage

You or your covered spouse must choose to continue coverage under the HRA Plan within 60 days after the later of the following dates:

- The date you or your covered spouse would lose coverage under the HRA Plan as a result of the qualifying event, or

- The date the Company notifies you and/or your covered spouse (through a "COBRA Continuation Coverage Election Notice") of your right to choose to continue coverage as a result of the qualifying event.

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is calculated on an annual basis using pre-Medicare HRA utilization and is approximately 102% of the cost of HRA Plan coverage. Thus, please note that this amount may fluctuate year over year.

Premium Due Dates: If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all contributions due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA Election Notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the HRA Plan. Payment is considered made on the date it is sent to the HRA Plan.

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The contribution due date and exact amount due each coverage period for each qualified beneficiary will be shown in the COBRA Election Notice you receive. Although periodic payments are due on the dates shown in the COBRA Election Notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the HRA Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any reimbursement request you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you elect COBRA continuation coverage but then fail to make an initial or periodic payment before the end of the 45- or 30-day grace period — respectively — for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any qualified beneficiary will end when the first of the following occurs:

- The applicable 36-month COBRA continuation coverage period ends

- Any required premium is not paid on time

- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as a retiree or otherwise) under another group health Plan (not offered by the Company)

- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes entitled to (that is, enrolled in) Medicare benefits (under Part A, Part B, or both). This does not apply to other qualified beneficiaries who are not entitled to Medicare and does not apply at all to end retiree COBRA continuation coverage if bankruptcy is the qualifying event

- The date the Company ceases to provide any group health plan for its employees and retirees

COBRA continuation coverage may also be terminated for any reason the HRA Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

Continuing Your Health Reimbursement Account under COBRA

If you elect to continue your HRA under COBRA, the HRA will provide for continuation of the maximum reimbursement available at the time of the qualifying event reduced by any reimbursement requests reimbursed during the period of coverage.

If you continue your HRA under COBRA, any amounts that would otherwise have been contributed by the Company into the HRA will continue.

Marketplace Coverage as an Alternative to COBRA

As explained above, when you lose your coverage under the HRA Plan by reason of a COBRA qualifying event, you temporarily can elect to continue that coverage under the applicable plan at your own expense at group rates (known as COBRA coverage). You also may have special enrollment rights to enroll under another group health plan (such as your spouse's employer plan). You also have viable purchasing options for individual health insurance policies through the Health Insurance Marketplace ("Public Marketplace") or through other commercial insurance issuers outside of the Public Marketplace. The Public Marketplace may offer you less expensive premiums and out-of-pocket costs than any other health care coverage options, including COBRA coverage, especially in the event that you qualify for governmental subsidies (i.e. tax credits) that help you pay for your coverage purchased from the Public Marketplace.

You should carefully and timely review all of your coverage options before making a final decision. If you decide to purchase other health coverage (e.g. through your spouse or through the Public Marketplace or other commercial insurance) and do not elect COBRA within the 60-day election period, you will no longer have the right to elect COBRA coverage under the health plans.

If you decide to elect COBRA coverage, you also should be aware that you are restricted in when you can enroll in an individual health insurance policy. For example, if you enroll in COBRA medical coverage under the plan, but decide mid-year that you want to drop that coverage because it is not affordable to you, most insurance carriers will not permit you to enroll in an individual health insurance policy until the next Open Enrollment period. This restriction applies even though COBRA is no longer affordable to you (e.g. when your financial situation changes or a COBRA subsidy, if any, from Ford or another source ends).

More information regarding COBRA coverage is included above and in the COBRA Notices available from the Plan Administrator. Additional information regarding Public Marketplace coverage is available by visiting **www.healthcare.gov** and also in the health plans' COBRA Notices.

COVID-19 and COBRA Continuation Coverage Timeframes

During the COVID-19 National Emergency and the COVID-19 Outbreak Period (as defined by federal law and regulations), certain COBRA deadlines were modified. The National Emergency ended on April 10, 2023 and the COVID-19 Outbreak Period ended on July 10, 2023 (per guidance provided by the DOL and IRS).

If you or a qualified beneficiary experienced a qualifying event prior to July 10, 2023, you have until 60 days after the earlier of (i) one year from the date you were first eligible for relief or (ii) July 10, 2023 (the end of the Outbreak Period) to elect continuation coverage, pay required COBRA premiums, and/or notify the Plan of a Qualifying Event.

