EMPLOYEE ASSISTANCE PROGRAM (EAP) FOR HOURLY EMPLOYEES
Plan Document and Summary Plan Description
Effective: January 1, 2024

This document serves as a Summary Plan Description and Plan Document of the Employee Assistance Program (EAP) for Hourly Employees for purposes of the Employee Retirement Income Security Act of 1974.

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WHAT YOU NEED TO KNOW ABOUT THE PLAN

This Plan Document and Summary Plan Description (hereinafter referred to as the "Document") is your guide to the benefits available through Ford Motor Company's Employee Assistance Program (EAP) Benefits Plan (the "Program" or "Plan") for Hourly Employees, effective January 1, 2024. Please read it carefully and refer to it when you need information about how the Plan works.

If you cannot find the answer to your question in this Document, a representative will be happy to help you.

- Health Management Systems of America (HMSA) at 1-800-550-7200 for the following locations:
  - CEP, KTP, LEP, LTP, LAP, MPG, NMDPC, NPE/Retirement Board, OHAP, RCP, R&E, STP, SAP, VDP, WPAC, WFP, WSP and WHQ
- Carelon Behavioral Health at **1-800-227-9622** for the following locations:
  - BSP, CAP, CSP, DEFTP, DSP, DFT, DT&D, DTP, Rouge Site Services, EMDO, FRAP, KCAP, MAP and all PDCs and HVC

All EAP services, plans and benefits are subject to and governed by the terms (including exclusions and limitations) of the agreements between HMSA, Carelon Behavioral Health and Ford Motor Company.

The information herein is believed accurate as of the date of publication and is subject to change without advance notice. This Document in no way limits the right of Ford Motor Company (the "Company") to change or discontinue this Plan or any benefit Plan at any time, and the Company reserves the right to amend or terminate the Plan at any time. It's also not a contract of employment but a reference source about Ford Motor Company's benefits.

ELIGIBILITY

Who Is Eligible to Join the Plan

To be eligible to access the Plan, you must be an active Ford hourly employee, or such individual's spouse/domestic partner or dependent child/child of domestic partner under the age of 26. (For purposes of this Document, references to "you" generally apply to both you and your dependent family members.)

"Domestic Partner" means an individual who is in a committed relationship with the Employee, regardless of gender. The Domestic Partner must meet each of the following criteria:

(a) Age 18 or older and legally competent to enter a contract
(b) Is the sole Domestic Partner of the Employee and intends to remain so indefinitely
(c) Maintains a common residence with the Employee for at least six (6) months and will continue to do so

(d) Shares joint living expenses with the Employee
(e) In a relationship of mutual interdependence in which each contributes to the maintenance and support of the other
(f) Is not married, in another domestic partnership or in a civil union with another party. If previously married, a legal divorce or annulment has been obtained or the spouse is deceased.
(g) Are not related in a way that would prohibit legal marriage

Domestic Partner coverage became effective May 1, 2023.

ENROLLMENT

Your coverage will begin on your first day of employment. You do not need to enroll in the Plan.

CONTRIBUTIONS

The Company pays the full cost of providing coverage for you and your family. You will be responsible for the cost of any services you receive after you exhaust the benefits provided under the Plan (for example, if you exhaust the number of counseling sessions available under the Plan).

Ford Motor Company reserves the right to reduce or eliminate its contribution to the cost of coverage at any time.

HOW THE PLAN WORKS

The Plan covers you and your eligible dependent family members when you become an employee. The Plan provides resources like:

- Three in-person, telephonic or video visits per problem per year to an EAP counselor for mental, emotional, psychological, stress, job, financial, family, marital, relationship or other matters;
- Referrals to professionals or community resources to help with life's difficulties;
- Mental Health and Substance Use Disorder in-patient approvals for those with Blue Cross Blue Shield of Michigan;
- Case Management;
- Online reference materials on various topics.
- The Plan's provider, HMSA or Carelon Behavioral Health, includes a National network of counselors that possess a minimum of a master's degree in a behavioral health discipline and are licensed through the state in which they practice. Trained counselors are also available by phone or video.

