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2021

Effective:
April 1, 2021

HONDA

A GUIDE TO YOUR BENEFITS

Honda

A GUIDE TO YOUR BENEFITS

This SPD is available both in print and online at myhondaconnect.com.

Honda is pleased to provide you with this Summary Plan Description: A Guide to Your Benefits (or SPD). Your benefit plans are an important part of the total rewards package that Honda provides for you and your family.

The SPD provides information about the plan provisions governing your benefits—including eligibility, coverage levels and plan guidelines. Consider this SPD, which is available both in print and online at **myhondaconnect.com**, to be your primary reference guide for your benefits. This is the first place to turn when you have a question about your rights as a plan participant. You can also contact your local Human Resources or Administration Department to request a free paper copy.

Contents

About This Guide

This SPD is designed to help you understand how your benefits work. Please refer to it when you have questions about your benefit plans. If you have a family, be sure to share the guide with them as well.

This guide is divided into sections describing each benefits plan, as shown in the table of contents. For details about a specific plan, refer to that section. There, you will find another table of contents to help you find what you are looking for in that benefits plan section.

If You Have Questions

*If you have questions about the information in this guide, contact the My Benefits Connect Center by calling **1-866-778-5885**, Monday – Friday from 8:30 a.m. to 10 p.m. ET. This guide is available both in print and online at **myhondaconnect.com**.*

This guide is the Summary Plan Description (SPD) for the Honda Health & Welfare Benefits Plan and the retirement plans offered by select Honda companies sponsored by American Honda Motor Co., Inc. (collectively referred to as "Honda" in this guide) effective April 1, 2021. The complete list of Honda companies participating in plans described in this SPD is listed in *Administrative Information* starting on page 316.

Note: Insured (health and welfare) benefits are also subject to the terms of the insurance certificates, policies or contracts of coverage. The Summary Plan Description, along with the insurance certificates, policies or contracts of coverage for the health and welfare plans listed in *Administrative Information* on starting on page 316, are considered the official plan documents for those plans. For the other welfare plans subject to the Employee Retirement Income Security Act of 1974 (ERISA), this Summary Plan Description also serves as the official plan document.

Eligibility under the health plans may be different from eligibility for retirement. See *Retirement Benefits* on page 258 for details.

This guide is not considered a plan document for the retirement plan(s) listed in *Administrative Information* starting on page 316. It is a summary only of information that is included in legal plan documents for those plans, and in all such cases, the legal plan documents will determine how those plans are administered.

About the Benefit Plans

This SPD is for active Honda associates employed by select Honda companies listed in *Administrative Information* starting on page 316. Your participation in these benefit plans does not guarantee continued employment with Honda.

The persons set forth below are not eligible for, and may not participate in, the benefit plans described in this SPD:

- An active associate who has a regular work schedule of less than 16 hours per week
- Any self-employed person who provides services to Honda through an agreement between Honda and that person
- Any person employed by or who obtains employment through a company that provides temporary workers to Honda
- A student, co-op, intern or temporary associate
- An associate of an international affiliate on temporary assignment at Honda

Eligibility under the health plans may be different from eligibility for retirement. See *Retirement Benefits* page 258 for details.

The plan sponsor for each plan has the sole right to terminate, suspend, withdraw, amend or modify the benefit plans described in this guide in whole or in part at any time. These actions may affect plans covering any associates and covered dependents.

Important to Remember

Honda's practices, policies and benefits for U.S. associates are outlined here for your information as required by law. However, this does not constitute an implied or express contract or guarantee of employment.

Please read this material carefully and keep it for future reference. If you have questions about this information or your Honda benefit plans, contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET.

Your Benefits: A Complete Package

Honda provides a complete and competitive benefits package to eligible associates. Many of these benefits are paid for entirely by Honda.

Honda benefits provide a broad range of assistance, as shown in the following chart. For details about a specific plan, refer to that section within this guide.

Your Situation	Honda Provides	See This Section
If You Need Healthcare…	Medical Coverage	*Medical Plan*
	Prescription Drug Coverage	*Prescription Drug Plan*
	Dental Coverage	*Dental Plan*

Your Situation	Honda Provides	See This Section
	Vision Coverage	*Vision Plan*
	Healthcare Flexible Spending Account	*Flexible Spending Accounts*
	Limited Purpose Flexible Spending Account	*Flexible Spending Accounts*
If You Have Dependents…	Healthcare Coverage	See the "If You Need Healthcare…" row above for more information about the sections to review.
	Dependent Care Flexible Spending Account	*Flexible Spending Accounts*
	Supplemental Life Insurance	*Supplemental Insurance Plans*
	Survivor Medical Insurance Program	*Supplemental Insurance Plans*
If You Become Disabled…	Company-Paid Short-Term Disability	*Disability Plans*
	Honda Disability Allowance	*Disability Plans*
	Company-Paid Long-Term Disability	*Disability Plans*
	Associate-Paid Long-Term Disability	*Supplemental Insurance Plans*
For Protection Against Loss of Life or Limb…	Basic Life and Accident Insurance	*Life and Accident Insurance*
	Business Travel Insurance	*Life and Accident Insurance*
	Supplemental Life Insurance	*Supplemental Insurance Plans*
	Voluntary Accidental Death and Dismemberment Insurance	*Supplemental Insurance Plans*
For Time Away from Work…	Family and Medical Leave	*Administrative Information*
For Home and Personal Issues…	Associate Assistance Program	*Other Benefits*
	Group Auto Insurance	*Supplemental Insurance Plans*
	Group Homeowners Insurance	*Supplemental Insurance Plans*
	Group Legal Plan	*Supplemental Insurance Plans*
	Adoption Assistance Program	*Other Benefits*
For Ownership in Honda…	Stock Purchase Plan	*Other Benefits*
When You Retire…	Pension Plan	*Pension Plan*
	401(k) Savings Plan	*401(k) Savings Plan*
	Retirement Medical Program	*Retirement Benefits*
	Supplemental Life Insurance	*Supplemental Insurance Plans*
	Group Legal Plan	*Supplemental Insurance Plans*
	Group Homeowners Insurance	*Supplemental Insurance Plans*
	Group Auto Insurance	*Supplemental Insurance Plans*
	Associate Assistance Program	*Supplemental Insurance Plans*

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Life Events

Honda benefits are designed to help and support you during all the events of your life, expected and unexpected. This section gives you information about your benefits and outlines the steps you should take when certain life events occur. Watch the “Life and Work Changes” video on **myhondaconnect.com** to see the overview of how benefits may be impacted by life events. See the following sections for more information about other situations or events that may affect benefits eligibility, allow you to enroll in or change beneficiary designations:

- *How the Benefits Program Works*
- *Participating in Health Benefits*
- *Flexible Spending Accounts*
- *Supplemental Insurance Plans*
- *401(k) Savings Plan*
- *Pension Plan*

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If You Marry

- Update your personnel and payroll records (e.g., name, address), if applicable.
- Notify the My Benefits Connect Center of your marriage and enroll your spouse and dependents for healthcare and Supplemental Life Insurance coverage, if appropriate. Stepchildren must be listed as the children of your spouse on a birth certificate, adoption decree, etc. To enroll your spouse (and, if applicable, your eligible stepchildren), contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET. You *must* enroll within 31 days of the marriage. **If you do not enroll within 31 days, you will not be able to enroll your spouse (and, if applicable, your eligible stepchildren) until the next Benefits Enrollment period.**

  Enrollment Deadline
  You must enroll within 31 days of the marriage. Otherwise, you will not be able to enroll your spouse (and, if applicable, your eligible stepchildren) until the next Benefits Enrollment period.

