HONDA

A Guide To
Your Retiree Medical Benefits

Summary Plan Description for the Honda Retirement Medical Program April 2021

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A. Introduction

Honda is pleased to provide you with this Summary Plan Description (SPD): "A Guide to Your Retiree Medical Benefits."

How to Use this Guide

This Guide is designed to help you understand your retirement medical benefits. Please refer to it when you have questions about your retiree medical benefits. If your family members are enrolled, be sure to share this Guide with them as well.

If You have Questions

If you have questions about information in this Guide, contact the My Benefits Connect Center at 1-866-778-5885 Monday through Friday from 8:30 a.m. to 10:00 p.m. ET / 5:30 a.m. – 7:00 p.m. PT.

About Your Retiree Medical Benefits

There are three components of the Retirement Medical Program:

- *Pre-Medicare Retiree Medical Plan* for retirees, spouses and eligible dependent children who are not eligible for Medicare. See Section B for full eligibility and benefit details.
- *Lump sum credit to a Retiree Reimbursement Account (RRA)* for retirees who retire from Honda on or after January 1, 2014 (a one-time Lump Sum contribution which is contributed upon retirement).
- *Post-Medicare monthly RRA credits* for Medicare-eligible retirees who retired on or before December 31, 2020 or who attained age 50 on or before December 31, 2020. Spouses and Dependent children are not eligible for the post-Medicare RRA credit. See Section C for full eligibility and benefit details.

The Retiree Medical Plan provides medical and prescription drug benefits to you and your eligible dependents. Your cost for the Retiree Medical Plan is offset by the monthly Honda Retiree Medical credit (described later). Your medical and prescription drug coverage under the Retiree Medical Plan ends when you become Medicare-eligible. Your spouse's coverage under the Retiree Medical Plan will also end when he or she becomes Medicare-eligible. Coverage for dependent children will end when both the you and your covered spouse are no longer participating in the Retiree Medical Plan or when your child is no longer considered an eligible dependent (see "*Who is an Eligible Dependen*t" on page 3).

For associates who attained age 50 on or before December 31, 2020, Honda will credit a monthly amount to your RRA once you become eligible for Medicare. The credits can be used to reimburse yourself for Medicare or medical insurance premiums or for medical expenses that are not covered by Medicare.

Only full years of continuous service are taken into account for purposes of eligibility and credits.

Temporary extension of deadlines due to COVID-19 National Emergency

Due to the COVID-19 National Emergency, the Department of Labor (DOL) temporarily extended certain otherwise-applicable deadlines. The extension period is the **shorter** of (1) the Outbreak Period (the period between March 1, 2020 and the 60th day after the end of the COVID-19 National Emergency or other date set by the DOL); or (2) a 12-month period starting on the first day of the regular (unextended) period for taking action. Under the DOL's current guidance, the extension period does count against:

- COBRA
    - 60-day period to make a COBRA election
    - 45-day grace period to pay the first COBRA premium
    - 30-day grace period to pay monthly COBRA premiums
    - 60-day period to give notice of a qualifying event for purposes of COBRA
- Periods for filing claims and appeals

You may take action at any time before the applicable extended deadline. However, it is strongly recommended that you take action as soon as possible because the last day of the Outbreak Period is not known and/or guidance may change. Please contact My Benefits Connect Center (1-866-778-5885) if you have questions.

B. Retiree Medical Plan

1. Who is Eligible for the Retiree Medical Plan

If you:

- are covered under the Honda active medical plan at retirement, and
- are at least age 55 with at least 10 years of continuous service (or age 65 with at least 5 years of continuous service) on your retirement date, and
- you, your spouse, or dependent children are not yet eligible for Medicare

You and your eligible dependents are eligible for the Retiree Medical Plan.

If you are participating in the Medically Inactive Transition Program (MIT Program) on or before April 1, 2021, see your MIT Program materials to determine if you are eligible for the Retiree Medical Plan.

2. Who is an Eligible Dependent

Your eligible dependents include:

Spouse:

- Your legally married spouse and not legally separated.

Child:

- Children up to age 26.
- Your totally disabled child of any age who:
  - cannot earn a living due to a mental or physical handicap which began prior to reaching age 26; and
  - depends on you for support.
  - Is not Medicare eligible.

Proof of disability must be submitted to the Quantum Health within 31 days of the date your child reaches age 26. If you want continued coverage for your disabled child, you may be asked by Quantum Health to provide proof of continuing disability (generally, annually).

All eligible dependents may only be covered once under Honda's benefit plans.

Children are your:

- Biological children (your natural children), adopted children and children placed with you for adoption.
- Stepchildren.
- Children for whom you are the legal guardian, who are dependent on you for support.

Only your dependents that are enrolled in the Honda active health care plan as of the date of your retirement, and who are not Medicare eligible, may be enrolled in the Retiree Medical Plan. A new spouse or child cannot be added to your Retiree Medical Plan coverage after you retire.

A retiree, spouse or dependent who is or who becomes eligible to enroll in Medicare is not eligible for the Retiree Medical Plan, regardless of whether that dependent enrolls in Medicare.

A Qualified Medical Child Support Order (QMCSO) is a legal judgment, decree or order issued under a state domestic relations law that satisfies certain statutory requirements. It directs the Plan administrator to provide coverage for an eligible dependent child under Honda's health care plans.

Coverage will be provided according to federal and applicable state law. If Honda receives such an order, you, and your child(ren) will be notified. If the order is issued for an eligible dependent child after your coverage begins, the child's coverage will take effect after the order is approved.

Your child is totally disabled if:

- He or she is not able to earn his or her own living because of a mental or a physical handicap which began prior to reaching age 26; and

- He or she depends chiefly on you for support and maintenance.

Proof of disability must be submitted to Quantum Health within 31 days after the date your child reaches age 26. If you want continued coverage for your disabled child, you may be asked by the medical plan provide annually to provide proof of continuing disability.

Coverage will end on the first to occur of:

- Cessation of the total disability.

- Failure to give proof that the total disability continues.

- Failure to have any required exam.

- Dependent’s eligibility for Medicare.

IMPORTANT NOTE: Eligible dependents are those who are enrolled in the Honda group health plan at the time the associate retires and who are not Medicare eligible. New dependents cannot be added after retirement.

3. Enrolling in the Retiree Medical Plan

- If you meet the eligibility requirements and are enrolled in a medical plan for active Honda associates, through your confirmed retirement date, you will automatically be enrolled in the Retiree Medical Plan upon retirement. Coverage is effective as of the first day of the month after your active coverage ends. Pre-Medicare benefits are offered through the UMR and Blue Cross Blue Shield of Alabama provider networks. The network you are in as under the Honda active plan, when you retire, will be the network you are enrolled in for the Retiree Medical Plan. You will have the option to change the network within 30-days of retirement or once annually during the Benefits Enrollment Period.

- If you want to *waive* Retiree Medical Plan coverage or that of your current eligible spouse or dependents, you may do so by calling the My Benefits Connect Center (**1**-**866-778-5885**)**.** You

must call no later than 60 days following your retirement date to avoid owing the premiums for the Retiree Medical Plan.

- You and your eligible dependents, covered under the Honda active plan, are automatically enrolled in Retiree Medical after your active Honda coverage ends. If you or your eligible dependent waives coverage when you retire, you or the dependent will **not** be permitted to enroll at a later date and will not be eligible for the post-Medicare RRA program.

Working Spouse Exception: If you (the retiree) elect Retiree Medical coverage and your eligible spouse is currently working and is enrolled or enrolls in medical coverage through his or her employer when you retire, you can waive coverage for your spouse until he or she retires, terminates employment or his/her employer terminates their plan. This also applies to dependent children enrolled in coverage through your spouse's employer.

If your eligible spouse waived coverage upon your retirement, and they are not Medicare eligible, your spouse will be eligible to enroll in the Retiree Medical Plan within the 31 days after his or her employer coverage ends. You may also enroll an eligible dependent child who was covered with your spouse. Note, your spouse must show proof of continuous coverage to enroll in the Retiree Medical Plan. Failure to enroll by calling the My Benefits Connect Center within the 31 days after your spouse loses other employment-based coverage will result in a permanent loss of eligibility for your spouse (and dependent child). You may be asked to provide proof of dependent eligibility.

Upon your loss of coverage under the Honda active plan you will be mailed information on continuing associate medical/prescription drug, dental and vision coverage at your expense through COBRA for a limited period of time. You will lose eligibility for the Retiree Medical Plan and you will not be permitted to enroll in the Retiree Medical Plan at a later date if you choose to continue associate medical/prescription drug coverage through COBRA. However, your eligibility for the Retiree Medical Plan is not affected by an election to continue associate dental or vision coverage. Please remember that the Retiree Medical Plan does not include dental and includes limited vision benefits.

You must notify the My Benefits Connect Center if you or any of your dependents are Medicare-eligible. If your spouse is eligible for Medicare when you retire, your spouse is not eligible for the Retiree Medical Plan but may be enrolled in the RRA, if eligible (See Section C for eligibility details),

Honda-Married Couples: If you are married to another active Honda associate at the time your retirement, you will have the choice of enrolling as a retiree on the Retiree Medical Plan or going onto your spouse's active Honda coverage as a spousal dependent. If you waive your coverage as a Honda retiree, due to obtaining coverage with a spouse employed by Honda, you will always be considered a spousal dependent even upon your spouse's retirement, and will not be eligible for post-Medicare spousal credits. Please note, that enrollment as a spouse under the Honda Retirement Plan, means that all applicable rules for the spouse will be applied to your eligibility and you will not have another opportunity to enroll as a retiree. This includes your spouse separating from Honda and not retiring or you and your spouse legally separating or divorcing.

4. When Retiree Medical Plan Coverage Begins

Retiree Medical Plan coverage for you and your enrolled eligible dependents begins on the first day of the month after your retirement from Honda (or active coverage ends).

Upon enrolling in the Retiree Medical Plan, you will receive a new medical and prescription ID card from the claims administrator.

5. Changing Your Retiree Medical Plan Coverage

Making coverage changes to your Retiree Medical Plan is limited. You can drop coverage for you or an eligible dependent at any time. You have the opportunity, at the time you retire or during the annual enrollment period, to change provider networks. These are the only changes you can make to your Retiree Medical Plan coverage.

If you drop coverage for yourself, your eligible dependents' coverage also ends, and you will not be permitted to re-enroll in any of the Honda Retiree Medical Programs in the future. If you drop coverage for an eligible dependent, that dependent will not be permitted to re-enroll in any of the Honda Retiree Medical Programs in the future. See the *Working Spouse Exception*.

6. When Retiree Medical Plan Coverage Ends

- Retiree: Your coverage ends on the earliest of:
  - the first of the month you become eligible for **Medicare** (regardless of whether you enroll in Medicare);
  - the date you fail to pay your share of the cost or waive coverage; or
  - the date the Retiree Medical Plan is terminated or amended to end your eligibility for coverage.
- Spouse: Coverage for your spouse ends on the earliest of:
  - the date your spouse becomes eligible for **Medicare** (regardless of whether your spouse enrolls in Medicare);
  - the date you fail to pay your share of the cost of dependent coverage or waive coverage;
  - the last day of the month in which you and your spouse get legally separated or divorced;
  - in the case of a surviving spouse, the date of remarriage after your death; or
  - the date the Retiree Medical Plan is terminated or amended to end dependent coverage.
- Dependent children: Coverage for your dependent children ends on the earliest of:
  - the date your dependent becomes eligible for **Medicare** (regardless of whether your dependent child enrolls in Medicare);
  - the last day of the month in which the dependent's eligibility ends unless the claims administrator has determined that the child is totally disabled;
  - the date neither your or your covered spouse is enrolled in the Retiree Medical Plan;
  - the date you fail to pay your share of the cost of dependent coverage or waive coverage; or
  - the date the Retiree Medical Plan is terminated or amended to end dependent coverage.

In the event of your death, Retiree Medical Plan coverage will continue for your enrolled spouse and eligible dependent children until the occurrence of one of the other events listed above.

Coverage will also end for any person who commits fraud or makes an intentional misrepresentation of a material fact.

To report a loss of eligibility, such as a legal separation or divorce, call the My Benefits Connect Center at 1-866-778-5885 Monday through Friday from 8:30 a.m. to 10:00 p.m. ET / 5:30 a.m. to 7:00 p.m. PT. Whenever possible, these changes should be reported in advance; changes must be reported within 31 days following the loss of eligibility.

You must notify the My Benefits Connect Center when you, your spouse or child becomes Medicare eligible due to disability prior to age 65. Your coverage under the Retiree Medical Plan ends when you become eligible for Medicare and your spouse's coverage under the Retiree Medical ends when he or she becomes eligible for Medicare. However, a special rule applies if you or your spouse becomes eligible for Medicare due to end-stage renal disease (ESRD). In that case, coverage under the Retiree Medical Plan can continue up to 30 months after Medicare eligibility. For more information on post-Medicare medical coverage, refer to pages 48 through 52 of this document.

If your spouse or dependent's eligibility ends, he or she may qualify for continued coverage under COBRA. For more information about qualifying for and electing COBRA coverage, see "*COBRA Continuation Coverage*" on page 66.

7. Your Cost of Coverage and the Honda Retiree Medical Credit Levels of Coverage

Your cost for coverage is based on the premium for the medical plan, the number of family members enrolled and your Retiree Medical credit. For current premium information, please contact the My Benefits Connect Center at 1-866-778-5885 Monday through Friday from 8:30 a.m. to 10:00 p.m. ET / 5:30 a.m. – 7:00 p.m. PT or log on to www.myhondaconnect.com.

How the Honda Retiree Medical Credit Works

Honda will provide a specified amount each month based on your years of service – called the Honda Retiree Medical credit – toward the cost of premiums for the Retiree Medical Plan. The longer you have worked at Honda, the more Honda contributes toward you and your eligible dependents' medical coverage.

The current amount of the Retiree Medical credit is shown in the chart below:

$473 for the first 10 continuous years of service
$22 x continuous years of service from 11 to 20 years
$13 x continuous years of service from 21 to 30 years

Your dependents will receive 50% of the credits you receive as a retiree.

Exceptions:

- If you retired from Honda Manufacturing of Alabama, LLC (HMA) or Honda of South Carolina Mfg., Inc. (HSC) before January 1, 2014, you and your dependents are not eligible for Honda Retiree Medical Plan or credits.

- If you retired from Honda Manufacturing of Indiana, LLC (HMIN) or Honda Precision Parts of Georgia, LLC (HPPG) before January 1, 2018, you and your dependents are not eligible for Honda Retiree Medical Plan or credits.