All discussions with HMSA or Carelon Behavioral Health providers are completely confidential. (Note that HMSA and Carelon Behavioral Health do abide with federal and state regulations regarding duty to warn of harm to self or others; in these instances, the consultant may have a duty to intervene and report a situation to the appropriate authority.)

SUMMARY OF BENEFITS

Benefits	Cost to You
Counseling sessions from participating HMSA or Carelon Behavioral Health providers (including but not limited to counseling for behavioral, interpersonal, family and other short-term solution-based counseling issues)	$0 (limit of 3 face-to-face, telephonic or video visits per issue per calendar year).

WHAT THE PLAN COVERS

Telephonic and Video Consultation

When you (or a family member) need help, a toll-free call connects you to a clinician who will assess the situation and determine the next steps. Those steps depend on the situation. Clinicians are trained in crisis intervention. Depending on your needs, the clinician may make a counseling appointment on your behalf or provide you with a referral.

For typical assessment and referral services, the representative will discuss the problem with you, offer additional information, and discuss what to expect in counseling. Clinicians may also explain the nuances of the EAP and offer advice on maneuvering the health care system.

Workplace

You can call a counselor for information regarding:

- Career development
- Training and development
- Diversity
- Productivity

In-Person, Telephonic or Video Counseling

The Plan provides three counseling sessions per problem per year with EAP providers who participate in HMSA or Carelon Behavioral Health's national network. These providers are licensed counselors in the state where the services are provided. Counseling is offered for many types of concerns, such as:

- Mental, emotional and psychological concerns
- Alcohol or drug concerns
- Family, marital and relationship problems
- Chemical dependence and other compulsions
- Stress, financial and job concerns

During in-person counseling, the counselor will attempt to determine the nature of the problem and develop an action plan to help you obtain relief. The intent of these sessions is to help you identify specific problems, see them from a manageable perspective and take steps toward resolving them. If needed, the counselor will refer you to the most appropriate resource as soon as possible.

If you require more than three counseling sessions, you may be referred to your mental health/substance use benefit, other work/life and/or other community resources.

Web Services

- Health Management Systems of America (HMSA) for the following locations:
  - CEP, KTP, LEP, LTP, LAP, MPG, NMDPC, NPE/Retirement Board, OHAP, RCP, R&E, STP, SAP, VDP, WPAC, WFP, WSP and WHQ

    On-line resources: www.my-life-resource.com
    USERNAME: UAW-Ford
    PASSWORD: myresource

- Carelon Behavioral Health for the following locations:
  - BSP, CAP, CSP, DEFTP, DSP, DFT, DT&D, DTP, Rouge Site Services, EMDO, FRAP, KCAP, MAP and all PDCs and HVC

    On-line resources:
    https://www.achievesolutions.net/achievesolutions/en/uawford/Home.do

Online services include:

- Self-assessment tools and quizzes
- Articles/Information on a variety of behavioral health topics including health management on topics like relationships, coping with chronic pain, depression, stress, substance abuse and leadership.

In addition, information on topics like the following are available online:

- Family and Caregiving – adoption, child care, parenting, senior care
- Emotional Well-Being – personal growth, relationship, grief and loss
- Health and Wellness – healthy living, health and aging, common health concerns

You can also complete a search for child care providers or older adult services located in your area.

WHAT THE PLAN DOES NOT COVER

The Plan does not cover counseling sessions unless you are referred to the provider by HMSA or Carelon Behavioral Health and the provider participates in the HMSA or Carelon Behavioral Health networks. If you receive more than three counseling sessions per issue in a calendar year, you must pay in full for the extra sessions. In some cases, extra counseling sessions may be covered by your medical plan even if they are not covered by this Plan. Please check with your medical plan to determine if additional counseling sessions may be covered.

In addition, the Plan does not cover:

- Inpatient or outpatient treatment for any medically treated illness
- Prescription drugs
- Treatment or services for intellectual disability or autism
- Counseling required by law or a court or paid for by Workers' Compensation.