  Note: You will need to provide supporting documentation for adding dependents to the Honda healthcare plan as a new hire, during Benefits Enrollment or as a result of a qualified life event change (e.g., birth of a child, adoption or marriage). You must submit documentation to the My Benefits Connect Center within 45 days of your benefit election to verify your dependent is eligible to participate. Required documents include, but are not limited to, marriage certificates, birth certificates, adoption decrees or guardianship paperwork. Depending on the situation, Honda may also require other forms of documentation to confirm eligibility (e.g., 1040 tax forms).

  It is your responsibility to provide accurate and up-to-date dependent information. Providing false information about your dependents could result in loss of the elected benefit(s) and/or corrective action, up to and including termination.

  Important Note!
  You are responsible for providing accurate and up-to-date dependent information. Providing false information about your dependents could result in loss of the elected benefit(s) and/or in corrective action, up to and including termination.
- Review your spouse's employer benefits so that you can select coverage to best suit your needs.
- Consider beginning or increasing your Healthcare Flexible Spending Account (FSA) or Limited Purpose FSA contributions, so you can be reimbursed for your and your spouse's (and, if applicable, your stepchildren's) eligible out-of-pocket healthcare expenses with tax-free dollars.
- If you're adding a child, consider contributing to a Dependent Care FSA, if appropriate.
- Consider participating in the Survivor Medical Insurance Program and other Voluntary/Supplemental Benefits, if appropriate.
- Update your beneficiary designations for Honda basic life insurance, accident insurance, 401(k) savings account and pension benefits (if applicable), and Supplemental Life Insurance coverage.

Benefit Changes to Consider	
Healthcare Coverage	• Enroll in or cancel coverage for your spouse and dependents • Add dependents
Flexible Spending Accounts	• Begin or stop contributions • Change the amount you contribute
Supplemental Life Insurance ***Voluntary Accidental Death and Dismemberment Insurance***	• Begin or increase or decrease coverage • Add spouse or child coverage if you are enrolled
Associate-Paid Long-Term Disability	• Begin or cancel coverage
Survivor Medical Insurance Program	• Enroll in or cancel coverage for your spouse and dependents
401(k) Savings Plan	• Change or begin contributions
Group Auto Insurance	• Change coverage
Group Homeowners Insurance	• Change coverage
Group Legal Plan	• No changes allowed

If You Divorce or Become Legally Separated

- Update your personnel and payroll records (e.g., name, address), if applicable.
- Notify the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET, within 31 days of the divorce or legal separation.

  Your ex-spouse, legally separated spouse and/or any stepchildren will no longer be eligible for Honda benefits with one exception; he or she will have the option to continue healthcare coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (see *COBRA* on page 204 for more information) if he or she was covered at the time of the divorce. **In *no* instance may you cover an ex-spouse or a spouse from whom you are legally separated as one of your dependents under the Honda plan.**
- Remove your legally separated spouse or ex-spouse as an eligible dependent even if they are not covered under any benefits.
- Update your beneficiary designations for Honda life insurance plans and retirement benefits by contacting the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET. To update your 401(k) savings account beneficiary, contact Fidelity at **1-800-835-5095** or log in to **401k.com**.
- Coverage for your spouse will end the last day of the month in which the divorce or legal separation occurred.

Important Note!
You are responsible for providing accurate and up-to-date dependent information. Providing false information about your dependents could result in loss of the elected benefit(s) and/or in corrective action, up to and including termination.

Benefit Changes to Consider	
Healthcare Coverage	• Begin coverage • Add or drop dependents
Family Data	• Remove spouse and stepchildren as eligible dependents
Flexible Spending Accounts	• Begin or stop contributions • Change the amount you contribute
Supplemental Life Insurance ***Voluntary Accidental Death and Dismemberment Insurance***	• Begin, cancel, increase or decrease coverage • Change beneficiary designation • Cancel dependent coverage (your former/legally separated spouse and stepchildren cannot be covered under you as a dependent)
Associate-Paid Long-Term Disability	• Begin or cancel coverage
Survivor Medical Insurance Program	• Begin or stop participation if you get divorced/legally separated and do not have children
401(k) Savings Plan	• Change contributions • Change beneficiary designation(s)
Pension Plan *(if applicable)*	• Change beneficiary designation(s)
Group Auto Insurance	• Change coverage
Group Homeowners Insurance	• Change coverage
Group Legal Plan	• No changes allowed

Becoming a Parent

This section describes what you should do if you or your spouse becomes pregnant or adopts a child.

If You (or Your Spouse) Is Pregnant…

- Contact Quantum Health Care Coordinators at **1-866-778-5885** (if you are enrolled in an HMO Plan, reference your medical/prescription ID card to contact Kaiser) to submit a notice regarding admissions for childbirth in advance, preferably 30 days prior to expected delivery. The plan and the care coordination process complies with all federal regulations regarding utilization review for maternity admissions. For more information, see *Medical Plan* on page 88.
- Contact Sedgwick at **1-866-409-2576** (AHM and subsidiaries) or **1-888-538-2732** (HDMA) to arrange for your leave of absence. For details about how to request a leave of absence, refer to your Associate Handbook. For details about how your benefits are affected, see "Leave of Absence" on page 14 and *Administrative Information* on page 316.
- Contact Sedgwick at **1-866-409-2576** (AHM and subsidiaries) or **1-888-538-2732** (HDMA) to apply for short-term disability benefits for which you may be eligible. See *Income Protection* on page 35.

When Your Child Arrives…

- Enroll your newborn or newly placed child in Honda's benefit plans within 60 days, so your child's medical expenses will be covered from the date of birth, placement for adoption or adoption. To enroll your dependents, contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET. You must enroll within 60 days of the birth or adoption. **If you do not enroll within 60 days, you will not be able to enroll your child until the next Benefits Enrollment period.**

  Please note that dependents cannot be double covered in a benefit plan if both parents work for Honda or Honda affiliate.

Enrollment Deadline

You must *(i) enroll within 60 days of the birth, placement for adoption or adoption and (ii) provide required documentation (such as a birth certificate or adoption decree) within 45 days of enrollment to verify his or her eligibility to participate in the Honda healthcare plan. Otherwise, you will not be able to enroll your child until the next Benefits Enrollment period.*

- Consider beginning or increasing your contributions to a Healthcare FSA, a Limited Purpose FSA and a Dependent Care FSA. This way, you can pay for uncovered medical, prescription drug, dental and vision expenses and child care expenses with tax-free dollars.
- Consider updating your will and life insurance coverage.

Benefit Changes to Consider

Healthcare Coverage	• Begin coverage • Add your new dependent within 60 days
Flexible Spending Accounts	• Begin or stop contributions • Change the amount you contribute
Supplemental Life Insurance ***Voluntary Accidental Death and Dismemberment Insurance***	• Begin or cancel coverage • Increase or decrease coverage for yourself • Buy coverage for your spouse and/or child
Associate-Paid Long-Term Disability	• Begin or cancel coverage
Group Legal Plan	• No changes allowed
Survivor Medical Insurance Program	• Enroll in or cancel coverage for your spouse and dependents in the event of your death
401(k) Savings Plan	• Change or begin contributions

When Your Child's Eligibility Ends

Adult children, up to age 26, are eligible for medical, prescription drug, dental, vision and dependent life insurance coverage under Honda's healthcare plan.