- If you retired from another participating employer before July 1, 2014, your eligible dependents will receive 100% of the credits you receive as a retiree.

Note: If you and your spouse are both Honda associates, you will receive your credits through only one Honda Company. If you or your spouse is a current or retired Honda associate, you can each be covered by one plan, in one capacity (i.e., active associate, retiree or dependent of an active associate or retiree). You cannot be covered more than once (e.g., you cannot enroll as both a retiree and a dependent of an active associate) and you will not receive double credits even if both you and your spouse enroll in the Retiree Medical Plan. If you waive your Retiree Medical coverage at retirement, you can be covered under your spouse's active healthcare coverage. However, you will not be able to be reinstated on the Retiree Medical plan under your own coverage.

Calculating Your Monthly Credit

Here are a few examples of how the monthly credit is calculated using different retirement dates:

Using an example with the 2021 Retiree Medical Rates, let's assume Martin retired on June 1, 2014, at age 55 with 22 years of continuous service and both he and his spouse are pre- Medicare. Here's how his 2021 credit is calculated:

1st 10 years of service	$473.00
Next 10 Years of Service x $22 per year	$220.00
Next 2 years of service x $13 per year	$ 26.00
Total Monthly Retiree Credit for Martin	$719.00
Total Monthly Credit for Martin's Spouse	$719.00
Total Monthly Retiree Medical Credits	$1,438.00
Retiree Medical Plan = $1,023 per covered individual Cost for Martin and his spouse: Less monthly Retiree Medical Credits: Total Monthly Cost for Martin:	 $2,046.00 $1,438.00 $ 608.00

Now assume Martin retired on October 1, 2014, at age 55 with 22 years of continuous service and both he and his spouse are pre-Medicare. Here's how his credit is calculated:

1st 10 years of service	$473.00
Next 10 Years of Service x $22 per year	$220.00
Next 2 years of service x $13 per year	$ 26.00

Total Monthly Retiree Credit for Martin	$719.00
Total Monthly Credit for Martin's Spouse	$359.50
Total Monthly Retiree Medical Credits	$1,078.50
Retiree Medical Plan = $1,023 per covered individual Cost for Martin and his spouse: Less monthly Retiree Medical Credits: Total Monthly Cost for Martin	 $2,046.00 $1,078.50 $ 967.50

How Much You Pay for Your Coverage

The amount you pay in premiums is determined by subtracting the credit you receive from Honda from the total monthly premium costs. The amount you pay will change as the premiums change from year to year. Honda may also change the amount of the Retiree Medical credit.

Please refer to the My Benefits Connect Center for the current premium cost.

Payment of Premiums

You will receive an invoice from Alight for your share of the cost of your Retiree Medical Plan coverage. If you receive a monthly annuity pension benefit when you retire, and you have sufficient funds available, your premiums for the Retiree Medical Plan will be automatically deducted from your monthly pension benefit 2-3 months after you begin receiving your pension. Since the timing for auto-deduction varies, please verify the Retiree Medical Plan premium has not been deducted from your pension check before your submitting your payment to Alight.

If you plan to postpone (defer) your pension, or receive a Lump Sum pension payment, you will continue to receive a Retiree Medical premium invoice monthly. The cost of the Retirement Medical Plan changes every year. You will be notified when your premium changes.

8. Receiving Medical Care

Each time you need care, you have a choice to make. That choice is whether to use a doctor or hospital in the Retiree Medical Plan's network or use a provider that is not in the network. You decide which choice makes sense for you each time you need care.

You may choose to receive care from any provider, but the Plan pays a higher level of coverage if you use network doctors or hospitals. That's because network doctors and hospitals have agreed to negotiated charges in return for using their services. You may use providers not in the Plan's network, but your share of the expenses may be greater. The deductible and coinsurance is higher for out-of-network care. In addition, an out-of-network provider may balance bill you for the difference between the allowed amount and the billed charge and the difference can be significant.

You may verify that the provider you are seeing is an in-network provider by checking www.myhondaconnect.com or the online directory on your claims administrator's website (www.UMR.com or www.bcbsal). You can also call Quantum Health at 1-866-778-5885.

Although there are financial advantages to using network providers, you always have the flexibility to choose out-of-network care if that better suits your needs.

If You Need to See a Doctor…

- Network Providers
  - Verify that the physician you are seeing is a network provider by checking the claims administrator's online directory or by calling Quantum Health.
  - Bring your medical ID card to the doctor's office and show it to the receptionist.
  - Pay your office visit Copay, Coinsurance or Deductible.
  - Receive further treatment from a network specialist, if necessary.

When you receive care from a network provider, your claims will be filed by the doctor's office.

- Out-of-Network Providers
  - Ask for an itemized bill and attach it to your claim form when you file it.
  - File your claim promptly so you won't lose track of expenses. You have up to 12 months after the date of service to file a claim.

If You Need Surgery…

Always ask your doctor about outpatient surgery or other alternatives to treat your condition before you undergo surgery. All surgeries need to be pre-authorized by Quantum Health.

- Network Providers
  - Reduce your costs by using a network surgeon.
- Out-of-Network Providers
  - Certify your care in advance by calling Quantum Health.
  - File medical claims promptly.

If You Need Hospitalization…

Bring your medical ID card to the hospital. The hospital will usually file a claim directly with the claims administrator for your hospital expenses. Then, you will receive a bill for your share of the costs.

- Network Providers
  - Confirm that your hospital is a network hospital. This way, you will reduce your costs.
- Out-of-Network Providers

- Remember, if you do not go to a network hospital, your benefits will be paid at the out-of-network level unless you have an emergency condition.

- Call Quantum Health at the number on your medical ID card to certify your hospital admission and length of stay.

If you are hospitalized it is important that you contact Quantum Health within 24-hours of admission for authorization.

If You Have a True Medical Emergency Condition…

- Go to the nearest emergency room if you have a true emergency condition. If you are unsure of the best source for care, you may call your family physician or Quantum Health at the number on your medical ID card.

- Bring your medical ID card to the hospital whenever possible. The hospital will usually file a claim directly with the claims administrator for your hospital expenses.

- You will receive a bill for your share of any costs.

- Keep your records up to date and tell your doctor about any previous emergency care you have received.

Emergency Condition

This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or

- serious impairment to bodily function; or

- serious dysfunction of a body part or organ; or

- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

In Case of an Urgent Condition

Call your PCP (primary care physician) if you think you need urgent care. You may contact any physician or urgent care provider, in- or out-of-network, for an urgent care condition if you cannot reach your physician. If it is not feasible to contact your physician, please do so as soon as possible after urgent care is provided. If you need help finding an urgent care provider you may call Quantum Health at the toll-free number on your I.D. card, or you may access the online provider directory.

Certification for Inpatient Admissions

You are responsible for checking with your doctor or provider to ensure that inpatient admissions to a hospital, Skilled Nursing Care facility, home healthcare, skilled nursing care, and hospice or residential treatment facility are certified with Quantum Health or benefits will be reduced.

In addition, you must call the Quantum Health within 24 hours of an emergency Hospital admission or benefits will be reduced.

To certify inpatient care, call Quantum Health at the number listed on your medical ID card. If care is not pre-certified, benefits are reduced as described below.

	You call but care is not approved	**You don't call and care...**	
		***is** Medically Necessary*	*is **not** Medically Necessary*

Medical inpatient admissions to:
▪ Hospital
  ▪ Radiology and Pathology
  ▪ Physician & Nursing Staff Services
▪ Skilled Nursing Care Facility
▪ Hospice Facility
▪ Home Health Care
▪ Outpatient hospice
▪ Skilled nursing
▪ Mental health/chemical dependency inpatient admissions to:
  ▪ Hospital
  ▪ Residential treatment facility
	No expenses are covered.	If care is approved, Board and Room paid after $400 penalty; other eligible expenses are covered.
		If care is not approved no expenses are covered.
			No expenses are covered.

Claims

If you receive care from a Network Provider, claims will be filed by the provider.

If you receive care from an out-of-network provider, you may need to file the claim for reimbursement. You should attach proper documentation of your claim including the provider's name, the date services were received and any bills/receipts. By providing a complete claim, you will avoid unnecessary delays in processing. You have 12-months after the date the service was provided to file a claim. Claims filed after that time are not payable unless you were unable to file because you were legally incapacitated.

If You Have Questions

If you have questions regarding your claims under the Retiree Medical Plan, please contact Quantum Health at 1-866-778-5885.

Medical Plan Claim Forms

Medical claim forms for out-of-network care are available by calling Quantum Health at 1-866-778-5885 or online at www.myhondaconnect.com by clicking on the Quantum Health tile.

Medical benefits are payable to you. However, the Plan has the right to pay any health benefits to the provider. You can indicate on the claim form if you prefer to have benefits paid directly to the provider.

However, a direction to make payment to the provider is not an assignment of your rights or benefits. You cannot assign your rights or benefits to anyone else without the written consent of the Plan Administrator (except as required by a Qualified Medical Child Support Order or National Medical Child Support Notice).

If a claim is denied, in whole or part, you can appeal the decision in writing to the claims administrator. See "*Claims and Appeals*" on page - 58 -.

Certain healthcare services require a pre-approval, and if you choose to use an out-of-network provider, you are responsible for securing pre-approval, with Quantum Health, before the procedure, when necessary. Failure to obtain a pre-approval will result in a $400 penalty, in additional to your normal out of pocket cost.

9. Retiree Medical Preferred Provider Organization (PPO) Plan

Honda offers retiree medical coverage under a PPO (Preferred Provider Organization) plan. The PPO Plan offers both in-network and out-of-network benefit and include an unlimited lifetime maximum benefit, while eligible.

The following chart provides a very high-level summary of benefits covered under the Plan.

Retiree Medical Plan

Preventive Services Covered at 100%

Make sure you take advantage of the preventive benefits such as wellness exams. The Plan pays 100% of the cost – you pay nothing.

The following chart provides an overview of the coverage available under the Retiree Medical Plan for retirees and eligible dependents who are not yet eligible for Medicare.

	In-Network	Out-of-Network
	YOU PAY	
Calendar Year Deductible Individual/Family	$800/$1,600	$1,000/$2,000
Annual Out-of-Pocket Maximum *(includes deductible)* Individual/Family	$3,200/$6,400	$4,000/$8,000
Lifetime Maximum	Unlimited	Unlimited
PREVENTIVE CARE		
	PLAN PAYS	
Physical Exam	100%	100%
Cholesterol Test	100%	100%
Mammogram	100%	100%
Routine Cancer Screening	100%	100%
Colonoscopy	100%	100%
Well-Child Visit	100%	100%
Immunizations	100%	100%
OTHER MEDICAL SERVICES		
Doctor's Office Visit *(non-preventive)* Primary Care Physician/Specialist	You pay $30/$50 copay	Plan pays 60% after deductible
X-rays and Laboratory	Plan pays 70% after deductible	Plan pays 60% after deductible
Vision Exams *(one every two years)*	Plan pays 100%	Plan pays 100%
Hearing Exams	*Preventive:* Plan pays 100% *Diagnostic:* You pay $30/$50 copay	*Preventive:* Plan pays 100% *Diagnostic:* Plan pays 60%
Hearing Aids *(up to $2,000 every two years)*	Plan pays 70% after deductible	Plan pays 60% after deductible
Emergency Care	You pay 30% after deductible, 50% after deductible if non-emergency	
SURGICAL SERVICES		
	PLAN PAYS (after deductible)	
Inpatient	70%	60%
Outpatient	70%	60%
Hospital Room and Board	70%	60%
PHARMACY BENEFITS		
	YOU PAY	OUT-OF-NETWORK COSTS NOT COVERED
Retail *(up to 30-day supply)* copay		
Generic	$7	Not covered at non-participating pharmacies
Formulary	$35	
Non-Formulary	$70	
Specialty	$125	
Mail order *(up to 90-day supply)* copay		
Generic	$14	Not covered
Formulary	$70	
Non-Formulary	$140	
Specialty	$250	

**Co-insurance begins after deductible is met for all services in surgery category or where deductible is applied. The deductible met while on Honda active coverage (within the calendar year) will be applied to Retiree Medical Coverage*

***Expenses which do not apply to the out of pocket maximum include: charges over the allowed amount, expenses incurred for outpatient prescription drugs, non-covered expenses, expense incurred for non-urgent use of a urgent care provider, and expense that are not paid, or pre-certified benefit reductions because a required pre-certification for the service(s) or supply was not obtained from the claims administrator.*

10. Benefits/Covered Medical Expenses

To be covered under the Retiree Medical Plan, medical expenses must be:

- Determined by the claims administrator to be medically necessary for the diagnosis, care, or treatment of non-work-related (non-occupational) illness or injury;

  - Non-Occupational Illness

    A non-occupational illness is an illness that does not:

    - arise out of (or in the course of) any work for pay or profit; or
    - result in any way from an illness that does.

    An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

    - is covered under any type of workers' compensation law; and
    - is not covered for that illness under such law.

  - Non-Occupational Injury

    A non-occupational injury is an accidental bodily injury that does not:

    - arise out of (or in the course of) any work for pay or profit; or
    - result in any way from an injury which does.

- Prescribed by a physician; and
- Incurred on a date of service while you (or your dependents) are covered under the Retiree Medical Plan.

Allowed Amount

The Retiree Medical Plan pays for network services based on negotiated rates or, for out-of- network services, based on the allowed amount. Only that part of the charge that is considered the allowed amount is covered. The Retiree Medical Plan does not cover any amounts above the allowed amount. You are responsible for any charges in excess of the allowed amount when you use providers not in the network. The excess may be significant. See the "*Glossary*" for a definition of the allowed amount.

The following sections show the benefits and services covered under each Retiree Medical Plan option.

Preventive Care

The following preventive care is covered at 100%:

- Routine Physical Exams (1 exam per calendar year)
- Routine Vision and Hearing Exam (1 exam every 2 years)

- **Routine Physical Exams**

Routine physical exams including related tests and immunizations.

- Adults and children ages two and over are covered for one exam per calendar year, including screenings for blood pressure, height and weight, physical and psychological development, urinalysis, testing for Tuberculosis, immunizations, and other age-related screenings.
- For children
  - In the first 12 months of life are allowed up to 7 exams;
  - In the second 12 months of life, are allowed 3 exams;
  - Ages 2 to 18 are allowed 1 exam per calendar year;
- Adults
  - One routine gynecological exam/pap smear per calendar year.
  - On routine mammogram per calendar year.
  - One routine prostate exam per calendar year for men (includes digital rectal exam and PSA tests).
  - One routine colon exam per calendar.