This list is meant to provide you with a brief description of the types of charges not covered by the Plan. To be certain of the benefits available to you, contact HMSA at **1-800-550-7200 or** Carelon Behavioral Health at **1-800-227-9622**. Ford Motor Company, HMSA and Carelon Behavioral Health have full discretionary authority to interpret the Plan and to determine all questions relating to benefits offered under the Plan. All determinations made by HMSA and Carelon Behavioral Health will be conclusive and binding on all parties.

CLAIMS AND APPEALS PROCESS

If you think there's an error in your EAP eligibility or if you believe you are eligible to participate in specific benefits under the Plan, you should contact the National Employee Services Center (NESC) for resolution. The NESC may advise you to file a claim.

These procedures apply if you are checking on your eligibility for, or participation in, benefits under the EAP.

Filing a Claim for Eligibility

Your eligibility claim should include your name and global identification number, and an explanation why you believe you or your dependents should be eligible to participate in the Plan. Your eligibility claim should be sent, in writing, to:

Ford Motor Company National Employee Services Center (NESC)
Dept. 01700
P.O. Box 1590
Lincolnshire, IL 60069-1590
Phone: 1-800-248-4444 (TDD: 711)

Claims Processing

If your claim for benefits or participation is denied in whole or in part, you'll receive written notification from the NESC within 30 days from the date your claim is received. The notice will be deemed given upon mailing, full postage prepaid in the U.S. mail or on the date sent electronically to you.

The decision will be in writing and will include:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provision(s) on which the denial is based, along with a copy of the Plan provision(s) or a statement that such provision will be provided to you upon your written request;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- A description of the Plan's review procedures and the time limits applicable to such procedures, along with a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, following a denial for benefits on review.

If the NESC determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 30-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the NESC expects to render the determination.

Appeal of Denied Claims

If the NESC denies a claim for benefits or participation, you may:

- Request a review by filing a written appeal,
- Review pertinent documents,
- Submit written comments, documents, records and other information relating to the claim for benefits.

The EAP Plan Committee will review your appeal and consider all relevant comments, documents, records and other information submitted by you relating to the appeal, without regard to whether the information was submitted or considered in the initial benefit determination. The appeal will be reviewed and responded to by a committee who did not participate in the initial determination of your eligibility or election claim.

You may send your written appeal to:

Claims and Appeals Management — Ford Motor Company
P.O. Box 1407
Lincolnshire, IL 60069-1407
Fax: 1-847-554-5101

You must request an appeal of the denial of the claim within 180 days after you receive written notification of denial of the claim. You'll receive notification of the outcome of the review in writing 45 days after the appeal is received unless special circumstances require an extension of time for processing. If the EAP Plan Committee determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 45-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the EAP Plan Committee expects to render the determination.

The decision will be in writing, and it will include:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provision(s) on which the denial is based, along with a copy of the Plan provision(s) or a statement that such provision will be provided to you upon your written request; and
- A description of the Plan's review procedures and the time limits applicable to such procedures, along with a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, following a denial for benefits on review.

Limitations Period

No legal actions for benefits under the Plan may be brought against the Plan until after the claims and appeal procedures have been exhausted. Unless the Employee Retirement Income Security Act (ERISA) of 1974, as amended, specifically provides a different period of limitations, legal actions 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.

Any such suit must be filed in the United States District Court with jurisdiction over the area in which the Company's corporate headquarters is located, which is currently the U.S. District Court for the Eastern District of Michigan.

Claims Administrator/Fiduciary

The Company, HMSA and Carelon Behavioral Health have full discretionary authority to interpret the Plan and to determine all questions relating to the Plan as they relate to eligibility to participate in the Plan. Alight's Claims and Appeals Management (CAM) is the Claims Processor (Master of Eligibility) for eligibility and enrollment claims only, as well as claims administrator for benefits claims.

If You Receive an Adverse Benefit Determination

If your claim is denied (in whole or in part), you will receive a notice that includes:

- The specific reason(s) for the decision
- Reference to the specific Plan provisions on which the decision is based
- A description of any additional material or information that is needed to complete the claim and an explanation why that material or information is necessary
- If an internal rule, guideline, protocol or other similar criterion was relied on in making the decision, either a copy of the internal rule, guideline, protocol or other similar criterion, or a statement that the denial was based on this authority and that a copy of the authority will be provided free of charge upon request
- If the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that this will be provided free of charge upon request
- Contact information for the Employee Benefits Security Administration and any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act; and
- A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), if your claim continues to be denied after exhausting all mandatory appeals.