As a Honda associate, it is your responsibility to provide accurate and up-to-date dependent information. If the status of a dependent you have enrolled in healthcare coverage changes during the year, you must report this to the My Benefits Connect Center within 31 days. Providing false information about your dependents could result in loss of the elected benefits and/or corrective action, up to and including termination. See *Participating in Health Benefits* on page 68 for more information on eligible dependent children.

Important Note
You are responsible for providing accurate and up-to-date dependent information. Providing false information about your dependents could result in loss of the elected benefit(s) and/or in corrective action, up to and including termination.

If your covered dependent is no longer eligible for coverage due to reaching age 26 or no longer meeting other eligibility requirements, remember the following:

- If your child is no longer an eligible dependent, you *must* contact the My Benefits Connect Center within 31 days to remove him or her from coverage.
- Note that on the last day of the month in which your child turns 26, he or she will automatically be removed from coverage—unless he or she is disabled (see "If Your Child Is Disabled" on page 13).
- Consider COBRA coverage if your child does not have his or her own insurance coverage. COBRA information will be mailed to your dependent upon loss of coverage. You also may want to review options on **healthcare.gov**.
- **Note that it is your responsibility to provide accurate and up-to-date dependent information. Providing false information about your dependents could result in loss of the elected benefit(s) and/or in corrective action, up to and including termination.**

If Your Child Is Disabled

- Contact Quantum Health or the My Benefits Connect Center at **1-866-778-5885** within 31 days of the date your child reaches age 26. A proof of disability form will be sent to you to complete. Upon receipt, Quantum Health or the My Benefits Connect Center will forward the form to your medical provider—UMR, Blue Cross Blue Shield of Alabama (BCBS-AL) or Kaiser Permanente (Kaiser) for approval. Once approved, contact the My Benefits Connect Center so the dependent will be updated as disabled and not dropped from coverage.

UMR, BCBS-AL or Kaiser will have the right to require proof of the continuation of the handicap. UMR, BCBS-AL or Kaiser also has the right to examine your child as often as needed while the disability continues at its own expense. An exam will not be required more often than once each year after two years from the date your child reached the maximum age.

Coverage will end on the first of the following to occur:

- The disability ends.
- You fail to provide proof that the disability continues.
- Your dependent does not have any required exam.

- Your dependent child's coverage ends for any reason other than reaching the maximum age.

Benefit Changes to Consider	
Healthcare Coverage	• Drop child from coverage
Flexible Spending Accounts	• Begin or stop contributions • Change the amount you contribute
Supplemental Life Insurance ***Voluntary Accidental Death and Dismemberment Insurance***	• Drop child from coverage (**Note:** Children can be covered under this program until they reach age 26 if they are eligible for the healthcare coverage.)

Leave of Absence

This section describes what you should do if you need to take a leave of absence.

When You Return from Leave

Your benefit coverages are restored to pre-leave levels if your leave and return are within the same calendar year. If your return crosses over into the following calendar year you will need to re-enroll.

If You Need to Take a Leave of Absence…

A leave of absence (LOA) is any time away from work for both occupational and non-occupational situations.

For more information about the LOA policy, refer to your Associate Handbook.

What Happens to Your Benefits?

Here is what happens to your benefits when you are on a leave of absence. (Please note that these terms may not apply to reduced leave schedules under the Family and Medical Leave Act of 1993 (FMLA).)

Your Benefits	What Happens If You Take a Leave of Absence…
Healthcare Coverage	Healthcare coverage will continue while you are on a leave of absence and still employed by Honda. You will be billed directly for any missed premiums.
Healthcare FSA ***Limited Purpose FSA***	Your contributions stop while you are on leave but will start again when you return. Your payroll contributions will be recalculated upon your return based on your annual elected amount and the number of paychecks remaining in the plan year. You may submit claims for eligible healthcare expenses incurred before and during your leave.
Dependent Care FSA	Your contributions stop while you are on leave. During your leave, you may submit claims for expenses incurred prior to your leave. However, you cannot submit claims for dependent care expenses incurred during your leave because only dependent care expenses incurred while you are working are eligible for reimbursement from your Dependent Care FSA. Your payroll contributions will be recalculated upon your return based on your annual elected amount and the number of paychecks remaining in the plan year.
Company-Paid Short-Term Disability ***Honda Disability Allowance*** *(if applicable)*	If your leave of absence qualifies for short-term disability benefits or Honda Disability Allowance as approved by Sedgwick, payments may continue for up to 26 weeks, as described in *Disability Plans* on page 37.

Your Benefits	What Happens If You Take a Leave of Absence…
Company-Paid Long-Term Disability ***Associate-Paid Long-Term Disability***	If your leave of absence qualifies for long-term disability benefits as approved by New York Life, you may receive long-term disability benefits as long as you remain eligible, as described in *Disability Plans* on page 37. For an associate-paid long-term disability benefit, if you are on an approved leave of absence, you will be billed directly and/or have catch-up payroll contributions for any missed premiums and you must make payments to continue coverage.
Basic Life and Accident Insurance	Coverage continues while you are on a leave of absence and still employed by Honda.
Supplemental Life Insurance	If you are on an approved leave of absence, you will be billed directly and/or have catch-up payroll contributions for any missed premiums and you must make payments to continue coverage. If your leave is for your own medical condition, you are eligible to apply for a premium waiver after approximately five months.
Voluntary Accidental Death and Dismemberment Insurance	If you are on an approved leave of absence, you will be billed directly and/or have catch-up payroll contributions for any missed premiums and you must make payments to continue coverage. Once you return to work, your paycheck deductions will begin the first pay period following the return date.
Group Legal Plan	If you are on a leave of absence, coverage continues as long as premium payments are made. For the first six weeks of your leave, any missed premiums due are divided evenly among the remaining pay periods for the rest of the policy period. If you miss premium payments for fewer than six consecutive weeks, your payments will be recalculated. If you miss required premium payments for more than six consecutive weeks, coverage will be cancelled. You will need to contact ARAG directly if you wish to continue coverage.
Group Auto and/or Homeowners Insurance	If you are on a leave of absence, coverage continues as long as premium payments are made. For the first six weeks of your leave, any missed premiums due are divided evenly among the remaining pay periods for the rest of the policy period. After six weeks of missed premiums, you will be billed directly by Mercer Voluntary Benefits. You can resume payroll deductions once you have returned and your policy renews.
Survivor Medical Insurance Program	If you are on an approved leave of absence, you will be billed directly and/or have catch-up payroll contributions for any missed premiums and you must make payments to continue coverage.
401(k) Savings Plan	Contributions end until you return to work unless you are receiving military differential pay from Honda. You may be able to make up any missed contributions/applicable matching contributions after you return from a military leave of absence. Employer contributions will be calculated upon your return from military leave.
Pension Plan *(if applicable)*	You continue to earn service credit while you are on a leave of absence as long as you continue to be employed by Honda.
Associate Assistance Program (AAP)	You may continue to access the services of the AAP.

If You Leave Honda

This section explains what happens if you leave Honda.