For example, if you experienced a Qualifying Event on March 1, 2023, during the COVID-19 Outbreak Period, you have until September 8, 2023 (60 days after the end of the Outbreak Period) to elect COBRA coverage.

All benefit plan payments associated with delayed enrollment or suspended payments will be due in full no later than September 8, 2023. Failure to pay past due amounts at that time will result in retroactive cancellation of coverage to align with the date of last payment.

Now that the Outbreak Period has ended, the "normal" 60-day COBRA deadlines have resumed. For example, if you experienced a Qualifying Event on July 11, 2023, you have until September 9, 2023 to elect COBRA coverage.

If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address and Contact Changes

In order to protect your rights, as well as the rights of your spouse/domestic partner and dependent children, you should keep the Plan Sponsor informed of any changes in the addresses of your spouse/ domestic partner and/or dependent children. You should also keep a copy for your records of any notices you send to the National Employee Service Center (NESC).

You may contact the NESC by:

- Visiting **myfordbenefits.com**.
- Calling 1-800-248-4444 Monday through Friday, 9 a.m. to 9 p.m. Eastern time.
  TIP: To avoid long wait times, call Tuesday through Friday between 11 a.m. and 7 p.m.

- **Regular mail:**
  Ford NESC
  Dept. 01700
  P.O. Box 1599
  Lincolnshire, IL 60069-1590

- **Express mail:**
  Ford NESC
  Dept. 01700
  4 Overlook Point, Ste. 4OB
  Lincolnshire, IL 60069

Recovery Rights

Overpayment or Reimbursement Errors

If it is determined that you and/or your covered dependent(s) received an overpayment, or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA.

If you do not refund the overpayment or erroneous payment, the Plan Sponsor reserves the right to offset future reimbursement equal to the overpayment or erroneous payment. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Sponsor may consider the payment to be taxable income to you.

In addition, if the Plan Sponsor determines you have submitted a fraudulent claim, the Plan Sponsor may terminate your coverage under this HRA.

Unclaimed Payments

Any HRA payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) automatically will forfeit six months from the date set forth on the check or from the date the payment was otherwise approved.

If the participant or other authorized person does not contact Via Benefits before the 18-month forfeiture time frame, the unclaimed reimbursement will be voided and the amount of the voided check will be considered to be a contribution as of such date and will be credited to the participant's HRA as of such date. This means that the contribution may be used to reimburse eligible health care expenses incurred from and after the date of such contribution in accordance with the terms of the HRA Plan on such date. If the participant's HRA has been closed as of the date the contribution otherwise would be made, the contribution will not be made, but rather will be forfeited.

If the participant or other authorized person contacts Via Benefits within six months, Via Benefits may cancel and void the original check or payment and re-issue a new check, or as otherwise determined by Via Benefits.

If the participant or other authorized person contacts Via Benefits after six months, Via Benefits will cancel and void the original check or payment and re-issue the payment by direct deposit, or as otherwise determined by Via Benefits.

Required Notices

HIPAA Notice of Privacy Practices

Effective September 23, 2016 and revised January 1, 2023: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

What Is HIPAA?

Ford Motor Company (“Ford”) offers its employees and their eligible family members a number of health care benefit options, which include coverage for medical care, prescription drugs, dental care, vision care and health care spending/savings accounts. This Notice of Privacy Practices applies to employees and their family members (referred to as “you” and/or “your”) who participate in any Ford Health Plan (FHP) group health benefit offerings.

The Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, and the Health Information Technology for Economic and Clinical Health Act, also known as the HITECH ACT, are federal laws enacted to protect your Personal Health Information (PHI). This Notice of Privacy Practices explains the legal obligations of the FHP and your legal rights regarding your PHI. This Notice of Privacy Practices also describes how your PHI may be used or disclosed to carry out treatment, payment or health care operations and for other purposes that are permitted or required by HIPAA.

What Is PHI?

PHI is your individually identifiable health information, including demographic data, that is:

- Transmitted by electronic media;
- Maintained in electronic media; or
- Transmitted or maintained in any other form or medium.

And, is in connection with the FHP and is defined as related to:

- Your past, present or future physical or mental condition;
- The provision of health care to you; or
- The past, present or future payments for the provision of health care to you.

PHI excludes individually identifiable health information, including, but not limited to:

- Information contained in education records covered by the Family Educational Rights and Privacy Act, also known as FERPA, another law not covered by this Notice of Privacy Practices;
- Information in employment records held by Ford in its role as “Employer”; and
- Information contained in your employee medical file located at any Ford medical office (for example, Plant Medical).