Not covered are charges for:

- Services which are covered to any extent under any other group plan of Honda.
- Services which are for diagnosis or treatment of a suspected or identified injury or illness.
- Exams given while the person is confined in a hospital or other facility for medical care.
- Services which are not given by a physician or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.
- Dental exams.
- A physician's office visit in connection with immunizations or testing for tuberculosis.

- **Routine Hearing Exam Expenses**

One routine hearing exam every 2 years provided by a licensed or certified hearing/ear specialist (otolaryngologist or otologist) or audiologist.

Not included are charges for:

- Any ear or hearing exam to diagnose or treat an illness or injury;
- Drugs or medicines;
- Any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through Honda;
- Any hearing care service or supply for which a benefit is provided under any workers' compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- Any hearing care service or supply which does not meet professionally accepted standards;
- Any service or supply received while the person is not covered;
- Any exams given while the person is confined in a hospital or other facility for medical care; or
- Any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government.

- **Routine Vision Exam Expenses**

One routine vision exam every 2 years provided by a licensed ophthalmologist or optometrist, including refraction and glaucoma testing.

Not included are charges for:

- Any eye exam to diagnose or treat an illness or injury.
- Drugs or medicines.
- A vision care service that is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through Honda.
- A vision care service for which a benefit is provided in whole or in part under any workers' compensation law or any other law of like purpose.
- Special procedures. This means things such as orthoptics or vision training.
- Any vision care supply.
- An eye exam which:
  - is required by an employer as a condition of employment; or an employer is required to provide under a labor agreement; or is required by any law of a government.
  - A service received while the person is not covered.
  - A service or supply which does not meet professionally accepted standards.
  - Any exams given while the person is confined in a hospital or other facility for medical care.

- An eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses.

Physician Services

The Retiree Medical Plan covers charges made by a physician for office visits, surgery (including pre- and post-operative care, as well as administering anesthesia) and other services.

	Retiree Medical Plan	
	Network	Out-of-Network
Primary Care Office Visits	$30 copay	60% after deductible
Specialist Office Visits	$50 copay	60% after deductible
Other Physician Services	70% after deductible	60% after deductible

Emergency Care and Ambulance

The Retiree Medical Plan covers emergency room treatment for injury, illness or disease network and out-of-network facilities. Benefits are paid based on whether or not emergency room care was used for an emergency condition.

For an emergency condition, you should seek care immediately at the nearest emergency facility. Ground ambulance, air or water ambulance services are also covered:

- in an emergency situation; and
- when an ambulance is required to move the patient for medical reasons to or from home or an appropriate treatment facility.

	Retiree Medical Plan	
	Network	Out-of-Network
Emergency Room*	If true emergency, 70% after deductible If non-emergency, 50% after deductible	
Urgent Care	70% after deductible	60% after deductible

	Retiree Medical Plan	
	Network	Out-of-Network
Ambulance	70% after deductible	60% after deductible

** Use of an emergency room for anything other than an Emergency Condition is covered at 50% after deductible*.

Inpatient Hospital

You must be admitted to a network hospital to receive network benefits for the hospitalization.

Prior to admission, you are responsible for making sure care is certified with Quantum Health. Benefits will be reduced for inpatient admissions that are not certified. See "*Certification for Inpatient Admissions*" on page 12 for details.

	Retiree Medical Plan	
	Network	Out-of-Network
Hospital Care	70% after deductible	60% after deductible

Hospital Expenses

Covered medical expenses include services and supplies provided by a hospital during your stay.

Room and Board

Covered expenses include charges for room and board provided at a hospital during your stay. Private room charges that exceed the hospital's semi-private room rate are not covered unless a private room is required because of a contagious illness or immune system problem.

Room and board charges also include:

- Services of the hospital's nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies

Covered expenses include charges made by a hospital for services and supplies furnished to you in connection with your stay. Covered expenses include hospital charges for other services and supplies provided, such as:

- Ambulance services.
- Physicians and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy, and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

Outpatient Hospital Expenses

Covered expenses include hospital charges made for covered services and supplies provided by the outpatient department of a hospital.

Important Reminders

The plan will only pay for nursing services provided by the hospital as part of its charge. The plan does *not* cover private duty nursing services as part of an inpatient hospital stay. If a hospital or other health care facility does not itemize specific room and board charges and other charges, the claims administrator will assume that 40 percent of the total is for room and board charge, and 60 percent is for other charges. Hospital admissions need to be pre-certified by Quantum Health.

In addition to charges made by the hospital, certain physicians and other providers may bill you separately during your stay.

Hospice Care

Hospice care is care arranged under a Hospice Care Agency for terminally ill patients with a life expectancy of twelve months or less who are no longer seeking treatment of any kind. Services provided through any hospice care agency, facility, or program must be pre-authorized through Quantum Health.

Hospice care does not include expenses for funeral arrangements, pastoral, financial or legal counseling, housecleaning, or caretaker services such as sitters and transportation and respite care.

	Retiree Medical Plan	
	Network	Out-of-Network
Hospice Care no lifetime maximum	70% after deductible	60% after deductible

Home Health Care Expenses

Services provided for Home Health Care must be pre-authorized through Quantum Health.

Covered expenses include charges made by a home health care agency for home health care, and the care:

- Is given under a home health care plan;
- Is given to you in your home while you are homebound. Home health care expenses include charges for:
- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services provided in conjunction with and in direct support of care by an R.N. or an L.P.N.
- Physical, occupational, and speech therapy.
- Part-time or intermittent medical social services by a social worker when provided in conjunction with and in direct support of care by an R.N. or an L.P.N.
- Medical supplies, prescription drugs and lab services by or for a home health care agency to the extent they would have been covered under this plan if you had a hospital stay.
- Benefits for home health care visits are payable up to the Home Health Care Maximum visits per calendar year.

Each visit by a nurse or therapist is one visit.

- In figuring the Calendar Year Maximum Visits, each visit of up to 4 hours is one visit.
- This maximum will not apply to care given by an R.N. or L.P.N. when:
  - Care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient; and
  - Care is needed to transition from the hospital or skilled nursing facility to home care.
- When the above criteria are met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.
- Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or custodial care service does not

cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Services or supplies that are not a part of the Home Health Care Plan.
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are custodial care. Important Reminders

The plan does *not* cover custodial care, even if care is provided by a nursing professional and family member or other caretakers cannot provide the necessary care. Home health care needs to be pre-certified by Quantum Health. Inpatient admissions must be pre-certified.

	Retiree Medical Plan	
	Network	Out-of-Network
Home Health Care (maximum of 120 visits per calendar year)	70% after deductible	60% after deductible

Outpatient Surgery, Lab and X-ray

The Retiree Medical Plan covers:

- Outpatient care (including surgical expenses and other services and supplies) in a hospital or surgery center, provided it is best performed in this setting rather than a physician's office.
- Diagnostic lab, radiology tests and x-ray expenses (including physician fees for interpretation) provided in a doctor's office or lab facility or on an outpatient basis in a hospital.

	Retiree Medical Plan	
	Network	Out-of-Network
Outpatient Care	70% after deductible	60% after deductible
Diagnostic X-Ray & Lab	70% after deductible	60% after deductible

Durable Medical and Surgical Equipment (DME)

The Retiree Medical Plan covers the following medical supplies and equipment:

- Anesthetics, oxygen, x-ray, radium and radioactive isotope therapy.
- Artificial limbs and eyes.
- Medically Necessary orthotics. This includes, but is not limited to, arch supports and orthopedic shoes prescribed by a physician or podiatrist to treat a foot or leg condition.
- Hearing aid purchase and replacement (for aids used at least two years) if prescribed by an otolaryngologist; subject to the maximum for each covered person described in the table below.
- Rental of durable medical or surgical equipment; initial purchase may be covered for long-term use if the equipment cannot be rented or purchase is less expensive than rental; replacement may be covered if necessary due to a change in physical condition or replacement is less expensive than repair or rental.

To receive network benefits, call Quantum Health for the nearest network provider of durable medical equipment.

Not covered are eyeglasses and orthotics used mainly for comfort or convenience, stock orthopedic shoes or charges for more than one item for the same or similar purpose.

	Retiree Medical Plan	
	Network	Out-of-Network
Durable Medical Equipment	70% after deductible	60% after deductible
Hearing Aids – maximum of $2,000 every 2 years	70% after deductible	60% after deductible

Short-Term Rehabilitation

The Retiree Medical Plan covers charges for short-term rehabilitation services provided on an outpatient basis, including physical, occupational and speech therapy. Covered expenses include charges for short-term therapy services when prescribed by a physician as described below up to the benefit maximums. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A hospital, skilled nursing facility, or hospice facility; or
- A physician.

Charges for the following short-term rehabilitation expenses are covered:

- Cardiac and Pulmonary Rehabilitation Benefits.
- Cardiac rehabilitation benefits are available as part of an inpatient hospital stay.
- A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.

  The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Coverage is subject to the visit limits. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this Guide.

- Physical therapy is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop, or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from illness or injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function. A "visit" consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period. The therapy should follow a specific treatment plan that:

  - Details the treatment, and specifies frequency and duration; and

  - Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Important Reminder

Unless specifically covered above, *not* covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders, Down's syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

- Any services which are covered expenses in whole or in part under any other group plan sponsored by an employer;

- Any services unless provided in accordance with a specific treatment plan;

- Services for the treatment of delays in speech development, unless resulting from illness, injury, or congenital defect;

- Services provided during a stay in a hospital, skilled nursing facility, or hospice facility except as stated above;

- Services not performed by a physician or under the direct supervision of a physician;

- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;

- Services provided by a physician or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; or your domestic partner;

	Retiree Medical Plan	
	Network	Out-of-Network
Short-Term Rehabilitation (60 visits combined for physical, occupational or speech therapy per calendar year)	70% after deductible	60% after deductible

Chiropractic Services & Acupuncture Treatment

Chiropractic services are paid subject to the deductible and co-pay. Any service (except x-ray and lab) performed by a chiropractor tracks to the limit. Acupuncture treatments are paid subject to the deductible and co-pay. Chiropractic and acupuncture treatments are limited to a combined 26 visits per calendar year.

Mouth, Jaws and Teeth

- Expenses for the treatment of the mouth, jaws and teeth are covered medical expenses, but only those for:

  - services rendered; and
  - supplies needed;

  for the following treatment of or related to conditions of the:

  - teeth, mouth, jaws, jaw joints; or
  - supporting tissues (this includes bones, muscles, and nerves). For these expenses, physician includes a dentist.

- Hospital services and supplies received for an inpatient hospital confinement required because of the person's condition.

- Surgery needed to:

  - Treat a fracture, dislocation or wound.
  - Cut out cysts, tumors or other diseased tissues.
  - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

- Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

- Dental work, surgery and Orthodontic Treatment needed to remove, repair, replace, restore, or reposition:

  - natural teeth damaged, lost, or removed; or
  - other body tissues of the mouth fractured or cut; due to accidental injury.

  Any such teeth must have been:

  - free from decay; or
  - in good repair; and
  - firmly attached to the jawbone at the time of the injury.

  The treatment must be done within 12-months of the accident or the next one. If:

  - crowns (caps); or
  - dentures (false teeth); or
  - bridgework; or
  - in-mouth appliances;

are installed due to such injury, covered medical expenses include only charges for:

- the first denture or fixed bridgework to replace lost teeth;
- the first crown needed to repair each damaged tooth; and
- an in-mouth appliance used in the first course of Orthodontic Treatment after the injury.

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy; or
- for tooth removal.

Not included are charges:

- to remove, repair, replace, restore, or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace or restore fillings, crowns, dentures, or bridgework;
- for periodontal treatment;
- for dental cleaning, in-mouth scaling, planning, or scraping;
- for myofunctional therapy; this is:
  - muscle training therapy; or
  - training to correct or control harmful habits.

Skilled Nursing Care Facility Expenses

Charges made by a Skilled Nursing Care Facility for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Board and Room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily Board and Room in a private room over the institution's semi-private room rate.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a Convalescent Facility. This does not include private or special nursing or Physician's services.
- Medical supplies.

Benefits will be paid for no more than 120 days during any one calendar year.

Limitations to Skilled Nursing Care Expenses

This section does not cover charges made for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

	Retiree Medical Plan	
	Network	Out-of-Network
Convalescent Facility – maximum of 120 days per calendar year	70% after deductible	60% after deductible

Skilled Nursing Care Expenses

Charges made by a R.N. or L.P.N. or a nursing agency for skilled nursing care.

- As used here, “skilled nursing care” means these services:
  - Visiting nursing care by a R.N. or L.P.N. Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
  - Private duty nursing by a R.N. or L.P.N. if the person's condition requires skilled nursing services and visiting nursing care is not adequate.
- Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of 70 shifts per calendar year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.
- Not included as "skilled nursing care" is:
  - that part or all of any nursing care that does not require the education, training and technical skills of a R.N. or L.P.N.; such as transportation, meal preparation, charting of vital signs and companionship activities; or
  - any private duty nursing care given while the person is an inpatient in a hospital or other health care facility; or

- care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair or toileting; or

- care provided solely for skilled observation except as follows:

  for no more than one 4-hour period per day for a period of no more than 10 consecutive days following the occurrence of:

  change in patient medication;

  need for treatment of an emergency condition by a physician or the onset of symptoms indicating the likely need for such treatment;

  surgery; or

  release from inpatient confinement; or

- any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a R.N. or L.P.N.

	Retiree Medical Plan	
	Network	Out-of-Network
Skilled Nursing Care-maximum of 70 shifts per calendar year	70% after deductible	60% after deductible

Treatment of Alcoholism, Drug Abuse or Mental Disorders

Certain expenses for the treatment shown below are covered medical expenses. Some treatment option need to be pre-certified by Quantum Health.

- Outpatient Treatment. If a person is not a full-time inpatient either:

  - in a hospital; or

  - in a Residential Treatment Facility;

then expenses for the Treatment of Alcoholism or Drug Abuse or the treatment of Mental Disorders are covered.

- Inpatient Treatment. If a person is a full-time inpatient either:

  - in a hospital; or

  - in a Residential Treatment Facility; then the following expenses are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens or hepatitis.

- Effective Treatment of Alcoholism or Drug Abuse.

- Treatment of Mental Disorders.

- Residential Treatment Facility. Certain Residential Treatment Facility expenses for the Treatment of Alcoholism or Drug Abuse or the treatment of Mental Disorders are covered. The expenses covered are those for:

  - Board and Room. Not covered is any charge for daily board and room in a private room over the institution's semi-private room rate.