If You Plan to Leave Honda…

- Notify your supervisor.
- Schedule an appointment with your Human Resources Department to complete any necessary paperwork.
- Apply for COBRA when you receive notification if you need to continue healthcare coverage (see *COBRA* on page 204 for more information).
- Convert your basic life insurance to a personal policy, if desired.

What Happens to Your Benefits?

Here is what happens to your benefits if you leave Honda:

Your Benefits	What Happens When You Leave Your Job…
Healthcare Coverage	Coverage ends on the last day of the month in which you terminate your employment. You and your dependents may continue coverage by electing COBRA at your cost.
Healthcare FSA ***Limited Purpose FSA***	Contributions end. Claims for healthcare expenses incurred prior to leaving may be submitted by March 31* of the following year. In addition, you may be able to elect COBRA to continue contributions on an after-tax basis through the end of the plan year in which you leave Honda.
Dependent Care FSA	Contributions end. You may continue to submit claims by March 31* of the following year for dependent care expenses incurred during the year in which you leave your job, both before and after you left. You are permitted to do this provided you are working somewhere else or are actively looking for work. Reimbursement is limited to the balance in your account on the day you left.
Company-Paid Short-Term Disability ***Honda Disability Allowance (if applicable)***	Eligibility ends as of the last day of employment. Coverage and benefits end as of the last day of employment even if benefits were approved for a period of time after your last day of employment. Any pending requests for benefits that were not approved as of your last day of employment are not payable.
Company-Paid Long-Term Disability ***Associate-Paid Long-Term Disability***	Eligibility ends as of the last day of employment. If you are receiving long-term disability (LTD) benefits as of your last day of employment, LTD coverage continues. Please note that disability insurance will continue if your active service ends due to a disability for which benefits under the plan are, or may become, payable. If you do not return to active service, this insurance ends when your disability period ends or when benefits are no longer payable, whichever occurs first.
Basic Life and Accident Insurance ***Supplemental Life Insurance*** ***Voluntary Accidental Death and Dismemberment Insurance***	Coverage ends as of the last day of employment. You may convert your life insurance to a personal policy, if desired, within 31 days. Contact MetLife at **1-800-638-6420**.
Survivor Medical Insurance Program	Coverage ends as of the last day of the month in which you terminate your employment.

Your Benefits	What Happens When You Leave Your Job…
Group Legal Plan	Coverage ends unless you convert your coverage to an individual policy by making direct payments to ARAG.
Group Auto and/or Homeowners Insurance	Coverage ends unless you convert your coverage to an individual policy by making direct payments to Mercer Voluntary Benefits.
Pension Plan *(if applicable)*	If you are vested when you leave Honda, benefits will be available after your termination of employment, or you can wait until your normal retirement age (or at early retirement age, if you qualify).
401(k) Savings Plan	You are eligible to receive your entire vested account balance when you leave Honda. Your account balance will be available for distribution within approximately 10 business days after your employment ends. Contact Fidelity at **1-800-835-5095** or **401k.com**.

*Under the Consolidated Appropriations Act, 2021, Honda elected to allow funds in excess of $50 to be carried over. This carryover option will end December 31, 2022, and remaining funds not claimed by March 31, 2023 will be forfeited.

Retirement

This section explains what happens if you retire from Honda.

If You Are Thinking About Retiring…

- Watch the "Road to Retirement Guided Experience" video at **myhondaconnect.com** for the overview of the Honda retirement benefits and retirement processes.
- Contact the My Benefits Connect Center at **1-866-778-5885** or log in to **myhondaconnect.com** for an estimate of your pension benefits and information about other retirement benefits and eligibility (if applicable).
- Once you have decided on a retirement date, and if you are eligible for pension benefits, contact the My Benefits Connect Center or go online to **myhondaconnect.com** to request a pension distribution kit. (This kit is valid for up to six months prior to the date you want to begin receiving benefits.)
- Notify your supervisor at least one month before you plan to retire.
- Contact the Social Security Administration to get an estimate of your benefits and information about Medicare, if applicable.

Who Is a Retiree?

You are considered a retiree if you work at Honda until age 55 with 10 or more years of service or age 65 with five or more years of service.

Requesting a Pension Estimate

You can request a Honda pension estimate online at any time by following these steps:

- Log in to **myhondaconnect.com** and select the **Pension** tile from the home page. You can use the available automated pension tools to help you estimate your benefit.
  - If it is your first time signing in, select **New User** on the login page and follow the prompts.
  - If you can't remember your User ID, password or phone PIN, click **Forgot User ID or Password** and follow the prompts to reset them. After answering your security questions, a one-time code will be sent to your mobile device or a temporary password will be sent by postal mail. Once you have confirmed your one-time code or received a temporary password in the mail, you can easily create a new password or phone PIN.
- When you are ready to retire, you can request your actual pension package online, which will include your pension estimate, or you can speak to a retirement specialist who is trained on Honda's retirement benefits. The specialist can help you request an actual pension package and

walk you through the retirement process. Retirement specialists are available at the My Benefits Connect Center at **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET.

- If you have questions regarding your Pension Plan information, including your estimate or actual package, contact the My Benefits Connect Center at **1-866-778-5885**. There may be special circumstances, such as a qualified domestic relations order, that will prohibit you from running your estimate online. A manual calculation will need to be completed. Please contact the My Benefits Connect Center to request a pension estimate.

What Happens to Your Benefits?

Here is what happens to your benefits when you retire:

Your Benefits	What Happens When You Retire…
Healthcare Coverage	Participation in Honda's active medical plan ends on the last day of the month in which you retire. You and your eligible dependents can participate in the Honda Retirement Medical Program. You share the cost of this coverage with Honda. Dental and vision coverage ends unless you elect coverage through COBRA. See *Retirement Medical Program* on page 306 for more information.
Healthcare FSA ***Limited Purpose FSA***	Contributions end. Claims for healthcare expenses may be submitted by March 31* of the following year for care received before your retirement. In addition, you may be able to elect COBRA to continue contributions on an after-tax basis through the end of the plan year in which you leave Honda.
Dependent Care FSA	Contributions end. You may continue to submit claims by March 31* of the following year for dependent care expenses incurred during the year in which you retire, both before and after your retirement. You are permitted to do this provided you are working somewhere else or are actively looking for work. Reimbursement is limited to the balance in your account at retirement.
Company-Paid Short-Term Disability ***Honda Disability Allowance*** *(if applicable)*	Eligibility ends as of the last day of employment. Coverage and benefits end as of the last day of employment even if benefits were approved for a period of time after your last day of employment. Any pending requests for benefits that were not approved as of your last day of employment are not payable.
Company-Paid Long-Term Disability ***Associate-Paid Long-Term Disability***	Eligibility ends as of the last day of employment. If you are receiving long-term disability (LTD) benefits as of your last day of employment, LTD coverage continues. Please note that disability insurance will continue if your active service ends due to a disability for which benefits under the plan are, or may become, payable. If you do not return to active service, this insurance ends when your disability period ends or when benefits are no longer payable, whichever occurs first.
Basic Life and Accident Insurance	Coverage ends on the last day of employment. You may continue coverage by converting your Honda policy to a personal policy within 31 days.
Supplemental Life Insurance	You may continue coverage for you and your eligible dependents by paying premiums directly to MetLife. Continuation rates will be determined by MetLife. You may also elect within 31 days to convert coverage to an individual policy.
Voluntary Accidental Death and Dismemberment Insurance	Coverage ends on the last day of employment.
Survivor Medical Insurance Program	Eligibility for Survivor Medical Insurance ends when you become retirement eligible.
Group Legal Plan	Coverage ends on the last day of employment unless you convert your coverage to an individual policy by making direct payments to ARAG through electronic fund transfer or credit card.