If your claim is denied (in whole or in part), you may appeal the decision under the procedures described in the next section.

In connection with a claim or appeal, you have the right to request and receive reasonable access to and copies of relevant documents, records and other information in the Plan's possession (other than legally or medically privileged documents) free of charge. For this purpose, a document, record or other information is treated as "relevant" to your claim 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 the 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 or
- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Procedures for Appealing an Adverse Benefit Determination

If you disagree with the denial of a claim (or if you do not receive a response to your claim within the appropriate time frame, in which case the claim for benefits is deemed to have been denied), you or your authorized representative can request that the Plan review its initial determination by submitting a written request to the NESC as described below. The time limits for appeal of a denial of your claim for benefits are as follows:

Time Limit for:	Post-Service Claim
You to file an appeal	180 days after receiving the claim denial notice.
The Plan to notify you of the appeal decision	Within a reasonable period, but no more than 60 days after receiving the appeal.

Notice of Determination on Appeal

If your appeal is denied (in whole or in part), you will receive a notice that includes:

- The specific reason(s) for the decision
- Reference to the specific Plan provisions on which the decision is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records and other information relevant to your claim

- If an internal rule, guideline, protocol or other similar criterion was relied on in making the decision, either a copy of the internal rule, guideline, protocol or other similar criterion, or a statement that the denial was based on this authority and that a copy of the authority will be provided free of charge upon request
- A description of the Plan's internal appeals procedures, any applicable external review process, information regarding how to file a second appeal, and the time limits applicable to these procedures
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures
- A statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA if your claim continues to be denied after exhausting all mandatory appeals.

If your appeal is denied, you have the right to take legal action against the Plan under ERISA.

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.
- 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 Office
    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.
  - We will not retaliate against you for filing a complaint.

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 to:
  - — 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-privacy-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 متوافرلك بالمجان. اتصل برقم 1-800-248-4444) 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 گفتگومی کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. بگیرید تماس 1-800-248-4444 (TTY: 1-800-248-4444)

WHEN COVERAGE ENDS

Your Coverage

Coverage terminates for you on the date:

- You no longer meet the eligibility requirements as designated by this SPD.
- You stop making required contributions, if applicable (if you fail to pay any required premium for coverage — beyond any applicable grace period).
- The Plan terminates or is amended to end coverage for a section that includes you.
- You die.

CONTINUATION OF COVERAGE UNDER COBRA

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Plan Administrator must be notified of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the NESC.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

The Social Security Administration (SSA) may determine that you were disabled at any time within 60 days of the qualifying event. The 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to continuation coverage as a result of the same qualifying event to which the disability extension applies, subject to the notice requirements (see the "When Is COBRA Continuation Coverage Available" section for details).

You must notify the NESC about the SSA's determination within 60 days of receiving it and prior to the end of the initial 18-month continuation coverage period to receive extended coverage. Monthly contributions for continuation coverage increase to 150% (from 102%) of the monthly amount for each of the 11 additional months of continuation coverage. If the SSA determines that the individual is no longer totally disabled, continuation coverage ends. The qualified beneficiary with respect to the qualifying event to which the disability extension relates must notify the NESC within 30 days after the determination. Continuation coverage ends on the first day of the month that's 31 or more days after the SSA's determination that the disability has ended.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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 the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov or call 1-800-318-2596.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

OTHER IMPORTANT INFORMATION

Indemnification of Employer

If you or your dependent(s) receive one or more payments or reimbursements that are later determined to be taxable, you must indemnify and reimburse the Company for any liability it may incur for failure to withhold federal income taxes, Social Security taxes or other taxes from such payments or reimbursements.

Non-Assignability of Rights

Except for voluntary assignments to health care Providers as may be required by law or as may be provided in applicable policies, your right to receive any reimbursement under this Plan is not alienable by you by assignment or any other method and shall not be subject to claims by your creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law, or except to the extent agreed to by the Plan and the Claims Administrator in settlement of litigation.