  - Other medically necessary services and supplies.

	Retiree Medical Plan	
	Network	Out-of-Network
Outpatient Care	$50 copay	60% after deductible
Inpatient Care	70% after deductible	60% after deductible

Post-Mastectomy Services

- reconstruction of the breast on which the mastectomy has been performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage will be provided in a manner determined in consultation between you and your attending physician. This coverage is subject to the same deductibles and coinsurance limitations that apply for other benefits under the Retiree Medical Plan.

Maternity Hospital Stays

Maternity hospital stays are covered like any other hospital stay. However, under the Newborns' and Mothers' Health Protection Act, coverage for a hospital stay for both mother and child cannot be limited to less than 48 hours after a normal delivery or 96 hours after a caesarean section (c- section) delivery. By law, no pre-certification is required for maternity stays within those time frames. Although you are always free to leave the hospital earlier if you and your doctor agree that is appropriate, a medical plan is not

allowed to force you or your baby to leave earlier than 48 hours after a normal delivery or 96 hours after a caesarean section delivery.

Organ Transplant Center of Excellence Network

UMR provides access to Optum Transplant Centers of Excellence (Blue Cross and Blue Shield provides access to Blue Distinction Transplant Centers of Excellence) — health care providers experienced in specialized care required for certain organ transplants. These facilities charge negotiated fees for services related to organ transplantation, including:

- Charges made by a physician or transplant team
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program
- Related supplies and services provided by the COE facility during the transplant process. These supplies and services may include:
  - Physical, speech and occupational therapy.
  - Bio-medicals and immunosuppressants.
  - Home healthcare expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members (biological parents, siblings or children).
- Inpatient and outpatient expenses directly related to a transplant.

If you are a participant in the COE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from a COE facility will be considered network care expenses. There is no coverage for non-COE transplant providers.

Once you receive advance approval from Quantum Health, you can receive care for certain transplants from a COE facility. The plan covers eligible physician, hospital and other services/supplies, as described above, for the following transplants:

- Heart, lung or heart/lung.
- Liver, kidney, pancreas or kidney/pancreas.
- Small bowel.
- Bone marrow or stem cell for certain conditions.

Then the plan will pay:

- In-network benefits for covered medical care; and
- Travel and lodging expenses for you and a companion, up to a maximum (see below).

Organ Transplants		
Expense	**Centers of Excellence™ facility**	**Other facility**
Lodging expense maximum benefit	$50 per night per person and $100 total for member and companion	Does not apply
Travel and lodging per transplant maximum	$10,000 total for patient and companion per transplant performed in Centers of Excellence facility	Does not apply

If you are a participant in the COE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need.

Limitations

Unless specified above, the plan does *not* cover the following expenses:

- Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient treatment occurrence (refer to the *Prescription Drug Plan* section).
- Services that are covered under any other part of this plan.
- Services and supplies furnished to a donor when the recipient is not covered under this plan.
- Home infusion therapy after the transplant occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.
- Harvesting or storage of bone marrow, tissue or stem cells, with the expectation of transplantation within 12 months for an existing illness.
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Quantum Health.

Bariatric Surgery

The Plan covers surgical treatment of morbid obesity provided all the following are true:

- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height and a minimum tanner stage of 4.
- You have a minimum body mass index (BMI) of 40, or > 35 with at least one co-morbid condition present.
- You must enroll in the Optum Bariatric Resource Services (BRS) Program.
- You must use an Optum-designated Bariatric Resource Services (BRS) provider and facility.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.

- You have a six-month physician-supervised diet documented within the last two years.
- One surgery per lifetime unless you experience complications.
- Excess skin removal post bariatric surgery is not covered, unless medically necessary.
- All authorization information and enrollment for bariatric surgery must be initiated through the Optum Bariatric Resource Services (BRS) Program. Members can initiate by contacting Quantum Health.

Bariatric Resources Services (BRS) is a surgical weight loss solution for those individual(s) who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. Our program is dedicated to providing support both before and after surgery. Nurses help with decision support in preparation for surgery, information and education in the selection of a bariatric surgery program, and post-surgery and lifestyle management.

Nurses can provide information on the nation's leading obesity centers, known as Centers of Excellence.

11. Prescription Drugs

Prescription drugs are covered under both Retiree Medical Plan options through Caremark. If you elect medical coverage, you automatically receive prescription drug coverage.

You have a choice each time you have a prescription filled. You can either:

- Go to a participating retail pharmacy; or
- Use the mail order prescription drug feature, saving you both time and money.

What services does CVS Caremark offer?

CVS Caremark provides Retail Pharmacy, Mail-order Pharmacy and Specialty Pharmacy services.

- Retail Pharmacy Services: You may use one of the participating pharmacies. Your prescription ID card is accepted at most major drug chains, as well as many independent pharmacies.
- Mail-order Pharmacy Services: Long-term maintenance prescriptions are delivered to your home from one of the Caremark mail service pharmacies. This provides you up to a 90-day supply.
- Specialty Pharmacy Services: For chronic and genetic disorders, this service offers convenient delivery of your specialty medicines, personalized service and education support for your specific therapy.

CVS Caremark assigns a team of professionals to help you and your family successfully manage chronic and genetic conditions. This service includes 24-hour access to a clinical pharmacist for consultation. Services are available for allergic asthma, Crohn's disease, enzyme replacement, Gaucher disease, growth hormone deficiency, hemophilia, hepatitis C, immune disorders, multiple sclerosis, psoriasis, pulmonary hypertension, rheumatoid arthritis, Respiratory Syncytical Virus (RSV) prevention and other conditions.

Added Choice for obtaining a 90-day Prescription

You may obtain a 90-day prescription at a CVS retail pharmacy for lower co-pays using the Maintenance Choice Option. To do so, the prescription must be written to dispense in a 90-day supply and taken to a

CVS retail pharmacy, just as you would a short-term supply. This gives you the flexibility to use a CVS retail pharmacy instead of the mail order program at no additional cost to you.

Smoking Cessation Prescriptions

You can save money by using your CVS Caremark prescription card at any pharmacy or through the mail order program. This allows you to obtain the prescription at a negotiated price—you pay 100% of the drug, but at the reduced cost. You are eligible for two treatments per year.

Prescription drugs are classified as:

- **Generic Drug** – Generic drugs are those whose active ingredients, safety, quality and strength are the same as its brand counterpart.
- **Preferred Formulary** – Preferred-brand drugs generally have no generic equivalent. Within a class of drugs, there are often several brand-name drugs protected by separate patents. Each of these is generally considered to be treating a particular condition.
- **Non-preferred Formulary** – Non-preferred brand drugs are those with less costly generic equivalents and/or have one or more preferred-brand options.
- Specialty: High cost medicates used to treat complex chronic conditions.

Retiree Medical Plan:

Prescription Drug	Retail 30-day supply	Mail order 90-day supply
Generic	$7	$14
Preferred Formulary	$35	$70
Non-preferred Formulary	$70	$140
Specialty	$125	$250

What is a preferred drug list?

A preferred drug list is a list of recommended brand-name prescription drugs reviewed and updated every three months by a CVS Caremark committee of independent physicians and pharmacists. A medication becomes a preferred formulary drug based on safety, effectiveness and cost. The preferred list identifies drug classes that may have generic availability that could save you money.

How do I find out what drugs are on the preferred drug list?

You can call CVS Caremark at the number on your ID card or by logging onto www.Caremark.com

Who decides what type of drugs to dispense?

Pharmacies are encouraged to dispense a generic medication whenever possible unless you or your physician specifically requests a brand-name prescription. If you request a formulary drug, the preferred or non-preferred formulary drug co-pay will apply plus the cost difference between the formulary drug and

the generic drug. To help manage your prescription drug choices, you may want to give a copy of the preferred drug list to your physician.

Please note that if you choose a brand-name drug when there is a generic equivalent available, you pay the brand name copay plus the difference between the brand-name and generic cost.

Prescription Prior Authorization

To ensure safe and cost-effective use of prescriptions, a prior authorization process for certain drugs has been established. Prior authorization is a check process on some drugs that are identified as having a narrowly defined use or are more likely to be taken inappropriately or for too long a time period. It also applies to certain drugs that are available over the counter or have over-the-counter equivalents.

A list of drugs needing prior authorization may be obtained by calling CVS Caremark at 1-800-386-1575 or log on to www.caremark.com. This list will change annually and is available on the Caremark.com site.

CVS Caremark's Prior Authorization number for your Doctor's office to use is 1-800-626-3046.

From the Retail Pharmacy

When you need a prescription filled, you can go to any of the Plan's participating pharmacies. Simply present your prescription, along with your prescription ID card, and you pay the Plan's prescription co-pay for up to a 30-day supply of medication. **You may also obtain a 90-day prescription of a maintenance prescription at a CVS retail pharmacy for a co-pay. The prescription must be written to dispense in a 90-day supply.**

By Mail Order

The Retiree Medical Plan also includes a mail order feature. You can order up to a 90- day supply of maintenance prescriptions for conditions, such as diabetes and high blood pressure, through the mail, and save money.

The mail order feature of your prescription drug program can save you time and money. Here's how:

- Convenience – By using the mail order feature, you can receive a 90-day supply of prescriptions you take for chronic conditions instead of going to the pharmacy once every month.
- Cost savings – When you order a prescription drug, you pay a smaller co-pay for a 90-day supply – this is a savings to you.

Save by using Mail Order or Maintenance Choice at CVS

Don't forget that if you receive the same 30-day maintenance prescription three times at a retail pharmacy, you will pay an additional $25 copay beginning with the fourth refill.

Use the mail order or 90-day supply from a CVS Pharmacy to avoid the penalty and save on co-pays.

Blood Glucose Meter Program

Plan participants who are diagnosed with diabetes and test their blood sugar may receive a complimentary blood glucose meter kit by calling the CVS Caremark Pharmacy Resource Center (PRC)

at 1-800-588-4456. The PRC's hours of operation are 9 a.m. to 7 p.m. ET / 6:00 – 4:00 PT., Monday through Friday.

To receive a complimentary meter, you must meet the following criteria:

- You must be diagnosed with diabetes or required by the doctor to test your blood sugar.
- You must agree to order a minimum of a 90-day supply of test strips through the mail order program to accompany the meter you choose.

Complimentary blood glucose meters are available once every three years, provided you qualify and continue to meet the criteria listed above.

When you call to request a meter kit, you will be transferred to the PRC Meter Team. The Meter Team staff will describe the preferred meters and help you choose one. They will also contact your physician to obtain the prescription for the test strips (and lancets if needed). The meter kits come directly from the manufacturer to your home, and the prescription for the test strips and lancets will come from the mail order pharmacy.

Note: The Meter Team can only address issues regarding the ordering of meters, test strips and lancets, not other diabetic supplies.

12. Expenses Not Covered by the Retiree Medical Plan

Coverage is not provided for the following charges:

- Those for services and supplies not medically necessary, as determined by the claims administrator, for the diagnosis, care or treatment of the disease or injury involved. This applies even if they are prescribed, recommended or approved by the person's attending physician or dentist. This includes services and supplies:
  - that don't require the technical skills of a medical or mental health professional.
  - provided mainly for the comfort or convenience of you, the caregiver, your family or health care provider.
  - provided solely due to the setting in which they are delivered if they could be delivered safely and effectively in a less costly setting.
- Services/supplies that are not prescribed, recommended or approved by the attending physician; services of a resident physician or intern rendered in that capacity.
- Charges connected with services or supplies that are experimental or investigational; this exclusion does not apply:
  - if death is expected within one year without other effective medical treatment and scientific data indicates these services or supplies may be effective.
  - for drugs deemed "treatment investigational" and being tested at certain levels by the National Cancer Institute or if scientific data indicates the drug may be effective.
- Amounts above the allowed amount or network negotiated charge as determined by the claims administrator.

- Charges for custodial care as determined by the claims administrator.

- Education, special education or job training, including education testing or training related to learning disabilities or developmental delays.

- Care provided to prevent a surrounding area from exposure to disease or injury.

- Charges for surgery, services or supplies provided mainly to improve, alter or enhance appearance (except if needed because bodily function is impaired due to: birth defect, accidental injury, disease or surgical treatment of disease or injury); this does not include wigs, which are covered if medically necessary.

- Those for plastic surgery, reconstructive surgery, cosmetic surgery or other services and supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

  - Improve the function of a part of the body that:

    - is not a tooth or structure that supports the teeth; and

    - is malformed:

    as a result of a severe birth defect; including cleft lip or webbed fingers or toes; or as a direct result of disease; or surgery performed to treat a disease or injury.

  - Repair an injury. Surgery must be performed:

    - in the calendar year of the accident which causes the injury; or

    - in the next calendar year.

- Those for a voluntary sterilization procedure or the reversal of a sterilization procedure.

- Blood testing for allergies, including RAST, PRIST and RIST (except if direct skin testing cannot be used due to age or a skin or medical condition).

- Those for or related to any eye surgery mainly to correct refractive errors.

- Marriage, family, child, career, social adjustment, pastoral or financial counseling.

- Treatment, therapy or supplies for:

  - primal therapy, Rolfing, psychodrama, megavitamin therapy, bioenergetics therapy, vision perception training or carbon dioxide therapy.

  - gender change, gender identity disorders.

  - sexual dysfunctions without a physiological or organic basis.

- Treatment of covered mental health care providers who receive such treatment as part of their training.

- Charges made only because there is health care coverage or that a covered person is not legally responsible for. The covered person is required to pay the out-of-pocket expenses (including

deductibles, copays or required plan participation) under the terms of the Plan. The requirement that you and your dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any “fee forgiveness,” “no out-of-pocket” or similar arrangement. If a provider waives the required out-of-pocket expenses, the covered person’s claim may be denied, and the covered person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the covered person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of the Plan.

- Those for services and supplies:

  - Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

  - Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled *Effect of Benefits Under Other Plans*. In addition, this exclusion will not apply to a plan established by government for its own employees or their dependents; or Medicaid.)

- Any benefits which are prohibited by law in your local area.

- Any charges for treatment of an occupational injury or illness arising out of the course of employment or covered by workers’ compensation or similar laws.

- Contraceptives used to prevent pregnancy. -

- Certain sleep aid prescription drugs.

- Stop smoking medications or aids including those with nicotine.

- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.

- Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy, including but not limited to:

  - sildenafil citrate;

  - phentolamine;

  - apomorphine;

  - alprostadil; or

  - any other drug that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.

  This exclusion applies whether or not the drug is delivered in oral, injectable or topical forms (including but not limited to gels, creams, ointments and patches).