Your Benefits	What Happens When You Retire…
Group Auto and/or Homeowners Insurance	Coverage ends on the last day of employment unless you convert your coverage to an individual policy by making direct payments to Mercer Voluntary Benefits.
401(k) Savings Plan	You are eligible to receive your entire vested account balance when you leave Honda. Your account balance will be available for distribution within approximately 10 business days after your employment ends. Contact Fidelity at **1-800-835-5095** or **401k.com**.
Pension Plan *(if applicable)*	If you are vested, benefits will be available after your termination of employment, or you can wait until your normal retirement age (or at early retirement age, if you qualify). Several payment options are available. **Note:** Please refer to *Retirement Benefits* on page 258 for more information.

*Under the Consolidated Appropriations Act, 2021, Honda elected to allow funds in excess of $50 to be carried over. This carryover option will end December 31, 2022, and remaining funds not claimed by March 31, 2023 will be forfeited.

Death

This section explains what to do in case of your death or the death of your spouse or child.

In the Event of Your Death, Your Beneficiary Should…

- Notify the My Benefits Connect Center at **1-866-778-5885** (voice prompt: Survivor Support) of your death. Your family members may also want to notify your local Human Resources Department and supervisor.
- Contact Sedgwick at **1-866-409-2576** (AHM and subsidiaries) or **1-888-538-2732** (HDMA) if you were on a leave of absence or receiving short-term disability.
- Contact ComPsych for the Associate Assistance Program at **1-866-778-5885** (voice prompt: Associate Assistance Program) or **1-800-232-6357** (the direct phone number) for help and support.
- Consider electing COBRA coverage after the 12 months of coverage paid by Honda ends and, if applicable, if coverage through the Survivor Medical Insurance Program was not elected.

In the Event of a Spouse's or Child's Death, You Should…

- Contact the My Benefits Connect Center by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET to:
  - Remove your dependent from covered plans;
  - Update beneficiary records; and
  - Update if spouse or child Supplemental Life Insurance was elected.
- Consider adjustments to your Healthcare and/or Dependent Care FSAs.
- Contact ComPsych for the Associate Assistance Program at **1-866-778-5885** (voice prompt: Associate Assistance Program) or **1-800-232-6357** (the direct phone number) for help and support.

What Happens to Your Benefits?

Here is what happens to your benefits in the event of your death:

Your Benefits	What Happens If You Die…
Healthcare Coverage	Coverage for your covered dependents will continue for up to 12 months after the end of the month of your death. After this date, your dependents may continue coverage through COBRA for up to an additional 36 months. Dependents must continue to meet eligibility requirements.
Healthcare FSA ***Limited Purpose FSA***	Claims may be submitted for healthcare expenses incurred up to your death. To avoid forfeiting prior contributions, dependents may continue contributions on an after-tax basis under COBRA by contacting the My Benefits Connect Center (**1-866-778-5885**).
Dependent Care FSA	Participation ends. Dependents may submit claims for day care expenses incurred up to the balance in your account when you died.
Company-Paid Short-Term Disability ***Honda Disability Allowance*** *(if applicable)*	Coverage ends. Pending requests for benefits that were not approved are not payable.
Company-Paid Long-Term Disability ***Associate-Paid Long-Term Disability***	Coverage ends. If you were receiving long-term disability (LTD) benefits at the time of death, your beneficiary may be eligible to receive a lump sum payment equal to three additional months of net LTD benefits.
Basic Life and Accident Insurance	Your beneficiary(ies) will receive 100% of your basic life benefit. If you die as a result of an accident, your beneficiary(ies) may also receive an additional amount equal to 100% of your basic life benefit, if applicable. **Exception:** The amount will be reduced if you received the accelerated death benefit prior to your death.
Supplemental Life Insurance	If participating, and your premiums were up to date through payroll deductions or direct bill payments, your beneficiary(ies) will receive 100% of your elected coverage. **Exception:** The amount will be reduced if you received the accelerated death benefit prior to your death. **Note:** There is a suicide exclusion on Supplemental Life Insurance.
Voluntary Accidental Death and Dismemberment Insurance	If participating and you die as the result of an accident and your premiums were up to date through payroll deductions or direct bill payments, your beneficiary(ies) will receive 100% of your elected coverage.
Survivor Medical Insurance Program	Coverage ends with your final paycheck. If you elected this coverage, your eligible dependents will receive medical/prescription drug coverage after the 12 months of Honda-provided coverage ends. Dependents must continue to meet eligibility requirements.
Group Legal Plan	A family member will need to contact ARAG and request the premium be waived for 12 months from the date of death. Coverage would then continue for your eligible dependents for the next 12 months at no cost. After that time, ARAG will send your family member(s) a conversion package. If your dependents want to continue coverage by converting to an individual policy, they will make direct payments to ARAG.
Group Auto and/or Homeowners Insurance	Coverage continues if your eligible dependents were on the policy prior to your death, as long as they make direct payments to the carrier.

Your Benefits	What Happens If You Die…
Group Auto and/or Homeowners Insurance	Coverage continues if your eligible dependents were on the policy prior to your death, as long as they make direct payments to the carrier.
401(k) Savings Plan	The entire vested value of your account is payable to your beneficiary in accordance with the terms of the plan. Your beneficiary may receive benefits in a lump sum payment.
Pension Plan *(if applicable)*	If you are vested in the plan and die before beginning benefit payments, your spouse (if married) or beneficiary will receive a death benefit. The death benefit amount will be based on your earned benefit at the time of your death. It may be payable to your surviving spouse or beneficiary in lifetime payments or in a lump sum payment. If payable in lifetime monthly payments, it will become payable when you would have been eligible for early retirement. If it is payable in a lump sum payment, it will be paid approximately one month after your death. If you are already receiving benefits at the time of death, payments may continue based on the form of payment you elected at retirement. **Note:** Please refer to *Retirement Benefits* on page 258 for more information.

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How the Benefits Program Works

Honda's Health & Welfare Benefits Plan provides a complete and competitive benefits package to eligible associates. It offers a number of benefit options to ensure that your benefits fit your personal situation. Under the program, some benefits are provided automatically to you; with others, you have a choice of plans.

For More Information

Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

The Benefits Program

The program is organized into three components:

- Income Protection
- Health Benefits
- Voluntary/Supplemental Benefits

Income Protection

Honda automatically provides these benefits:

- Basic Life Insurance
- Accident Insurance
- Business Travel Insurance
- Company-Paid Short-Term Disability Insurance
- Company-Paid Long-Term Disability Insurance
- Honda Disability Allowance
- Associate Assistance Program

Health Benefits

- Medical Plan (includes prescription drug benefits)
- Dental Plan
- Vision Plan

Voluntary/Supplemental Benefits

You choose which benefits you want and pay for them on a pre-tax or after-tax basis, depending on the benefit:

Pre-Tax

- Healthcare Flexible Spending Account
- Limited Purpose Flexible Spending Account
- Dependent Care Flexible Spending Account
- Associate-Paid Long-Term Disability Insurance

After-Tax

- Supplemental Life Insurance
- Voluntary Accidental Death & Dismemberment Insurance
- Group Auto and/or Homeowners Insurance
- Group Legal Plan
- Survivor Medical Insurance Program

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Eligibility

The eligibility requirements for you and/or your dependents may vary by benefit. See each specific benefits section for the eligibility information that applies to each benefit.