Amendment or Termination of the Plan

Ford Motor Company has adopted the Plan with the intent of it being maintained for an indefinite period of time. Notwithstanding this intention, the Company, through its Director, Total Rewards (or such individual holding comparable roles in the event of a restructuring of positions or re-designation of titles) reserves the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified within the time periods required by law, which may be after the effective date of the change.

The Company's right to amend or terminate benefits for employees subject to a Collective Bargaining Agreement may be limited by federal labor law or by the terms of that agreement. You can obtain a copy of the Collective Bargaining Agreement (CBA) by writing to the Plan Administrator. You also can review a copy of the CBA at your work location.

Moreover, the Company, through its Director, Total Rewards (or such individual holding comparable roles in the event of a restructuring of positions or re-designation of titles) has discretion to amend the eligibility, the cost-sharing between you and the Company, or to change benefit levels or benefit availability. The Company can change a policy with an insurance company only with the consent of the insurance company. Insurance companies can generally change their policies and contracts from time to time and may eliminate or reduce future coverage of certain benefits or change their procedures.

Nothing contained in this Document shall be construed as a contract of employment between the Company and any employee, or as a right of any employee to be continued in the employment of the Company, or as a limitation of the right of the Company to discharge any of its employees, with or without cause.

YOUR RIGHTS UNDER THE LAW

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 or union halls (as applicable) and in some cases Ford World Headquarters, all documents governing the Plan, including insurance contracts and collective bargaining agreements (as applicable) 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 Administrator is required by law to furnish each Plan participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 and beneficiaries. The law provides that fiduciaries who violate ERISA requirements may be removed.

Enforce Your Rights

No one, including the Plan Administrator or any other person, may fire or 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 welfare benefit is denied, in whole or in part, the Plan Administrator must provide you a written explanation of the reason for the denial and the option to obtain copies of documents relating to the decision without charge. You have the right to appeal any denial to the Plan Administrator within certain time schedules.

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 Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator).
- If 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN INFORMATION

Formal Plan Name, Plan Number and Plan Type

Plan No.	Plan Name	Plan Types
594	Ford Motor Company - Employee Assistance Plan for Hourly Employees	Benefits: EAP

Plan Contact Information

Contact the NESC at:

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

Plan Year

The Plan year runs from January 1 to December 31.

Employer Identification Number

38-0549190

Plan Sponsor and Administrator

Ford Motor Company
One American Road
Dearborn, MI 48126

The Plan Administrator acts in the sole interest of plan participants and their beneficiaries. The Plan Administrator has designated HMSA and Carelon Behavioral Health as its agents to administer the Plan, to pay all benefits claims and process appeals and to provide other administrative services.

Any errors of the Plan Administrator or the delegates in collecting contributions, paying benefits or communicating and recording such contributions and benefits will be corrected upon discovery by the Plan Administrator in whatever manner the Plan Administrator determines is consistent with his or her responsibilities in administering the Plan.

Plan Administrator Discretion

The Plan Administrator or his or her designee has full and complete discretion and authority to determine eligibility for benefits, to construe the terms of the Plan and to decide any matter presented through the claims procedure. Benefits under the Plan will be paid to a party only if the Plan Administrator or his or her designee, decides in his or her discretion that the claimant is entitled to them. Any final determination by the Plan Administrator or its designee, will be binding upon all parties. If challenged in court, such determination will not be overturned unless proven to be arbitrary and capricious based upon the evidence considered by the Plan Administrator or his or her designee, at the time of the determination.

Master of Eligibility

If you have any questions on filing an eligibility claim or appealing your denied claim, contact Claims and Appeals Management (CAM) at:

Claims and Appeals Management — Ford
P.O. Box 1407
Lincolnshire, IL 60069-1407
Fax: 1-847-554-5101

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 Administrator with respect to disputes arising under the Plan.

Type of Funding, Administration and Source of Contributions

EAP benefits through HMSA and Carelon Behavioral Health are fully insured and claims are adjudicated by HMSA and Carelon Behavioral Health . Premiums are paid from the Company's general assets. There are no employee contributions.