- Those for performance, athletic performance or lifestyle enhancement drugs or supplies.

- Those for or related to artificial insemination, in vitro fertilization or embryo transfer procedures.

- Those for or in connection with speech therapy. To the extent coverage for speech therapy is specifically provided in this Guide, this exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) as the result of a disease or injury.

- Those for services and supplies that, in the opinion of the claims administrator or its authorized representative, are associated with injuries, illness or conditions suffered due to the acts or omissions of a third party.

- Those for weight control services including: weight control/loss programs; dietary regimens and supplements; appetite suppressants; food or food supplements; exercise programs; exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction**,** regardless of the existence of co morbid conditions. Use of Centers of Excellence required for surgery,

- Elective abortions unless the life of the mother is in danger.

- Massage therapy.

- Aqua therapy.

13. Glossary

The following definitions are provided to help you understand your medical and prescription drug coverage:

Allowed Amount - UMR:

When UMR receives a claim for a service or supply that has been provided to a covered person, it will determine if the service or supply is a covered benefit under this group health plan. If the service or supply is not a covered benefit, the claim will be denied, and the covered person will be responsible for paying the provider for these costs. If the service or supply is a covered benefit, UMR will establish the allowable amount for that service or supply.

UMR has contracts with network providers to provide services and supplies at contracted rates. For a network provider, the contracted rate is the allowed amount. For out-of-network providers, the allowable amount is the highest fee the Plan will consider for payment for a particular service or supply. If you use an out-of-network provider and the charge is more than the Plan's allowable amount, you are responsible for paying the difference in addition to any deductibles or coinsurance amounts applied to your claim. Charges that exceed the allowable amount do not count toward your annual deductible or out-of-pocket maximum. Please note, that if you use an out-of-network provider, the difference between the allowable amount and the provider's actual charges can be significant.

The allowable amount for out-of-network services is based on 140% of the Medicare fee schedule. If a Medicare fee schedule is not available for a particular service or supply, the allowable amount will be based on 50% of billed charges. Charges that exceed the allowable amount do not count towards the annual deductible or the out-of-pocket maximum.

Allowed Amount – Blue Cross Blue Shield of Alabama:

Benefit payments are covered based on the amount of the provider's charge that Blue Cross and Blue Shield of Alabama (BCBSAL) recognizes for payment of benefits. This amount is the lesser of the provider's charge for care or the amount of that charge that is determined by BCBSAL to be allowable depending on the type of provider and the state in which the services are rendered.

- In-Network Providers. Blue Cross and/or Blue Shield plans contract with providers to furnish care at a negotiated price. This price is often at a discounted rate (also known as "negotiated rate") and the in network provider normally accepts this rate (subject to any applicable copayments, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered care. Not all participating or contracting providers are in-network providers. Each local Blue Cross and/or Blue Shield plan determines which of its participating or contracting providers will be considered in-network providers.

- Out-of-Network Providers. The allowed amount for care for out-of-network providers is normally determined by the Blue Cross and/or Blue Shield plan where services are rendered. This amount may be based on the negotiated rate payable to in network providers or on the average or anticipated charge or discount for care in the area or state, or for care from that particular provider. When the local Blue Cross and/or Blue Shield plan does not provide pricing data or when BCBSAL is determining the allowed amount, the allowed amount is determined using the following data:

  - The charge for the same or a similar service.

  - The relative complexity of the service.

  - The preferred provider allowance for the same or a similar service.

  - The average expected or estimated provider discount for the type of provider in the service area, as reported by the Blue Cross and Blue Shield Association from time to time.

  - Applicable state healthcare factors.

  - The rate of inflation using a recognized measure.

  - Other reasonable limits, as required with respect to outpatient prescription drug costs.

Out-of-network providers include providers that have not signed a contract with a Blue Cross and Blue Shield plan where services are rendered as well as participating or contracting providers who have not been designated by the local Blue Cross and Blue Shield plan as preferred providers. In this situation, the provider may bill you for charges in excess of the allowed amount. The allowed amount will not exceed the amount of the provider's charge.

Board and Room Charges: Charges made by an institution for board and room and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

Brand-Name Drug: A prescription drug that is protected by trademark registration.

Coinsurance or Coinsurance Percentage: The amount the Plan pays – you pay the difference – for a doctor's office visit, hospital visit or other medical treatment, expressed as a percentage (not a dollar amount); in most cases this amount counts toward your Deductible and Out-of- Pocket Maximum.

Skilled Nursing Care Facility: This is a licensed facility that provides inpatient care for persons recovering from illness or injury, including professional nursing care and physical restoration services. The facility must provide 24-hour nursing care by licensed nurses supervised by a full- time physician or R.N., keep complete medical records and have a utilization review plan. It cannot be an institution that provides custodial or educational care, or is mainly a place for rest, the aged, drug and alcohol addiction patients, or those with Mental Disorders.

Copayment: The amount you pay for a doctor's office visit, ER visit or prescription, expressed as a flat dollar amount (not a percentage); does count toward your Deductible or out-of-pocket maximum.

Custodial Care: This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes Board and Room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Deductible: The deductible is what you pay first each calendar year before a Plan starts to pay for benefits.

Dentist: This means a legally qualified dentist or a physician who is licensed to do the dental work he or she performs.

Substance Abuse: This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a physician and either:

- has a follow-up therapy program directed by a physician on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not Treatment of Alcoholism or Drug Abuse:

- Detoxification. This means mainly treating the after-effects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Emergency Condition: This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational: A service or supply is considered Experimental or Investigational if the claims administrator, in its sole discretion, determines that one of the following applies:

- There is insufficient data from controlled, clinical trials for which results are published in peer-reviewed medical literature to determine its safety and effectiveness for a given condition;
- FDA-required approval for marketing has not been granted;
- A recognized health care society or regulatory agency has determined in writing that the service or supply is experimental, investigational or for research purposes; or

- Research or facility protocols indicate the service or supply is experimental or investigational, or informed consent to this effect is required for treatment or research.

Generic drug: A prescription drug that is not protected by trademark registration but is produced and sold under the chemical formulation name.

Home Health Care Agency: This is an agency that mainly provides skilled nursing and other therapeutic services. It must be licensed as a home health care agency and have a full-time administrator. In addition, the agency must have full-time supervision by a physician or R.N. and keep complete medical records on all patients.

Home Health Care Plan: This is a plan that provides for care and treatment of an illness or injury. The care and treatment must be:

- prescribed in writing by the attending physician; and
- an alternative to confinement in a hospital or Skilled Nursing Care Facility.

Hospice Care Agency: This is a licensed agency that provides terminally ill patients with hospice care services (e.g., skilled nursing services, medical social services, psychological and dietary counseling and bereavement counseling, physical or occupation therapy, home health aide services and inpatient care for pain control). The agency must establish policies for providing care, keep complete medical records on all patients and permit access to services by area medical personnel. In addition, personnel must include a full-time administrator, a physician, R.N., a licensed social worker and a counselor, with volunteers providing non- medical services.

Hospice Facility: This is a licensed facility (or part of a hospital) run by a staff of physicians with established quality procedures and review that provides inpatient hospice care to terminally ill patients. It must provide 24-hour nursing services as directed by an R.N. with one physician on call at all times. Complete medical records must be kept on all patients.

Hospital: This mainly provides inpatient facilities for surgical and medical diagnosis, treatment and care for injury and sickness. It must be supervised by a staff of physicians and provide 24- hour nursing services by R.N.s. It cannot be a place mainly for rest, the aged or drug and alcohol addiction patients, or be a nursing home.

Medically Necessary: A service or supply furnished by a particular provider is Medically Necessary if the claims administrator determines that it is appropriate for the diagnosis, the care or the treatment of the illness or injury involved.

To be appropriate, the service or supply must:

- be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the illness or injury involved and the person's overall health condition;
- be a diagnostic procedure indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the illness or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, the claims administrator will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to the claims administrator's attention.

In no event will the following services or supplies be considered to be Medically Necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person
- who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's illness or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

For prescription drugs, the determination of Medical Necessity is made by Caremark.

Mental Disorder: This is an illness commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.

- Obsessive compulsive disorder.

Network Provider: This is a health care provider that has contracted to furnish services or supplies for a negotiated charge for:

- the service or supply involved; and
- the class of covered persons of which you are member.

Orthodontic Treatment: This is any:

- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain. Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Out-of-Pocket Maximum: The maximum amount you'll pay for eligible expenses under the Plan in a calendar year. After you reach your maximum, the Plan pays 100% of eligible expenses for the rest of that year. The deductible is included in the Out-of-Pocket-Maximum.

Physician: This means a physician licensed in accordance with applicable state law.

Prior Authorization or Pre-Certification: Certain medical treatments and prescription medicines need prior approval before the Plan will cover them. This requirement is to ensure that the treatment or medication is appropriate and cost-effective.

Residential Treatment Facility: This is a licensed agency that mainly provides a program for diagnosing, evaluating and treating alcohol and drug abuse. It does not include facilities that only treat the after-effects of specific episodes of abuse or provide maintenance care through an alcohol or drug-free environment. The facility must prepare and maintain a written treatment plan, be supervised by a physician for all patients, and provide 24-hour on-site services for the following detoxification needed for treatment, infirmary-level medical services, with arrangements to make hospital services available as needed, skilled nursing care by licensed nurses directed by an R.N., and supervision by a staff of physicians.

14. Effect of Benefits Under Other Plans

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

If this Plan is primary, it will pay for expenses up to the Plan's normal benefits. If this Plan does not cover the full cost, the secondary plan may cover a portion of the remaining cost, up to its plan limits.

If this Plan is secondary, the primary plan will pay for expenses first, up to its plan limits. If the expense is covered in full by the primary plan, there is no need for this Plan to cover any remaining expenses. If the expense is not covered in full by the primary plan, this Plan may pay the amount normally reimbursed minus the amount paid or payable by the primary plan. Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans."

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent,

3. Except in the case of a dependent child whose parents are divorced or separated; the Plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

      If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

      If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. The benefits of a plan which covers the person on whose expenses claim is based as a:

- laid-off or retired employee; or
- the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or
- a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

6. The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

   If the other plan does not have a provision:

   - regarding right of continuation pursuant to federal or state law; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

7. If the preceding paragraphs do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to the claims administrator for consideration that have been grouped together for administrative purposes as a "claim transaction" in accordance with the claims administrator's then current rules.

In order to administer this provision, the claims administrator can release or obtain data. The claims administrator can also make or recover payments.

Other Plan

This means any other plan of health expense coverage under:

- group insurance.
- any other type of coverage for persons in a group. This includes plans that are insured and those that are not.

- no-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Medicare - If you or your spouse are eligible for Medicare, eligibility under the Retiree Medical Plan will end so that you and your spouse will not have double coverage with the Retiree Medical Plan and Medicare. The only exception is if an individual becomes entitled to Medicare solely on the basis of having end-stage renal disease ("ESRD"). In that case, coverage under the Retiree Medical Plan may continue and the Retiree Medical Plan will be primary for the period that begins on the date the individual first becomes entitled to Medicare Part A benefits under Social Security Act §226A and ends thirty (30) months later.

C. Retiree Reimbursement Account (RRA)

1. Who is Eligible for an RRA

There are two types of credits to your RRA, a lump sum credit to your RRA at retirement and post-Medicare monthly credits to your RRA. To be eligible for either type of credit, you must retire from Honda on or after age 55 with at least 10 years of continuous service, or on or after age 65 with at least 5 years of continuous service.

- The Lump Sum Credit is available to associates who retired on or after January 1, 2014. The Lump Sum Credit is a one-time credit at retirement, equal to $1,000.00 multiplied by your years of continuous service, up to thirty (30).

- The post-Medicare monthly RRA credits are available to Medicare-eligible retirees who attained age 50 on or before December 31, 2020.

Limitations:

- If you declined to participate in the Retiree Medical Plan or dropped Retiree Medical Plan coverage, you are not eligible for the monthly Retiree Reimbursement Credits.

- Post-Medicare monthly RRA credits are only for you (the retiree) and not your spouse unless you retired on or before December 31, 2020.

- If you retired on or before December 31, 2020, and your spouse declined to participate in the Retiree Medical Plan, your spouse is not eligible for monthly Retiree Reimbursement Credits unless the reason your spouse declined coverage was that he or she was still working and had coverage through his or her employer. If your spouse declined coverage because of coverage through his or her employer, your spouse must be able to demonstrate continuous coverage under a group health plan sponsored by his or her employer. Also, if your spouse enrolled in the Retiree Medical Plan but subsequently dropped coverage, your spouse is not eligible for the monthly Retiree Reimbursement Credits.

- Children are not eligible to receive (earn) a monthly Retiree Reimbursement Credits but you may use your RRA credit balance to reimburse medical expenses incurred by your eligible children up to age 26.

- If you retired from Honda Manufacturing of Alabama, LLC (HMA) or Honda of South Carolina Mfg., Inc. (HSC) before January 1, 2014, you are not eligible for post-Medicare monthly RRA credits.

- If you retired from Honda Manufacturing of Indiana, LLC (HMIN) or Honda Precision Parts of Georgia, LLC (HPPG) before April 1, 2021, you are not eligible for post-Medicare monthly RRA credits.

For active associates who were participating in the Health Fund and had a balance as of 12/31/2017, that Health Fund balance was transferred to a special HRA account. If you meet the requirements for the Retirement Medical Program, this special HRA account will be rolled over to your RRA account upon your retirement.

2. Enrolling for the RRA

- If you are eligible for Medicare when you retire and you are actively at work through your confirmed retirement date, you will automatically be enrolled in the RRA.

- If you are a participant in the Retiree Medical Plan, you will be automatically enrolled in an RRA when you become eligible for Medicare and your Retiree Medical coverage will end. Also, if your spouse is a participant in the Retiree Medical, and qualifies for the post-Medicare monthly credit, your spouse will be automatically enrolled in your RRA upon his or her eligibility for Medicare. You must notify the My Benefits Connect Center when you or your spouse becomes eligible for Medicare for a reason other than age.

- If your spouse did not enroll in the Retiree Medical Plan because he or she was currently working and receiving coverage through his or her employer, you will need to contact the My Benefits Connect Center when that coverage ends. You will need to provide proof of continuous coverage under the other plan in order for your spouse to enroll in your RRA if they are eligible to participate. No amounts will be credited to your RRA for your spouse until your spouse enrolls. Also, failure to demonstrate your spouse's continuous coverage under an employer's plan will result in a permanent loss of eligibility for the RRA.