Enrolling in the Benefits Program

If you are an eligible associate, you automatically receive Income Protection. You do not have to enroll to participate in these plans, although you should designate beneficiaries for your life and accident insurance coverages.

You must enroll in Health Benefits and Voluntary/Supplemental Benefits if you want those coverages.

Note: If you choose to waive healthcare coverage for you or your eligible dependents, the Company assumes you are enrolled in coverage outside of the Honda Plan.

New Hire

New hires must actively enroll within 31 days of your hire date. If you want to enroll your family or enroll in certain Voluntary/ Supplemental Benefits, you must do so within 31 days of your hire date.

You are encouraged to enroll as soon as possible. For medical and prescription drug coverage during the current plan year (the year in which you are hired), you will be eligible for the medical plan incentive.

Medical and Rx Coverage

*You should contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET, to enroll in medical and prescription coverage for you and your family.*

You will be required to provide documentation to verify that dependents being added to coverage are eligible to participate in the Honda healthcare plan. Required documentation and your completed verification form should be submitted to the My Benefits Connect Center within 45 days of your benefit elections. (See “If You Do Not Enroll” on page 25 for information about default coverage.) If verification is not completed within 45 days, the dependent will not be enrolled.

If you are a newly hired associate, you can enroll in benefits through the Honda Health & Welfare Benefits Plan (or waive coverage) by:

- Logging in to **myhondaconnect.com**; or
- Calling the My Benefits Connect Center at **1-866-778-5885** (Monday through Friday, from 8:30 a.m. to 10 p.m. ET).

If made during your initial 31-day election period, your benefit elections will be effective retroactive to your eligibility date for those plan benefits.

If you acquire new dependents through marriage, birth, adoption or placement for adoption, you must enroll them within 31 days of the marriage or 60 days of the birth, adoption or placement for adoption in order to receive coverage for that year based on the effective date of the life event.

Newly Eligible

You must enroll in or waive medical, dental and vision coverage and certain Voluntary/Supplemental Benefits within 31 days of becoming eligible due to a qualified life event (see *Life* on page 8). You are encouraged to enroll as soon as possible.

Newly Eligible Spouse Due to Marriage

A newly eligible spouse (due to marriage) can be enrolled in your healthcare plan for the *current* plan year based on your eligibility for the medical plan incentive. Your spouse's eligibility for the medical plan incentive in the following year depends on his or her effective date of coverage and whether you and your spouse meet program requirements. See *Connect to Your Wellbeing* on page 83.

If you are a newly eligible associate or have newly eligible dependents, you can enroll in the Health & Welfare Benefits Plan benefits (or waive coverage) by:

- Logging in to **myhondaconnect.com**; or
- Calling the My Benefits Connect Center at **1-866-778-5885** (Monday through Friday, from 8:30 a.m. to 10 p.m. ET).

If You Do Not Enroll

If you are newly hired and do not enroll within 31 days of your date of hire, it will be assumed you have waived coverage. You will not be able to enroll yourself or your dependents until the next Benefits Enrollment period unless you have a qualified life event or status change during the year.

Benefits Enrollment

During a specific time each year (generally in the fall), you have the opportunity to select and make changes to Health Benefits and Voluntary/Supplemental Benefits for the upcoming year. This is known as Benefits Enrollment. You will receive detailed information on the enrollment process, key dates and what you need to do prior to the enrollment period. To see an overview of Benefits Enrollment process, watch the "Benefits Enrollment Guided Experience" video at **myhondaconnect.com**.

Benefits Enrollment Required

Each year, you must update your spousal contribution waiver and choose a contribution amount for the Health Savings Account and any of the Flexible Spending Accounts, if applicable.

During the Benefits Enrollment period, you can:

- Select the healthcare coverage you want (or choose no coverage for medical/prescription drug, dental and/or vision);
- Make other changes to your benefits and levels of coverage; and
- Add or remove dependents.

If you do not want to make any changes to your benefits for the upcoming year, you do not need to do any of the actions above. You will receive the same benefits and coverage levels, with the exception of the Spousal Contribution Waiver, your contribution election to Health Savings Account, Healthcare Flexible Spending Account, Limited Purpose Flexible Spending Account and Dependent Care Flexible Spending Account.

Note: You will need to provide supporting documentation for dependents added to the Honda healthcare plan as a new hire, during Benefits Enrollment or as a result of a qualified life event change (e.g., birth of a child, adoption or marriage). You must submit documentation to the My Benefits Connect Center within 45 days of your benefit elections to verify your dependent is eligible to participate. Required documents include, but are not limited to, marriage certificates, birth certificates, adoption decrees or guardianship paperwork. Depending on the situation, Honda may also require other forms of documentation to confirm eligibility (e.g., 1040 tax forms). It is important to remember that your documents *must* be received within 45 days of making the enrollment for your new dependent and, on an ongoing basis, whenever you are asked to verify a dependent's eligibility (e.g., by documenting current marital status). If the required documents are not received within 45 days, the dependent will not be covered, and COBRA will not be offered for the dependent.

It is your responsibility to provide accurate and up-to-date dependent information. Providing false information about your dependents could result in loss of the elected benefit(s) and/or in corrective action, up to and including termination.

What You Need to Do

The following table shows what you need to do within 31 days of your date of hire (or becoming newly eligible) and during each Benefits Enrollment period. It also shows the benefit choices you can make at any time:

Benefit	What You Need to Do	How You Enroll
Within 31 days of becoming eligible…		
Income Protection • Basic Life Insurance • Accident Insurance • Business Travel Insurance • Company-Paid Short-Term Disability • Company-Paid Long-Term Disability • Associate Assistance Program	• No enrollment is required —these benefits are automatically provided to you by Honda. • Remember to designate beneficiaries for your life and accident insurance (see "Naming a Beneficiary" on page 57 under *Life and Accident Insurance*).	N/A

Benefit	What You Need to Do	How You Enroll
Health Benefits		
• Medical (HSA or PPO Plan, includes prescription drug coverage) • Dental • Vision • Spousal Contribution Waiver	• Choose the medical, dental and vision option you want —or choose no coverage for medical, dental and/or vision. • Choose the level of coverage you want (e.g., associate only, family, etc.). • Make an HSA election, if applicable. • If you do not enroll and/or complete necessary steps within 31 days, you will be assumed to have waived coverage (see "If You Do Not Enroll" on page 25 for more information). • You may waive the spousal contribution if you have a qualifying reason.	• Visit **myhondaconnect.com**. • Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).
Voluntary/Supplemental Benefits		
• Associate-Paid Long-Term Disability • Supplemental Life Insurance	• You must actively enroll to receive associate-paid long-term disability and/or Supplemental Life Insurance.	• Visit **myhondaconnect.com**. • Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).
• Flexible Spending Accounts • Survivor Medical Insurance Program	• Enroll in the Healthcare Flexible Spending Account or Limited Purpose Flexible Spending Account and/or Dependent Care Flexible Spending Account if you want to participate in those benefits (elections for the Flexible Spending Accounts do not roll over from year to year). • You may also enroll in the Survivor Medical Insurance Program as a new hire (or when newly eligible). This election will continue from year to year (as long as you are eligible) unless you choose to stop participation during Benefits Enrollment or because of becoming retirement eligible or a qualified life event.	• Visit **myhondaconnect.com**. • Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).
• Group Legal Plan • Group Auto and/or Homeowners Insurance	• Enroll in the Group Legal Plan if you want to participate in this benefit. • Enroll in group auto and/or homeowners insurance if you want to participate in these benefits.	• Visit **myhondaconnect.com**. • Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).