Note: While some items are excluded from HIPAA, there are other state privacy laws and/or Ford corporate policies in place to safeguard your data and maintain confidentiality.

What Are Your Rights?

When it comes to your health information, you have certain rights. The following explains your rights and some of our responsibilities to help you:

- **Get an electronic or paper copy of your health and claims records. For example:**
  - — You can ask to see or get an electronic or paper copy of your health and claims records and other health information we have about you.
  - — We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable fee.
- **Ask us to correct your health and claims records. For example:**
  - — You can ask to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
  - — We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- **Request confidential communications. For example:**
  - — You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
  - — We will say “yes” to all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.
- **Ask us to limit what we use or share. For example:**
  - — You can ask us not to use or share certain health information for treatment, payment or our operations.
  - — We are not required to agree to your request, and we may say “no” if it would affect your care.
  - — If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. In this circumstance, we will agree unless a law requires us to share that information.
- **Get a list of those with whom we’ve shared information. For example:**
  - — You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, including whom we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make or those required under HIPAA). We'll provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- **Get a copy of this privacy notice by:**

  - Asking for a paper copy of this Notice of Privacy Practices at any time, even if you have agreed to receive the Notice of Privacy Practices electronically.

  - Obtaining a copy of this Notice of Privacy Practices via Ford's website, at **myfordbenefits.com**, under "Plan Information," click "Benefits Communications" and navigate to "Health and Welfare Benefits" to "Legal Notices for the HIPAA Notice."

  - Contacting the NESC at 1-800-248-4444.

- **Choose someone to act for you:**

  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

  - We will make sure the person has this authority and can act for you before we take any action.

- ***Exercise your right to be notified of a breach:***

  - You have the right to be notified in the event of a reportable breach of unsecured PHI.

- **File a complaint if you feel your rights are violated:**

  You have the right to file a complaint if you feel we have violated your rights by contacting the FHP at:

  HIPAA Privacy & Security Officer
  World Headquarters Building
  1 American Road
  Dearborn, MI 48126-2798
  1-313-390-4734

  Or send an email to: ***fmchipaa@ford.com***

  Questions about how to submit a complaint may be directed to **fmchipaa@ford.com**.

  You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, S.W.
  Room 509F, HHH Building
  Washington, D.C. 20201

You may also call HHS at 1-877-696-6775, or visit **hhs.gov/ocr/privacy/hipaa/complaints/**.

Or, contact the Office of Civil Rights Customer Response Center:
Phone: 1-800-368-1019
Fax: 1-202-619-3818
TDD: 1-800-537-7697
Email: ocrmail@hhs.gov

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with the FHP.

What Are Your Choices?

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions:

- **In these cases, you have both the right and choice to tell us to:**

  — Share information with your family, close friends or others involved in your care

  — Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- **We *never* share your information unless you give us written permission for:**

  — Marketing purposes

  — Selling of your information

How Do We Typically Use or Share Your Health Information?

Under HIPAA, the FHP may disclose your PHI in certain circumstances without your permission. The following categories describe the different ways that the FHP may use and disclose your PHI. It is not possible to list every viable use or disclosure in each category. However, all of the ways the FHP is permitted to use and disclose information will fall within one of the categories. “Minimum Necessary” requirements apply to the uses and disclosures of your PHI. This means that reasonable efforts must be made to limit the use and disclosure of your PHI to the minimum necessary to accomplish the compliant intended purpose of the use, disclosure or request.

We typically use or share your health information in the following ways:

- **Help manage the health care treatment you receive** – The FHP can disclose your health information and share it with professionals who are treating **you**.

- **Run our organization** – We can use and disclose your health information for operational purposes, including to administer the FHP, for quality improvement, general administrative activities, and to contact **you** when necessary.

- **Pay for your services** – We can use and disclose your health information to verify eligibility for FHP benefits and/or authorize payment for covered services.

- **Administer your plan** – We may disclose your health information to Ford, as your health plan sponsor for plan administration.

How Else Can We Use or Share Your Health Information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for any of the following reasons:

- **Help with public health and safety issues** – We can share health information about **you** for certain situations such as:

  — Preventing disease

  — Helping with product recalls

  — Reporting adverse reactions to medications

  — Reporting suspected abuse, neglect or domestic violence

  — Preventing or reducing a serious threat to anyone's health or safety

- **For research** – We can use or share your information for health research.