- Honda-Married: If you waived participation in the Retiree Medical Plan due to coverage with a spouse employed by Honda, you are not eligible for monthly Retiree Reimbursement Credits as a retiree.

***Please note**, if you have access to the RRA, you are not be eligible for premium assistance to purchase individual health insurance coverage through the public exchange. Similarly, because your RRA can be used to pay medical expenses incurred by your spouse and children, your spouse and children are not eligible for premium assistance to purchase individual health insurance coverage through the public exchange.*

Please review the IRS guidelines to how this may impact your application (or your family's application) for subsidy assistance. If you choose to waive your RRA for yourself or one or more family members, please contact the My Benefits Connect Center at 1-866-778-5885.

3. When Participation in the RRA Begins

Your monthly Retiree Reimbursement Credits will begin the first day of the month in which you become eligible for Medicare, provided you are enrolled as of that date. If you have a lump sum contribution or rollover dollars in your RRA, you can use these funds for yourself or your eligible family members so long as you remain an eligible member of the plan.

4. When Participation in the RRA Ends

You may waive participation in the RRA at any time by calling the My Benefits Connect Center. You may waive participation for yourself and all family members or just specific family members. A waiver of the Lump Sum Contribution to your RRA is irrevocable and will result in forfeiture of any remaining RRA credit balance. (The IRS considers a RRA to be employer-sponsored health coverage and you won't qualify for federal subsidies for the purchase of individual health insurance on a public exchange while you have an RRA credit balance.) However, a waiver of the Lump Sum Contribution to the RRA before you become Medicare-eligible will not constitute a waiver of Retiree Reimbursement Credits to your RRA when you and/or your spouse become Medicare-eligible.

Your spouse will lose eligibility for your RRA if you get legally separated or divorced or if your spouse remarries after your death. You need to contact the My Benefits Connect Center within 31 days if you get legally separated or divorced. To report a change, visit www.myhondaconnect.com or call the My Benefits Connect Center at 1-866-778-5885 Monday through Friday from 8:30 a.m. to 10:00 p.m. ET / 5:30 a.m. – 7:00 p.m. PT.

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Coverage will also end for any person who commits fraud or makes an intentional misrepresentation of a material fact.

Otherwise, coverage under the RRA as currently structured continues until the later of your death or the death of your spouse, subject to Honda's right to amend or terminate the coverage.

5. The Honda Retiree Reimbursement Credit

Once you are Medicare-eligible, Honda will credit a specified amount (the Honda Retiree Reimbursement Credit) to your RRA each month.

- If you retired on or after January 1, 2021, your spouse is not eligible for monthly RRA post-Medicare credits.
- If you retired on or after July 1, 2014 and before January 1, 2020 and your Medicare-eligible spouse is enrolled, the monthly RRA credit for your spouse is equal to 50% of your credit.
- If you retired before July 1, 2014 and your Medicare-eligible spouse is enrolled, the monthly RRA credit for your spouse is equal to 100% of your credit.

You may use the credits in your RRA to help pay for eligible health care expenses such as premiums, deductibles, copayments and coinsurance.

Unused credits in your RRA will roll over from month to month and year to year. However, if you are single (or if your spouse is not enrolled), any remaining, unused credit in your account will be forfeited upon your death. If you are married and your spouse is enrolled in the Retirement Medical Plan and/or receiving Retiree Reimbursement Credits at the time of your death, your surviving spouse may continue to use the RRA (with any remaining RRA credit balance forfeited upon your surviving spouse's death).

Note if your spouse is a current or retired Honda associate, you can each be covered by one plan, in one capacity (i.e., active associate, retiree or dependent of an active associate or retiree). You cannot be covered more than once (e.g., you cannot enroll as both a retiree and a dependent of a retiree) and you will not receive double credits even if both you and your spouse enroll in the Retirement Medical Program.

The amount of your monthly Retiree Reimbursement Credit depends on how long you worked for Honda. The longer you worked, the more that is contributed toward your RRA.

The calculation formula in effect for the RRA credit as of January 1, 2014 is shown below:

$7 x years of continuous service up to 20 years $5 x years of continuous service from 21 to 30 years

For Example…

Here are a few examples of how the monthly credit is calculated using different service amounts:

Example 1: Martin, who is married, retires with 22 years of continuous service on June 1, 2014. His monthly RRA Credit will be calculated as follows:

First 20 years of continuous service:	$140
Next 2 years of continuous service:	$10
Total monthly RRA Credit for Martin:	$150
Total monthly RRA Credit for Martin's spouse	$150
Total monthly post-Medicare RRA Credit	**$300**
Plus: **Lump sum RRA credit:**	**$22,000**

Example 2: Martin, who is married, retires with 22 years of continuous service on October 1 2014. His monthly RRA Credit will be calculated as follows:

First 20 years of continuous service:	$140
Next 2 years of continuous service:	$10
Total monthly RRA Credit for Martin:	$150
Total monthly RRA Credit for Martin's spouse	$75
Total monthly post-Medicare RRA Credit	**$225**
Plus: **Lump sum RRA credit:**	**$22,000**

Example 3: Martin, who is married, retires with 22 years of continuous service on June 1, 2021. His monthly RRA Credit will be calculated as follows:

First 20 years of continuous service:	$140
Next 2 years of continuous service:	$10
Total monthly RRA Credit for Martin:	$150
Total monthly RRA Credit for Martin's spouse	$0
Total monthly post-Medicare RRA Credit	$150
Plus: **Lump sum RRA credit:**	**$22,000**

6. Expenses Eligible for Reimbursement

- Your RRA funds can be used to pay for most medical expenses, including:
  - Retiree Medical and qualified long-term care insurance premiums.
  - Medicare premiums for Part B and Part D coverage.
  - Medigap plan premiums used to supplement your Medicare Part A and Part B coverage.
  - Medicare Advantage premiums or Medicare Advantage Prescription Drug plan premiums.

Items That Are Eligible Expenses	Items That Are Not Eligible Expenses
- Doctor and hospital visits and prescription expenses (including insulin) - Over-the-counter medicines **Note**: Medical and prescription expenses that are reimbursed by Medicare or any other plan are not eligible to be reimbursed by the RRA - Certain medical-related travel expenses - Health insurance premiums, Medicare Part B and Medicare prescription drug coverage, Medigap Plans, Medicare Advantage Plans or premiums for individual health policies - Premiums for qualified long-term care insurance policies - COBRA premiums	- Cosmetic surgery - Previously deducted or reimbursed expenses - Expenses incurred while an individual wasn't participating in the RRA - Health plan premiums paid by the retiree, spouse or dependent on a pre-tax basis - Other types of long-term care expenses not covered by insurance -

It is not recommended that you use your RRA to pay for prescription drug benefits not covered by a Medicare prescription drug plan prior to satisfying all of your out-of-pocket costs for the Medicare prescription drug plan. Reimbursements from the RRA are considered employer payments and may reduce the benefits available to you under the Medicare prescription drug plan.

7. Reimbursements from Your RRA

UMR administers the RRA. You can take advantage of UMR's *Navigator* tool to see the balance in your RRA and how your reimbursements are being processed.

When you enroll in the RRA, you will receive a confirmation statement from the UMR confirming your participation in the account.

To be reimbursed for eligible health care expenses, simply complete a reimbursement request form and submit it with a copy of your itemized receipt(s) to UMR at the address shown on the form or through the online portal. You can also get a reimbursement request form by:

- Logging on to www.myhondaconnect.com and click in on the RRA tile to access the UMR RRA site.

D. Administrative Information

This section contains information about the administration and funding of the Plan as well as your rights as a Plan participant.

Plan sponsor and Employer Identification Number (EIN)	American Honda Motor Co., Inc. 24025 Honda Parkway Marysville, OH 43040-9251 95-2041006
Plan administrator	American Honda Motor Co, Inc. 24025 Honda Parkway Marysville, OH 43040-9251 Telephone: 1-937-642-5000 The Plan administrator is the named fiduciary for purposes of ERISA and has the discretionary authority to interpret the terms of the Plan and to perform all other aspects of Plan administration, including but not limited to, determining eligibility for benefits and making factual determinations.
Participating employers	You may request a list of participating by contacting the Plan Administrator at regional_retirement@ahm.honda.com
Agent for service of legal process	American Honda Motor Co., Inc. Attn.: General Counsel 24025 Honda Parkway Marysville, OH 43040-9251 Telephone: 1-937-642-5000 Service of legal process may also be made upon the Trustee or the Plan Administrator
Plan year	Calendar year
Source of contributions	Honda and retirees contribute toward the cost of benefits under the Retiree Medical Plan. RRA benefits are funded by Honda.
Source of funds	Benefits are self-insured and funded through the Honda Health and Welfare Benefits Trust and/or a medical benefit account under the Honda Retirement Plan. The claims administrators do not insure benefits.
Trustee	The Northern Trust Co. 50 South LaSalle St. Chicago, IL 60675
Claims Administrators – Medical	Pre-service medical claims (pre-certification) and appeals of both pre-service and post-service medical claims: Quantum Health Care Coordinators by Quantum Health 5240 Blazer Parkway Dublin, OH 43017-3309

	Post-service medical claims: UMR P.O. Box 30541 Salt Lake City, UT 84130-0543 -- or – Blue Cross Blue Shield of Alabama 450 Riverchase Parkway East Birmingham, AL 35244-2858
Claims Administrator – Prescription Drugs	CVS/Caremark 211 Commerce Street Suite 800 Nashville, TN 37201
Claims Administrator – RRA	UMR P.O. Box 30541 Salt Lake City, UT 84130-0543
Benefits Provided	Retiree Medical Plan (medical and prescription drug benefits) Retiree Reimbursement Account (RRA)
Official Plan Name and Number	Honda Retirement Medical Program Plan Number 503 When referring to the Plan in claims appeals or other correspondence, you need to identify the Plan by its official name and number.

1. Future of the Plan

This Guide describes the benefits currently available under the Honda Retirement Medical Program. Honda reserves the right to terminate, suspend, withdraw, amend or modify the Plan. Any change or termination of benefits (a) will be based solely on the decision of the Plan sponsor and (b) may apply to some or all retirees.

2. Plan Rights

The Plan has certain rights that allow proper administration. The Plan has the right to:

- **Information**. The Plan may provide or obtain any data needed for administration. You may also need to provide data, if requested. Otherwise, benefits may not be payable.

- **Recover Overpayments**. The Plan may recover payments (from persons, including you, or plans) that exceed Plan provisions for benefits provided on your or your dependents' behalf. To recover the payments, the Plan will request that funds be returned. The Plan reserves the right to deduct or offset any amounts not recovered from pending or future claims for you or your family members. This includes, but is not limited to, situations where the plan has made payments on behalf of your ineligible dependent. This provision is separate from the provision described below regarding expenses caused by a third party.

- **Make Direct Payment**. The Plan may directly reimburse other plans or persons (such as service providers) for any amounts payable by the Plan. However, benefits may not be pledged, assigned or garnished in payment of debts.

- **Set Rules for Subrogation and Right of Recovery**. These provisions apply when the Plan pays benefits as a result of an injury, illness or condition and you or your covered dependent (i.e., the covered person) has a right of recovery or has received a recovery. Recoveries are for the benefit of the plan as a whole and are not credited or applied to the benefit of a specific covered person or his or her RRA.

3. Subrogation and Right of Recovery

- **Definitions**

As used throughout this provision, the term "Responsible Party" means any party actually, possibly or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, you, your spouse and your children.

- **Subrogation**

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness or condition to the full extent of benefits provided or to be provided by the Plan.

- **Reimbursement**

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury**,** illness or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury, illness or condition, from such payment, up to and including the full amount the Covered Person receives from any Responsible Party. If the Covered Person fails to reimburse this plan for any payment received from a Responsible Party or Insurance Coverage, the Plan has the right to suspend further benefit payments on behalf of the Covered Person and his or her covered family members until either (i) the Plan is reimbursed; or (ii) claims for otherwise covered expenses on behalf of the Covered Person and his or her covered family members have been submitted to the Plan (and not paid pursuant to this provision) in an amount equal to the payment from the Responsible Party or Insurance Coverage which is owed to the Plan.

- **Constructive Trust**

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness or condition, he or she

will serve as a constructive trustee over the funds that constitutes such payment and that are subject to the Plan's right of reimbursement.

Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

- **Lien Rights**

Further, the Plan will automatically have a first priority lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

- **First-Priority Claim**

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights, whether through subrogation or reimbursement, are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. Also, by accepting benefits from this Plan, the covered person agrees that the Plan's rights of subrogation and reimbursement are not subject to any equitable defenses that the Covered Person may assert in any action by the Plan to exercise its rights of recovery including, but not limited to, the common fund doctrine and the double recovery. This Plan shall be entitled to full recovery, whether through subrogation or reimbursement, on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

- **Applicability to All Settlements and Judgments**

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

- **Cooperation**

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Plan, the claims administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to

provide this information may result in the termination of health benefits for the Covered Person and his or her family members or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Responsible Party. The Plan reserves the right to notify Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

- **Interpretation**

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the applicable claims administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

- **Jurisdiction**

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

4. Claims and Appeals

Discretionary authority

Honda, acting as Plan Administrator, has discretionary authority to make findings of fact, determine eligibility for benefits and to administer, interpret and manage the Plan in accordance with its terms and applicable law. Honda has the right to delegate its discretionary authority and responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan. Honda has, through this document, delegated discretionary authority for the administration and determination of claims and appeals to any and all claims administrators for the Plan. This grant of discretionary authority applies not only to current claims administrators, but also to any future claims administrators regardless of whether this document lists a claims administrator under the Plan. The claims administrator is the third-party administrator that administers the Plan and decides claims and appeals for benefits under the Plan. In all circumstances relating to any claim or appeal for benefits under the Plan, the claims administrator responsible for making a determination on the claim or appeal has discretionary authority in making such determination, including but not limited to, interpreting and applying the terms and conditions of the Plan, making any necessary factual determinations and determining eligibility under the Plan.

Designation of an authorized representative and prohibition on assignment

You may designate an authorized representative to represent you in the claims and appeals process. An "authorized representative" is a person you authorize, in writing, to act on your behalf in the claims and appeals process. The Plan has the right to require that you sign a form provided by the Plan to verify the designation. In the case of an urgent care claim, a health care provider with knowledge of your condition may act as your authorized representative. An appeal filed by a health care provider is not an appeal under the Plan unless the health care provider is your authorized representative.

The authorization of a representative is not an assignment of benefits. You cannot assign your rights or benefits to anyone else without the written consent of the Plan Administrator (except as required by a Qualified Medical Child Support Order or National Medical Child Support Notice).