Benefit	What You Need to Do	How You Enroll
Annually, during benefits enrollment…		
Health Benefits		
• Medical (HSA or PPO Plan, includes prescription drug coverage) • Dental • Vision • Spousal Contribution Waiver	• Choose the level of coverage you want (e.g., associate only, family, etc.) or choose no coverage for medical/ prescription drug, dental and/or vision. • Make an HSA election, if applicable. • Your medical plan premium amount depends on whether you (and your covered spouse) completed the wellbeing program the previous year. • You must actively waive the spousal contribution, provided you have a qualifying reason.	• Visit **myhondaconnect.com.** • Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).
Voluntary/Supplemental Benefits		
• Associate-Paid Long-Term Disability • Supplemental Life Insurance	• You must actively enroll to receive associate-paid long-term disability and/or Supplemental Life Insurance.	• Visit **myhondaconnect.com**. • Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).
• Flexible Spending Accounts • Survivor Medical Insurance Program	• You *must* enroll each year if you want to participate in the Healthcare Flexible Spending Account or Limited Purpose Flexible Spending Account and/or the Dependent Care Flexible Spending Account during the following year. • If you did not enroll in the Survivor Medical Insurance Program when newly eligible, you may do so due to a change in status or during Benefits Enrollment. You also may choose to stop participation during Benefits Enrollment. • **Note:** You may also want to update your life and accident insurance beneficiary information during Benefits Enrollment periods.	• Visit **myhondaconnect.com**. • Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).
• Group Legal Plan	• Decide if you want to enroll or remain enrolled in the Group Legal Plan.	• Visit **myhondaconnect.com**. • Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).

Benefit	What You Need to Do	How You Enroll
At any time…		
Health Benefits		
• HSA Associate Contribution	• You can elect or change your election at any time.	• Visit **myhondaconnect.com**. • Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).
• Spousal Contribution	• You can change your spousal contribution at any time due to a change in your spouse's access to coverage. Refunds will not be given for changes made after the 31-day period.	• Visit **myhondaconnect.com**. • Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).
Voluntary/Supplemental Benefits		
• Supplemental Life Insurance	• You can enroll in Supplemental Life Insurance at any time. • **Note:** If you enroll in Supplemental Life Insurance when newly eligible, you have an opportunity to enroll for up to 2x annual base earnings or a maximum of $450,000, with no evidence of insurability (EOI) review and approval, provided you enroll within the 31 days of your date of hire. These are non-medical limits. EOI review and approval will apply in certain circumstances, for coverage amounts in excess of these limits. For a life event change or annually during Benefits Enrollment, you may elect up to an additional 1x annual base earnings (maximum of 6x base or $2,000,000 coverage).	• Visit **myhondaconnect.com**. • Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).
• Dependent Care FSA • Voluntary Accidental Death and Dismemberment Insurance	• You can make prospective changes to your Dependent Care FSA any time your dependent care needs change. • You can enroll in voluntary accidental death and dismemberment insurance at any time.	• Visit **myhondaconnect.com**. • Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).
• Group Auto and/or Homeowners Insurance	• You can enroll in group auto and/or homeowners insurance at any time.	• Contact Mercer Voluntary Plans directly. See *Contacts* on page 354 for details.

Adding or Changing Dependents

Your children, up to age 26, are eligible for medical (including prescription drug), dental, vision and dependent life insurance coverage under Honda's benefits plan. **Note:** You must be enrolled in Supplemental Life Insurance yourself for your children to enroll.

As a Honda associate, it is your responsibility to provide accurate and up-to-date dependent information. If you wish to enroll a dependent child in healthcare coverage, you *must* verify and confirm that the dependent is eligible to participate.

See *Participating in Health Benefits* on page 68 for more information about eligible dependent children.

What You Need to Do

- If you are changing your coverage level, you must do so during Benefits Enrollment unless you experience a change in status during the year.
- If your child is no longer an eligible dependent, you *must* contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885** (Monday through Friday, from 8:30 a.m. to 10 p.m. ET) within 31 days to remove him or her from coverage.
- An eligible dependent cannot be covered under a specific benefit by more than one Honda associate.

Note that it is your responsibility to provide accurate and up-to-date dependent information. Providing false information about your dependents could result in loss of the elected benefit(s) and/or corrective action, up to and including termination.

How to Make Changes

- Visit **myhondaconnect.com**.
- Call the My Benefits Connect Center at **1-866-778-5885** (Monday – Friday, 8:30 a.m. – 10 p.m. ET).

Health Benefits Coverage Levels

You have four levels of coverage to choose from for your medical/prescription drug, dental and vision coverage:

- Associate Only
- Associate + Spouse
- Associate + Child(ren)
- Family

You may choose different coverage levels for each Health Benefit, depending on your needs. You can also elect no coverage.

If You Are Married to a Honda Associate

If you are married to a Honda associate (including affiliates of Honda), you have several options for benefits coverage. Please note that only one associate can cover eligible dependents in each type of benefit. Both associates, however, can choose different benefit options.

If this situation applies to you, these are your options:

If You and Your Spouse Are Honda Associates

Option 1

- One associate can select Associate Only coverage.
- The other associate can select Associate Only coverage or Associate + Child(ren) if you have eligible children.

Option 2

- One associate can select Family coverage or Associate + Spouse coverage if you do not have eligible children.
- The other associate can waive coverage.

Duplicate Dependent Coverage

You cannot be enrolled as an associate and also covered as a dependent by your Honda associate spouse or parent. Only one associate (of Honda or a Honda affiliate) can cover eligible dependents in each type of benefit. Dependents of associates cannot be covered more than once. If it is later determined that you have dependents covered more than once, the associate with the earlier birthday in the calendar year will cover the eligible dependents.

Pre-Tax and After-Tax Benefits

Certain benefits can be paid for on a pre-tax basis, which provides you with tax savings. Internal Revenue Service (IRS) guidelines determine which benefits Honda can provide on a pre-tax basis.

Pre-Tax Benefits	After-Tax Benefits
• Medical/Prescription Drug • Dental • Vision • Flexible Spending Accounts (Healthcare, Limited Purpose and Dependent Care) • Health Savings Account • Associate-Paid Long-Term Disability Insurance	• Supplemental Life Insurance • Voluntary Accidental Death and Dismemberment Insurance • Survivor Medical Insurance Program • Group Legal Plan • Group Auto and/or Homeowners Insurance

Changing Your Coverage During the Year

IRS rules state that once you have enrolled in the Health Benefits and the Flexible Spending Account programs you are not allowed to make changes in your elections during the calendar year **unless you have a qualified life event change**. This restriction does not apply to changes to HSA elections.