- **Comply with the law** – We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

- **Respond to organ and tissue donation requests** – We can share health information about you with organ procurement organizations.

- **Work with a medical examiner or funeral director** – We can share health information with a coroner, medical examiner or funeral director when an individual dies.

- **Address workers' compensation, law enforcement and other government requests** – We can use or share health information about you, including but not limited to the following ways:

  — For workers' compensation claims

  — For law enforcement purposes or with a law enforcement official

  — With health oversight agencies for activities authorized by law

  — For special government functions such as military, national security and presidential protective services

- **Respond to lawsuits and legal actions** – We can share health information about you in response to a court or administrative order, or in response to a subpoena.

- **We are not allowed to use generic information to decide whether we will give you coverage and the price of that coverage.**

For more information see: **hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**

How Does Ford, the Plan Sponsor, Protect PHI?

Ford, the Plan Sponsor ("Ford"), will:

- Not use or further disclose your PHI, other than as permitted or required by the Plan documents, or by HIPAA.

- Ensure that any other organizations with access to your PHI agree to the same restrictions and conditions that apply to Ford.

- Not use or disclose the PHI for employment-related actions and decisions, or in connection with any other benefit plan offered by Ford, unless specifically provided for under HIPAA (for example, with regard to worker's compensation).

- Report to the FHP any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted by the FHP and/or under HIPAA.

- Maintain your right to access your own PHI.

- Comply with your right to request an amendment to your PHI.

- Make available to you an accounting of disclosures, if requested.

- Make its internal practices, books and records, relating to the use and disclosure of PHI received from the FHP, available to the Secretary of Health and Human Services (HHS) for purposes of determining compliance by the FHP with HIPAA.

- If feasible, return or destroy all PHI received from the FHP.

In no event will Ford be permitted to access, use or disclose PHI in a manner that is inconsistent with the regulations under HIPAA.

For any electronic PHI that is disclosed to Ford, Ford will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that is created, received, maintained or transmitted to or by Ford on behalf of the FHP;

- Ensure that the adequate separation between the FHP and Ford (i.e., the firewall), required under HIPAA, is supported by reasonable and appropriate security measures (see upcoming section “How Does Ford Satisfy the Requirement for Adequate Separation between the FHP and Ford?”); and

- Ensure that any agent to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information.

How Does Ford Satisfy the Requirement for Adequate Separation Between the FHP and Ford?

HIPAA requires that there is an adequate separation between the FHP and Ford, the Company. The following describes who at Ford may have access to PHI and why:

- For purposes of supporting the FHP in the areas of health care operations, payment and administration, employees may have access to PHI. Ford employees may also include employees of any of its affiliates or subsidiaries, any agency employees and subcontractors (“Ford employees”).

- Ford employees given access to PHI **may** include individuals from the following organizations:

  — Corporate Human Resources

  — Purchasing

  — Finance

  — Information Technology

  — Internal Control

  — Office of the General Counsel

  — Global Data Analytics

  — Other Department Plan Sponsor workforce members, as required

- Access to PHI by Ford is further restricted to only the Ford employees, within the organizations above, who are essential to the performance of the administrative functions Ford performs for the FHP.

- In the event that any Ford Employee does not comply with the HIPAA provisions, the person will be subject to disciplinary action for non-compliance pursuant to the discipline and termination procedures.

What Are the FHP’s Responsibilities?

We are required by law to maintain the privacy and security of your protected health information. As a result, we will:

- Accommodate reasonable requests to communicate PHI by alternative means or at alternative locations in the form and format you request, if possible.

- Notify you if the FHP is unable to agree to a requested restriction on how your information is used or disclosed.

- **Let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**

- **Follow the duties and privacy practices described in this Notice of Privacy Practices and give you a copy of it.**

- **Not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: hhs.gov/hipaa/for-individuals/notice-provacy-practices/index.html.

Except for the privacy rights described in this Notice, nothing contained in this Notice will be construed to change any rights or obligations you may have under the FHP. You should refer to the FHP documents for complete information regarding any rights or obligations you may have under the FHP.

Changes to the Terms of this Notice of Privacy Practices

We can change the terms of this Notice of Privacy Practices, and the changes will apply to the protected health information we have about you. This revised Notice of Privacy Practices will be available upon request, in our office, and on our website. State law may provide for additional protection of your health information. Please contact the National Employee Services Center (NESC) at 1-800-248-4444 for more information.