Statute of limitations and venue

Any legal proceeding to recover denied benefits under the Plan may not be instituted until the claims and appeals process is exhausted, and in no case may legal action be brought beyond one year after the date notification of an adverse determination on appeal is issued. This deadline is tolled while a voluntary appeal is pending. Suits brought against the Plan must be brought in the United States District Court for the Southern District of Ohio, Eastern Division.

Exhaustion of internal appeals process

Generally, you are required to complete all appeal processes of the Plan before being able to bring an action in litigation. However, if the claims administrator, or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with any available remedies under §502(a) of ERISA.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to litigation if:

- A rule violation was minor and is not likely to influence a decision or harm you;
- It was for a good cause or was beyond the claims administrator's or the Plan's or its designee's control; and
- It was part of an ongoing good faith exchange between you and the claims administrator or the Plan.

This exception is not available if the rule violation is part of a pattern or practice of violations by the claims administrator or the Plan.

You may request a written explanation of the violation from the Plan or the claims administrator, and the Plan or the claims administrator must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

Claims and Appeals for Pre-Service Medical and Prescription Drug Benefits

Application

If the Plan requires you to pre-certify certain expenses in order to receive coverage, reimbursement, or avoid a reduction in reimbursement, a request for such pre-certification will be subject to the procedures in this section.

The claims administrator will consider a request for pre-certification to be urgent if the application of the normal time frames in this section could seriously jeopardize your life, health or ability to regain maximum function, or could subject you to severe pain that could not be managed without the requested treatment. Any claim that a physician (with knowledge of your condition) considers to be an urgent care claim will be treated as an urgent care claim.

Processing a Claim

When you request pre-certification, you will usually be notified within 15 calendar days (72 hours in the case of an urgent claim). If you do not provide the necessary information, the claims administrator may either deny pre-certification or contact you to obtain the missing information. If you are contacted, you will be given a period of 45 calendar days (48 hours, in the case of an urgent claim) to provide the missing information. If due to matters beyond its control the claims administrator needs more time to decide a claim, it may take a 15-day extension on a non-urgent pre-service claim (not applicable to an urgent claim). If an extension is taken, you will be notified of the circumstances and the date by which the claims administrator expects to decide the claim. The claims administrator will review each request for pre-certification and make a determination, in its sole discretion, based upon its interpretation of applicable Plan provisions, whether to pre-certify the admission.

Denial of a Claim

If pre-certification is denied, you will be notified. The notice of the decision will be in writing and will include:

- the reasons for the denial;
- a reference to the relevant Plan provisions;
- a description of additional information needed and an explanation of why the additional information is needed;
- an explanation of the appeal procedure (including your right to file suit following an appeal);
- if an internal rule, guideline, protocol or other similar criterion was relied upon, either (a) a copy of the specific rule, guideline, protocol or other similar criterion; or (b) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request; and
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or statement that such explanation will be provided free of charge upon request.

In the case of an urgent claim, notice of the decision may be oral if the Plan sends written notice within three calendar days after the oral notice.

Right of Appeal

If your claim is denied, you may ask the claims administrator for a review. A request for review of a denied claim must be submitted, in writing (or, in the case of an urgent appeal, verbally), to the claims administrator within 180 calendar days after the date that the claim is denied. You should submit any additional written comments, documents, records and other information relating to your claim that you think the claims administrator should see in connection with deciding your appeal.

You have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits, free of charge.

Review Procedure

The claims administrator will make a decision on a non-urgent appeal of a pre-service claim within 30 calendar days. A decision on an urgent appeal of a pre-service claim will be made within 72 hours. Notice of the decision will be in writing and will include:

- reasons for the decision;
- references to 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 documents, records and other information relevant to your claim for benefits;
- an explanation of the appeal procedures and your right to bring an action under Section 502(a) of ERISA following exhaustion of the appeal process;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request; and
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Notice of the decision on an urgent appeal may be oral if the claims administrator sends written notice within three calendar days after the oral notice.

The person who decides the appeal will not be the same individual who decided the claim (or a subordinate of the individual who decided the claim). For a decision based on medical judgment, the person deciding the appeal will consult with a health care professional. The health care professional will not be a health care professional who was consulted in connection with the decision on the claim (or a subordinate of a health care professional who was consulted in connection with the decision on the claim). The claims administrator will make a determination, in its sole discretion, based upon the applicable provisions of the Plan, whether to approve or deny the appeal. Benefits under the Plan will be paid only if the claims administrator decides in its discretion that you are entitled to benefits under the terms of the Plan. The construction, interpretation and application of Plan provisions are vested with the claims administrator, in its absolute discretion, including, without limitation, the determination of facts, benefits and eligibility.

You have the option to request a voluntary second appeal. However, the decision on your first appeal exhausts the appeals process. You are not required to request a voluntary second appeal before taking legal action.

Voluntary Second Appeal for Pre-Service Claims

A voluntary second appeal is available if your first appeal of a medical or prescription drug claim is denied. A request for second review of a denied claim must be submitted, in writing, to the claims administrator within 60 calendar days (for prescription drug claims, 180 calendar days) after the date that the claim is denied on first appeal. You should submit any additional written comments, documents, records and other information relating to your claim that you think the claims administrator should see in connection with deciding your appeal. You have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits, free of charge.

The claims administrator will make a decision on your second appeal within 15 calendar days. The review procedure (described above) that applied to your first appeal will also apply to your second appeal. However, the person who decides the second appeal will not be the same individual who decided the claim or the first appeal (or a subordinate of the individual who decided the claim or the first appeal). For a decision based on medical judgment, the person deciding the appeal will consult with a health care professional. The health care professional will not be a health care professional who was consulted in connection with the decision on the claim or the first appeal (or a subordinate of a health care professional who was consulted in connection with the decision on the claim or the first appeal).

Concurrent Care Decisions

Reduction in a Course of Treatment

If, after a claims administrator has approved a course of treatment, the claims administrator decides to reduce or end the health benefits it has approved for you, it will notify you sufficiently in advance of the reduction or end of benefits to allow you the opportunity to appeal the decision before the reduction in benefits or the end of benefits occurs. If you want to appeal the reduction or end of benefits, the appeal must be filed at least 24 hours prior to the reduction or end of benefits. The claims administrator will notify you of its decision before the reduction or end of benefits and will otherwise handle your appeal in accordance with the applicable appeals procedures.

Extension of a Course of Treatment

After a claims administrator has approved a course of treatment, you may submit a request for an extension of the course of treatment.

If the claims administrator receives your request for additional benefits at least 24 hours prior to the end of the initially prescribed course of treatment and the treatment is considered to be an urgent care claim, the claims administrator will notify you of its decision within 24 hours. If the claims administrator denies your request for additional benefits, you may appeal the adverse benefit determination in accordance with the appeals procedures for urgent pre-service health benefits.

If you request the extension of the course of treatment when there is less than 24 hours before the end of the initially prescribed course of treatment (or if the treatment is not considered to be an urgent care claim), your request will be handled as a new claim for benefits.

Claims and Appeals for Post-Service Health Benefits

Application

Except where the Plan requires that you pre-certify an expense in order to receive coverage, reimbursement, or avoid a reduction in reimbursement, a claim for benefits will be subject to the procedures in this section. This includes requests for reimbursement from an RRA. See "*Claims and Appeals for Pre-Service Health Benefits"* for pre-certification requests.

An initial claim must be submitted within one year of the date it was incurred. A claim filed more than one year after the date it was incurred will not be considered unless you can demonstrate to the satisfaction of the claims administrator that, due to circumstances beyond your control, you were unable to file the claim within the period.

Processing a Claim

When a claim for benefits is submitted to the claims administrator for payment, it will usually be processed within 30 calendar days.

If your claim does not include necessary information, the claims administrator may either deny your claim or contact you to obtain the missing information. If you are contacted, you will be given a period of 45 calendar days to provide the missing information.

If due to matters beyond its control the claims administrator needs more time to decide a claim, it may take a 15-day extension. If an extension is taken, you will be notified of the circumstances and the date by which the claims administrator expects to decide the claim.

The claims administrator will review each claim for benefits and make a determination, in its sole discretion, based upon its interpretation of applicable Plan provisions, whether to approve or deny such claim.

Denial of a Claim

You will be notified if a claim is denied. The notice will be in writing and will include:

- the reasons for the denial ;
- a reference to the relevant Plan provisions;
- a description of additional information needed and an explanation of why the additional information is needed;
- an explanation of the appeal procedure (including your right to file suit following an appeal);
- if an internal rule, guideline, protocol or other similar criterion was relied upon, either: (a) a copy of the specific rule, guideline, protocol or other similar criterion; or (b) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request; and
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Right of Appeal

If your claim is denied, you may ask the claims administrator for a review. A request for review of a denied claim must be submitted, in writing, to the claims administrator within 180 calendar days after the date that the claim is denied. You should submit any additional written comments, documents, records and other information relating to your claim that you think the claims administrator should see in connection with deciding your appeal. You have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits, free of charge.

Review Procedure

The claims administrator will make a decision on your appeal within 60 calendar days. Notice of the decision will be in writing and will include:

- reasons for the decision;
- references to 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 documents, records and other information relevant to your claim for benefits;
- an explanation of the appeal procedures and your right to bring an action under Section 502(a) of ERISA following exhaustion of the appeal process;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request; and
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The person who decides the appeal will not be the same individual who decided the claim (or a subordinate of the individual who decided the claim). For a decision based on medical judgment, the person deciding the appeal will consult with a health care professional. The health care professional will not be a health care professional who was consulted in connection with the decision on the claim (or a subordinate of a health care professional who was consulted in connection with the decision on the claim). The claims administrator will make a determination, in its sole discretion, based upon the applicable provisions of the Plan, whether to approve or deny the appeal. Benefits under the Plan will be paid only if the claims administrator decides in its discretion that you are entitled to benefits under the terms of the Plan. The construction, interpretation and application of Plan provisions are vested with the claims administrator, in its absolute discretion, including, without limitation, the determination of facts, benefits and eligibility.

You have the option to request a voluntary second appeal. However, the decision on your first appeal exhausts the appeals process. You are not required to request a voluntary second appeal before taking legal action.

Voluntary Second Appeal

A voluntary second appeal is available if your first appeal of a medical or prescription drug claim is denied. A request for a second review of a denied claim must be submitted, in writing, to the claims administrator within 60 calendar days (for prescription drug claims, 180 calendar days) after the date that the claim is denied on first appeal. You should submit any additional written comments, documents, records and other information relating to your claim that you think the claims administrator should see in connection with deciding your appeal. You have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits, free of charge.

The claims administrator will make a decision on your second appeal within 60 calendar days. The review procedure (described above) that applied to your first appeal will also apply to your second appeal. However, the person who decides the second appeal will not be the same individual who decided the claim or the first appeal (or a subordinate of the individual who decided the claim or the first appeal). For a decision based on medical judgment, the person deciding the appeal will consult with a health care professional. The health care professional will not be a health care professional who was consulted in connection with the decision on the claim or the first appeal (or a subordinate of a health care professional who was consulted in connection with the decision on the claim or the first appeal).

5. COBRA Continuation Coverage

If your spouse or dependent children are enrolled in the Plan, your family may have the option to temporarily continue coverage in certain instances when coverage would otherwise end. The right to continue coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to members of your family when they would otherwise lose Plan coverage. This section generally explains COBRA continuation coverage, when it may become available to your family, and what your family needs to do to protect their right to receive it.

Instead of enrolling in COBRA continuation coverage, a family member may have other more affordable coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. It is important that they consider their options promptly because the special enrollment periods for Marketplace and other group health coverage are limited.

- The Marketplace special enrollment period is generally within the 60 days after coverage under the Plan ends.
- If the family member is eligible for group health coverage through an employer, the special enrollment period for that coverage is generally within the 30 days after coverage under the Plan ends.

Qualifying Events

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Your spouse will become a qualified beneficiary if he or she loses coverage under the Retiree Medical Plan or RRA because you and your spouse become legally separated or divorced.

Also, a surviving spouse will become a qualified beneficiary if he or she loses coverage under the Retiree Medical Plan or the RRA because he or she remarries.

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

- you die without a surviving spouse,
- your surviving spouse remarries,
- you or your spouse become entitled to Medicare,
- you become legally separated or divorced, or
- the dependent child stops being eligible for coverage under the Plan as a "dependent child."

Note, in the event you die or become entitled to Medicare, your dependent children will still be able to participate in the Retiree Medical Plan provided your spouse continues to participate in the Retiree Medical Plan. When your spouse's Retiree Medical Plan coverage ends, your dependent children can elect COBRA continuation coverage for up to 36 months. Otherwise, your dependent children's coverage under the Retiree Medical Plan will end on the first day of the first month after your spouse's coverage ends.

Giving Notice That a Qualifying Event Has Occurred

In the event of your legal separation, divorce or death, remarriage of a surviving spouse or a dependent child's losing eligibility for coverage as a dependent child, you or a family member must notify the My Benefits Connect Center, at 1-866-778-5885, within 60 days after the qualifying event occurs. The Plan will send the qualified beneficiary a COBRA election form if it receives this notice within the 60 days. If timely notice is not provided, the qualified beneficiary will lose all rights to COBRA continuation coverage under the Plan.

Electing COBRA Continuation Coverage

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Parents may elect COBRA continuation coverage on behalf of their dependent children.

In order to elect COBRA continuation coverage, you or a family member must call the My Benefits Connect Center at 1-866-778-5885 within 60 days from the later of: (a) the date of the qualifying event, (b) the date that the COBRA election notice is sent, or (c) the date Plan coverage would otherwise end. If this deadline is not met, your spouse and/or dependent children's right to COBRA continuation coverage will be lost.

Paying for COBRA Continuation Coverage

Each qualified beneficiary is required to pay the entire cost of continuation coverage plus 2% for administration costs.

- First payment for COBRA coverage – The first payment for continuation coverage must be made not later than 45 days after the date of your spouse's and/or dependent children's election. If the first payment for continuation coverage is not made within 45 days after the date of election, your spouse and/or dependent children will lose all COBRA continuation coverage rights under the Plan.

- Monthly payments for COBRA coverage – After the first payment for COBRA continuation coverage is made, your spouse and/or dependent children will be required to make monthly payments. Each of these monthly payments for COBRA continuation coverage is due on the first day of the month. If each monthly payment is made on or before the first day of the month, your spouse's and/or dependent children's coverage under the Plan will continue for that month without any break.