Nondiscrimination and Accessibility Requirements

Ford Motor Company (Company) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, religion, national origin, age, disability, sexual orientation, gender identity or veteran status. The Company does not exclude people or treat them differently because of race, color, religion, national origin, age, disability, sexual orientation, gender identity or veteran status.

- The Company provides free aids and services to people with disabilities to communicate effectively with us.

- The Company also provides free language services to people whose primary language is not English.

If you need these services, contact the National Employee Services Center (NESC), contact information below. If you believe that the Company has failed to provide these services or discriminated in another way on the basis of race, color, religion, national origin, age, disability, sexual orientation, gender identity or veteran status, you can file a grievance. You can call the following hotline: 1-888-735-6650.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- Electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**.

- By mail at:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building Washington, D.C. 20201

- By phone at:

  1-800-368-1019, (1-800-537-7697 (TDD))

- Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

If You Have Questions

- Visit **myfordbenefits.com**.

- Call the NESC at 1-800-248-4444 Monday through Friday, 9 a.m. to 9 p.m. Eastern time.
  TIP: To avoid long wait times, call Tuesday through Friday between 11 a.m. and 7 p.m.

For Translation Services, call the NESC at 1-800-248-4444.

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-248-4444 (TTY: 1-800-248-4444).

- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-248-4444 （TTY：1-800-248-4444）。

- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-248-4444 (TTY: 1-800-248-4444).

- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-248-4444 (TTY: 1-800-248-4444)번으로 전화해 주십시오.

- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-248-4444 (TTY: 1-800-248-4444).

- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-248-4444 (телетайп: 1-800-248-4444).

- ملحوظة: إذا كنت تتحدثاذكر اللغة، فإن اللغوية خدماتالمساعدة تتوافرلك بالمجان. برقم اتصل 1-800-248-4444(رقمهاتف الصم والبكم: 1-800-248-4444.

- ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-248-4444 (TTY: 1-800-248-4444).

- ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-248-4444 (ATS : 1-800-248-4444).

- UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-248-4444 (TTY: 1-800-248-4444).

- ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-248-4444 (TTY: 1-800-248-4444).

- ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-248-4444 (TTY: 1-800-248-4444).

- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-248-4444 (TTY: 1-800-248-4444).

- 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-248-4444 TTY:1-800-248-4444）まで、お電話にてご連絡ください。

- **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-800-248-4444 (TTY: 1-800-248-4444) بگیرید تماس

Administrative Information

Formal Name of the Plan

The Plan benefits described in this SPD and Plan document are part of the Plan known as the Salaried Health Reimbursement Arrangement (HRA) Plan for Pre-Medicare Retirees.

Plan Year

The plan year is January 1 to December 31.

Identification Numbers of the Plan

Ford Motor Company is identified by the Employer Identification Number (EIN) 38-0549190. The Plan Number (PN) is 564. You should include these numbers in all correspondence concerning this Plan.

Type of Plan, Type of Administration

The Plan described in this SPD and Plan document is a health reimbursement plan.

Via Benefits is the Claims Processor and third-party administrator for the Plan, makes the determination of benefits and pays the claims and also is the named fiduciary of the Plan.

The third-party administrator of the Plan is:

Via Benefits
10975 South Sterling View Drive
South Jordan, UT 84905
1-833-363-3673 (FORD)

Plan Sponsor

Ford Motor Company
One American Road
Dearborn, MI 48126

Ford Motor Company is the Plan Sponsor. In most cases, including the Health Reimbursement Arrangement Plan, the responsibility for administering the plans and making interpretations on such issues as eligibility and payment of benefits has been delegated to the Human Resources staff. Human Resources staff and/or the committees (where applicable), have discretionary authority to interpret the plan and, upon appeal, to determine eligibility for and entitlement to benefits and the amount of such benefits. Any such interpretation or determination is final and binding subject only to the arbitrary and capricious standard of judicial review, to the fullest extent permitted by law including case law.

Benefit Claims Processor

If you have any questions on filing a claim or appealing your denied claim, contact:

Via Benefits
P.O. Box 981156
El Paso, TX 79998-1156
Fax: 1-866-886-0878
Phone: 1-833-363-3673 (FORD)

For claims and benefits inquiries, call 1-833-363-3673 (FORD).

website: **marketplace.viabenefits.com/ford**

Agent for Service of Legal Process

Ford Motor Company
World Headquarters
Corporate Secretary's Office
One American Road
Dearborn, MI 48126

Legal Process may also be served on the Plan Sponsor with respect to disputes arising under the Plan.