- Grace periods for monthly payments – Although monthly payments are due on the first day of every month, your spouse and/or dependent children will be given a grace period of 30 days to make each monthly payment. Continuation coverage will be provided for each month as long as payment for that coverage period is made before the end of the grace period for that payment. However, if a monthly payment is made later than the first day of the month, but before the end of the grace period for the coverage period, your spouse's and/or dependent children's coverage under the Plan may be suspended and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated. If a monthly payment is not made before the end of the grace period for that month, your spouse and/or dependent children will lose all rights to COBRA continuation coverage under the Plan.

Coverage During the Continuation Period

If coverage under the Plan is changed for retirees, the same changes will be provided to individuals on COBRA continuation.

When COBRA Continuation Coverage Ends

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is legal separation, divorce, the death of the retiree, remarriage of a surviving spouse or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

COBRA continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid by the deadline;

- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan;

- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage; or

- the Plan is terminated.

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

Questions About COBRA

Questions concerning the Plan or your family's COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your or your family's rights under ERISA, including COBRA 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.)

In order to protect your family's rights, the My Benefits Connect Center should be informed of any changes in the addresses of family members. Your family should also keep a copy for your records of any notices sent to the My Benefits Connect Center.

Plan Contact Information

All notices must be provided to the My Benefits Connect Center by calling 1-866-778-5885. Also, if you or a family member has questions about COBRA continuation coverage, you or that family member may call the My Benefits Connect Center.

6. Medicare Part D

"Creditable prescription drug coverage" is prescription drug coverage that is, on average for all plan participants, expected to pay out at least as much as the standard Medicare Part D prescription drug coverage. The prescription drug coverage offered under the Retiree Medical Plan is creditable prescription drug coverage. However, the RRA does not provide creditable prescription drug coverage.

- Because coverage under the Retiree Medical Plan ends when a retiree or spouse becomes eligible for Medicare, you and your spouse will not be eligible for prescription drug coverage under both the Retiree Medical Plan and a Medicare Part D prescription drug plan at the same time (except for a limited period when eligibility for Medicare is due to end-stage renal disease).

- When your coverage ends under the Retiree Medical Plan, your creditable prescription drug coverage ends. If your coverage under the Retiree Medical Plan ends when you are eligible for Medicare and you don't enroll in a Medicare prescription drug plan at that time, you may have to wait to enroll in Medicare prescription drug coverage and you may have to pay a higher premium (a penalty) when you do enroll. If you are Medicare-eligible and you go sixty-three (63) days or longer without creditable prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen (19) months without creditable prescription drug coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

7. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Application

This notice is effective April 1, 2021. It describes the privacy practices of the Honda Retirement Medical Program (the Retiree Medical Plan and the RRA, collectively, the "Plan"). This notice does not apply to life insurance or any non-health plans or benefits.

"Protected health information" is health information that identifies you and relates to your medical history (i.e., the medical care you receive or the amounts paid for that care) that is created or obtained by the Plan in connection with your eligibility for or receipt of medical benefits under the Plan. Federal law requires that the Plan maintain the privacy of protected health information, give you this notice of the Plan's legal duties and privacy practices, and follow the terms of this notice as currently in effect.

Honda contracts with claims administrators and other third parties to provide Plan services. The current claims administrators are listed under Contact Information, below. When their services involve the use of protected health information, the third parties will be required to perform their duties in a manner consistent with this notice. For purposes of this notice, the Plan includes third parties when performing services for the Plan. Protected health information may be shared among the components of the Plan, and the third parties providing services for components of the Plan, in the course of paying benefits and conducting Plan operations.

Use of Protected Health Information for Payment, Operations and Treatment

The Plan uses and discloses your protected health information for payment of benefits, Plan operations and treatment activities. The following paragraphs describe the ways that the Plan might use your protected health information for payment, Plan operations and treatment. For each category, a number of uses or disclosures will be listed, along with an example. However, not every use or disclosure in a category will be listed.

- **Payment** – The Plan will use and disclose your protected health information to determine and pay for covered services. Payment activities include determining eligibility, conducting pre-certification, utilization and medical necessity reviews; coordinating care; calculating cost sharing amounts; coordination of benefits; reimbursement and subrogation; and responding to questions, complaints and appeals. For example, the Plan may use your medical history and other health information to decide whether a particular treatment is Medically Necessary and what the payment should be. During that process, the Plan may disclose information to your provider. The Plan will mail Explanation of Benefits forms and other information to the retiree at the address it has on record for the retiree.

- **Plan Operations** – The Plan will use and disclose your protected health information for Plan operations. Operational activities include quality assessment and improvement, performance measurement and outcomes assessment, health services research and preventive health, disease management, case management and care coordination. For example, the Plan may use protected health information to provide disease management programs for participants with specific conditions, such as diabetes, asthma or heart failure. Other operational activities requiring use and disclosure of protected health information include administration of stop loss coverage; legal, actuarial and audit services; business planning and cost management; detection and investigation of fraud; administration of pharmaceutical programs and payments; and other general administrative activities, including data and information systems management and customer service. The Plan is prohibited from using or disclosing protected health information that is genetic information for underwriting purposes.

- **Treatment** – While the Plan does not conduct medical treatment, the Plan may use or disclose your protected health information to facilitate medical treatment or services by providers. The Plan may disclose protected health information to doctors, pharmacies, hospitals and other health care providers who take care of you. For example, doctors may request medical information from the Plan to supplement their own records. The Plan may also send certain information to doctors for patient safety or other treatment-related reasons.

Disclosure to Others Involved in Your Health Care

The Plan may disclose protected health information to a family member, a friend or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls the Plan with prior knowledge of a claim, the Plan may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure. See *Contact Information*, below.

Disclosures Authorized by You

The Plan will not use or disclose your protected health information for any reason other than those described in this notice unless you provide a written authorization. For example, unless you provide written authorization, the Plan is prohibited from selling your protected health information or using or disclosing your protected health information for marketing activities that result in financial remuneration to the Plan.

You may give the Plan written authorization to use and/or disclose your protected health information to anyone for any purpose. If you give the Plan an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure made pursuant to your authorization while it was in effect.

Disclosures to Honda

The Plan will share enrollment information about you and your family members with Honda. The Plan will also periodically disclose protected health information to My Benefits Connect Center and the Benefits Department of Honda so that My Benefits Connect Center and/or the Benefits Department can assist participants with benefits questions and oversees the administration of the Plan. My Benefits Connect Center and the Benefits Department will only use the protected health information for participant assistance and Plan administration, or as required by law. Specifically, Honda certifies that it will:

- Not use or disclose protected health information for employment-related actions and decisions or in connection with any non-health benefits or non-health plan sponsored by Honda.
- Not use or further disclose protected health information other than as permitted or required by this notice or as required by law.
- Ensure that any agents (including a subcontractor) to whom Honda provides protected health information received from the Plan agree to the same restrictions and conditions that apply to Honda with respect to such information.
- Report to the Plan's Privacy Officer any use or disclosure of protected health information that is inconsistent with the uses or disclosures provided for of which Honda becomes aware.
- Arrange for the Plan to make your protected health information available to you for access, amendment and/or accounting, as described below.
- Make internal practices, books and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with federal law.
- Return protected health information to the Plan (when feasible), destroy protected health information (when return is not feasible and retention is not required by law), or continue to maintain the privacy of all protected heath information (when return is not feasible or retention is required by law).
- Use its best efforts to request only the minimum necessary type and amount of protected health information to carry out the functions for which the information is requested.
- Ensure adequate separation between My Benefits Connect Center and the Benefits Department of Honda and the other departments of Honda by utilizing reasonable and appropriate security measures, so that protected health information received by My Benefits Connect Center and/or the Benefits Department is not disclosed to associates in other departments of Honda in violation of

this notice. Any Honda staff that works with protected health information will undergo training on the protection of health information and the privacy practices described in this notice.

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that Honda creates, receives, maintains or transmits on behalf of the Plan.

- Ensure that any agents (including subcontractors) to which they provide such electronic protected health information agree to implement reasonable and appropriate security measures to protect such electronic protected health information.

- Report to the Plan any security incident of which it is aware.

Other Uses of Protected Health Information

- Communications about Benefits – The Plan may use or disclose protected health information in providing you with treatment alternatives, treatment reminders or other health-related benefits and services.

- Disclosures to Providers and Other Health Plans – The Plan may disclose protected health information to providers or other health plans for payment, treatment and certain operational activities of the provider or other health plan.

- Law Enforcement – The Plan may disclose protected health information to law enforcement officials under limited circumstances. For example, the Plan may release protected health information in response to a warrant or subpoena; for the purpose of identifying or locating a suspect, witness, or missing person; or to provide information concerning victims of crimes.

- Legal Proceedings – The Plan may disclose protected health information in response to a court order or other lawful process. If you are involved in a lawsuit or a dispute, the Plan may disclose your protected health information in response to a court or administrative order. The Plan may also disclose your protected health information in response to a valid subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- Public Welfare – The Plan may disclose your protected health information for public health activities. These activities generally include reports to prevent or control disease, injury or disability, of births and deaths, of child abuse or neglect, public health investigations and/or interventions, such as reactions to medications or problems with products, to notify people of recalls of products they may be using, to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition, and, if you agree or when required or authorized by law, to notify the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect or domestic violence.

- Governmental Regulation – The Plan may disclose protected health information to the U.S. Department of Labor and other government agencies for activities authorized by law. These activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor group health plans, the health care system, government programs and compliance with civil rights laws.

- Coroners, Medical Examiners and Funeral Directors – The Plan may disclose protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release protected health information to funeral directors as necessary to carry out their duties.

- Organ and Tissue Donation – The Plan may disclose protected health information, if you are an organ donor, to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- Research – The Plan may disclose protected health information to researchers provided measures are taken to protect your privacy.

- To Avert a Serious Threat to Health or Safety – The Plan may disclose protected health information to the extent necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of others.

- Specialized Government Functions – The Plan may disclose protected health information in certain circumstances or situations to a correctional institution if you are an inmate in a correctional facility; to an authorized federal official when it is required for lawful intelligence or other national security activities; or to an authorized authority of the armed forces as required by military command authorities.

- Workers' Compensation – The Plan may disclose protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Participant Rights

Federal privacy regulations give you the right to:

- See and/or get a copy of protected health information held by the Plan in a "designated record set" (e.g., records used in making eligibility, claims, medical management and other decisions), to the extent required by law. You must make your request in writing. The Plan will charge a reasonable fee for producing and mailing the copies.

- Amend protected health information that is in a "designated record set." If you think that your protected health information held by the Plan is incorrect or incomplete, you may ask the Plan to amend that information. Your request must be in writing and include the reason for the request. The Plan may deny your request if you ask the Plan to amend information that:

  - is not part of the protected health information kept by or for the Plan;

  - was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;

  - is not part of the information that you would be permitted to inspect and copy; or

  - is accurate and complete.

If the Plan denies the request, you may file a written statement of disagreement with the Plan administrator.

- Get a list of certain disclosures the Plan has made about you. The list will not include disclosures made to you or with your written authorization or in the course of treatment, payment, or health care operations. Your request must be in writing and specify the time period for which you are requesting information. The period cannot go back more than six years from the date of your request. If you request such an accounting more than once in a 12-month period, the Plan will charge a reasonable fee.

- Request that the Plan communicate with you at an alternative location (for example, by sending materials to a post office box instead of the retiree's home address) if you believe that normal communications would endanger you or you have other good cause. The Plan will accommodate reasonable requests.

- Request restrictions as to the ways that the Plan uses or discloses your protected health information. The Plan will consider, but need not agree to, such requests. Generally, you have the right to require a healthcare provider to restrict the disclosure of your protected health information to the Plan. However, to obtain such a restriction, you would need to pay your healthcare provider in full for services and supplies because the restriction would prevent the Plan from making payments on your behalf to your healthcare provider.

- Request a copy of this notice.

- Receive notification of breaches of unsecured protected health information.

Contact Information

If you want to exercise any of the rights described in this notice, you may contact:

- For matters concerning medical and medical expense reimbursements:

  Quantum Health
  Care Coordinators by Quantum Health
  7450 Huntington Park Drive, Suite 100
  Columbus, Ohio 43235

  UMR
  P.O. Box 30541
  Salt Lake City, UT 84130 0543

  Blue Cross Blue Shield of Alabama
  450 Riverchase Parkway East
  Birmingham, AL 35244-2858

  For matters concerning prescription drug benefits and prescription expense reimbursements:

  CVS/Caremark
  Customer Care Correspondence
  P.O. Box 6590
  Lee's Summit, MO 64064 6590

- For matters concerning enrollment, coverage elections and changes to coverage elections:

  My Benefits Connect Center
  www.myhondaconnect.com
  1-866-778-5885

Questions and Complaints

If you have questions regarding this notice, you may contact the Plan's Privacy Officer, American Honda Motor Co., Inc..; 24025 Honda Parkway; Marysville, Ohio 43040-9251; 1-937-642-5000. You may also direct questions to the claims administrator listed under Contact Information, above.

You have the right to file a written complaint with the Plan's Privacy Officer if you think your privacy rights have been violated. Include your name, address and telephone number. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

The Plan's Privacy Officer will investigate and address any issues of noncompliance with this notice of which he/she is notified or becomes aware.

Changes to This Notice

Honda may change the terms of this notice and the Plan's privacy policies at any time. If Honda makes a change, the new terms and policies will then apply to all protected health information maintained by the Plan, even if the information was created or received before the change to the notice. If Honda makes any material changes, it will distribute a new notice.

8. Statement of Rights under ERISA

As a participant in the Plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants will be entitled to:

Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan administrator's office and at other specified locations, all Plan documents, a list of participating employers and a copy of the latest annual report (Form 5500 Series) and an updated summary plan description.

You may obtain, upon written request to the Plan administrator, copies of Plan documents, copies of the latest annual report (Form 5500 Series), and a list of participating employers and updated summary plan description. The Plan administrator may make a reasonable charge for the copies. You may also obtain, without charge, a copy of the Plan's qualified medical child support order procedures.

You will receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each 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 the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for welfare benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request copies of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the courts 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 you have a claim for benefits which is ignored, or an appeal which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Right to Continue Group Health Plan Coverage

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration; U.S. Department of Labor; 200 Constitution Avenue N.W.; Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

9. A Closing Word

This Guide is the official summary plan description of the Honda Retirement Medical Program. Because this Guide describes your retiree health benefits, please read this material carefully and keep it for future reference. The Retirement Medical Program is also subject to the terms of an official Plan document. If you have questions about the Retirement Medical Program, contact the My Benefits Connect Center at 1-866-778-5885.

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