How the Cost of the Plan Is Paid

The Plan is funded through Company contributions.

Plan Accounting

Via Benefits will periodically furnish you with a statement of your HRA balance and reimbursements so you can track your account balance during the year. This will also help you budget for expense reimbursement needs in future plan years. You may also submit a written request to the Plan Sponsor to receive a copy of your account information at any time.

Plan Continuance

Ford Motor Company fully intends to maintain the Plan indefinitely. However, Ford reserves the right to terminate, suspend or amend this Plan with respect to any or all employees or retirees at any time and for any reason without prior notice or consent of any participant or of any person entitled to receive payment of benefits under the Plan. No person or entity has any authority to make oral changes or amendments to this Plan. The Plan Sponsor will establish the effective date of the amendment, modification, change or termination of the Plan.

If this Plan is amended, your rights are limited to eligible claims incurred before you received written notice from the Plan Sponsor that the Plan had been amended.

If this Plan is terminated, your rights are limited to eligible claims incurred before you received notice of the Plan's termination.

No person will become entitled to any vested rights under this Plan, and nothing in this Plan or SPD will be construed as creating any vested rights to Plan benefits.

Authorization to Approve Plans or Programs

As part of normal business planning, the Company is continually reviewing and evaluating various proposals for changes in employee programs. Your supervisors typically do not know whether the Company will or will not adopt any such programs and are not authorized to give any information about future programs. Until new programs are formally adopted and announced, no one is authorized by the Company to give any assurance that such changes will or will not occur.

Plan Amendment or Termination

The Company's benefit plans may be amended pursuant to the amendment procedure applicable to the Plan. Designated officers or their designees may approve amendments to employee benefit plans.

The detailed provisions of the Plan, not this summary, govern the actual rights and benefits to which you may be entitled. If there is a conflict between this summary and the Plan document, the Plan document will control.

Your Rights Under the Law

ERISA Rights

As a participant in the Company's benefit plans that are subject to ERISA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Included are the right to receive certain Plan information and the right to file a lawsuit if you believe your rights have been violated.

Here is a listing of your rights under ERISA:

Receiving Information About Your Plan and Benefits

- Examine, without charge, at the NESC and at other specified locations, such as work sites, and in some cases Ford World Headquarters, all documents governing the Plan, including any contracts and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all Plan documents and other Plan information upon written request to the NESC (the Company may make a reasonable charge for the copies). Write to the NESC at:

  National Employee Services Center
  Dept. 01700
  P.O. Box 1590
  Lincolnshire, IL 60069-1590
  1-800-248-4444

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon persons who are responsible for the operation of the Plan. The people who operate the Plan are called "fiduciaries" of the Plan and have a duty to do so prudently and in the interest of all Plan participants. The law provides that fiduciaries that violate ERISA requirements may be removed.

Enforce Your Rights

No one, including the Plan Sponsor or any other person, may exclude a Plan participant or otherwise discriminate against or in any way prevent a Plan participant from obtaining a welfare benefit or exercising their rights under ERISA.

If a claim for a health benefit is denied, in whole or in part, the Plan Administrator must provide you a written explanation of the reason for the denial. You have the right to have the Plan Sponsor review and reconsider a claim.

Conditions for Legal Action

Besides creating rights for Plan participants, ERISA also spells out certain duties for people who are responsible for operating the Plan. These people are called fiduciaries. The fiduciaries of a plan have a duty to operate the Plan prudently and in the interest of Plan participants and beneficiaries.

There are steps you can take to enforce your ERISA rights. For example:

- If you request materials from a Plan and don't receive them within 30 days, you may file suit in a federal court (in such a case, the court may require the Plan Sponsor to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator).

- If your claim for benefits is denied in whole or in part after a final review, you may file suit in a state or federal court.

- If the fiduciaries misuse a plan's money or if you are discriminated against for asserting your ERISA rights, you may seek help from the U.S. Department of Labor or file suit in a federal court.

If you file a suit, the court will decide who should pay costs and legal fees. If you win your suit, the court may order the person you have sued to pay the costs and fees. If you lose your suit, or if the court decides your suit was frivolous, the court may order you to pay the costs and fees.

Assistance with Your Questions

If you have any questions about your plans, you should contact the National Employee Services Center. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.