A qualified life event change can include:

- Marriage
- Divorce, legal separation or annulment
- Birth, adoption or placement for adoption of a child
- Death of your spouse or eligible dependent child
- Change in work schedule including an unpaid leave of absence
- Change in qualifying status of a dependent such as your dependent reaching age 26
- Issuance of a court order or administrative decree requiring coverage of a dependent child
- Change of coverage (such as your spouse starts/loses a job and begins/ends healthcare coverage as a result)
- Change in your residence or worksite (out of the country)
- Significant increase or decrease in or end of other coverage during the coverage period
- Spouse or dependent has different annual enrollment than Honda's

Qualified Life Event Changes

If you do not add a dependent, enroll or waive a plan within 31 days (60 days for birth, adoption or placement for adoption) after the qualifying status change, you will not be able to change your coverage until the next Benefits Enrollment period.

You must submit documentation to the My Benefits Connect Center within 45 days of the benefits election to verify and confirm that your dependent is eligible to participate in the Honda healthcare plan.

Any mid-year change in your coverage must be consistent with the change in status that affects eligibility for coverage. For example, if you have a baby, adding a dependent to your coverage would be consistent as your baby would be newly eligible, but dropping coverage for your spouse would not be.

Note: You will need to provide supporting documentation for adding dependents to the Honda healthcare plan as a result of a qualified life event change (e.g., birth of a child, adoption or marriage). You must submit documentation to the My Benefits Connect Center within 45 days of your benefits election to verify your dependent is eligible to participate. Required documents include, but are not limited to, marriage certificates, birth certificates, adoption decrees or guardianship paperwork. Depending on the situation, Honda may also require other forms of documentation to confirm eligibility (e.g., 1040 tax forms). **If the required documents are not received within 45 days, the dependent will not be covered, and COBRA will not be offered for the dependent.**

If you have a qualified life event change and want to make an allowed change to your benefits, contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885** (Monday through Friday, from 8:30 a.m. to 10 p.m. ET) within 31 days following the event (60 days for birth, adoption or placement for adoption) (see *Life Events* on page 8). **If you do not request a change within the 31-day period (60-day period for birth, adoption or placement for adoption), you will not be able to change your coverage until the next Benefits Enrollment period.**

For more information on changing your coverage because of a life event, see *Life Events* on page 8.

Important Note!

You are responsible for providing accurate and up-to-date dependent information. Providing false information about your dependents could result in loss of the elected benefit(s) and/or in corrective action, up to and including termination.

Special Notice of Enrollment Rights under the Health Insurance Portability and Accountability Act (HIPAA)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if:

- You or your dependents lose eligibility for other coverage;
- The employer stops contributing towards your or your dependents' other coverage;
- COBRA continuation coverage is exhausted;
- You or your eligible dependent becomes eligible for a premium assistance subsidy under Medicaid or a state's Children's Health Insurance Program (CHIP); or
- You or your eligible dependent loses Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility.

Premium Assistance Subsidy

You have a special enrollment period if you or your eligible dependent becomes eligible for a premium assistance subsidy under Medicaid or a state's Children's Health Insurance Program (CHIP) and you notify the My Benefits Connect Center within 60 days of that event.

However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). You also must contact the My Benefits Connect Center and request enrollment within 60 days of an event that involves gaining or losing Medicaid or CHIP coverage or eligibility for state premium assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 31 days after the marriage (60 days after the birth, adoption or placement for adoption).

To request special enrollment or obtain more information, contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885** (Monday through Friday, from 8:30 a.m. to 10 p.m. ET).

Dependent Eligibility Documentation Requirements

You will have to provide supporting documentation for adding dependents to the Honda healthcare plan as a result of a special life event (e.g., birth of a child, adoption or marriage), qualified life event change or during Benefits Enrollment. You must submit documentation to the My Benefits Connect Center within 45 days of your benefits election to verify your dependent is eligible to participate. Required documents include, but are not limited to, marriage certificates, birth certificates, adoption decrees or guardianship paperwork. Depending on the situation, Honda may also require other forms of documentation to confirm eligibility (e.g., 1040 tax forms). **Your documentation must be received**

within 45 days of your dependent's enrollment. If requested documentation is not received by that date, the dependent will not be covered, and COBRA will not be offered.

Note: It is your responsibility to provide accurate and up-to-date dependent information. Providing false information about your dependents could result in loss of the elected benefit(s) and/or in corrective action, up to and including termination.

INCOME PROTECTION

Contents

Income Protection is designed to provide you and your family with financial protection in the event that you become ill, you are injured or in the event of your death. Most of these benefits are automatically provided by Honda at no cost to you.

Receiving Income Protection

Honda pays the entire cost of these benefits. You do not need to enroll to receive the financial protection these benefits provide.

Income Protection

Honda offers these benefits to help ensure financial security for you and your family:

- Disability plans, which include:
  - Company-paid short-term disability
  - Company-paid long-term disability
- Life and accident insurance, which includes:
  - Basic life insurance
  - Accident insurance
  - Business travel insurance

Benefits for Honda

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Disability Plans

Honda offers both Company-paid short-term and long-term disability benefits that provide you with continuing income if you become disabled from a non-occupational illness or injury—or in some circumstances an occupational illness or injury.

For More Information

Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

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Company-Paid Short-Term Disability

The Company-paid short-term disability (STD) plan for associates continues part of your income when you cannot work due to illness or injury.

Highlights	
Cost	Paid for by Honda
Who Is Covered	Associates regularly working at least 16 hours per week
Coverage Begins	First day of the month following date of hire, provided the associate is actively at work that day
Benefits	Provides a benefit of up to 60% of base pay per paycheck when you cannot work due to an illness or injury
Plan Features	Benefits continue while disabled for up to 26 weeks
Coverage Ends	When your Honda employment or plan eligibility ends
Benefits End	On day of separation from the Company
Administered By	Sedgwick

Who Is Eligible

Associates who routinely work at least 16 hours per week are eligible to participate in the plan on the first (1st) day of the month following date of hire.

You are not eligible for the STD plan if you:

- Are an active associate who has a regular work schedule of less than 16 hours per week;
- Are a self-employed person who provides services to Honda through an agreement between Honda and you;
- Are employed by or obtain your employment through a company that provides temporary workers to Honda;
- Are a student, co-op, intern or temporary associate;
- Are an associate of an international affiliate on temporary assignment at Honda; or
- Are working in Rhode Island, Hawaii or Puerto Rico, since you automatically participate in the STD plan required by your state or territory.

Short-Term Disability Regulations in Some States

Some states offer their residents statutory disability plans. If you reside in one of these states, you may refer to your state statutory plan at **myhondaconnect.com**. Since Honda provides a Company-paid STD to all eligible associates, the most beneficial plan will apply. Contact Sedgwick for questions.

When Coverage Begins

Short-term disability coverage begins on the first day of the month after you meet the eligibility criteria described in “Who Is Eligible” on page 38 provided you are actively at work on that day.

If you are a new associate, you are automatically enrolled on your date of hire. Your participation will begin on the first day of the month after your hire date.

For example: If your hire date is August 2, you will be eligible for STD benefits on September 1 of the same calendar year, provided you are actively working immediately prior to the first day of absence and meet the other eligibility criteria noted above.

How the STD Plan Works

To qualify for STD benefits, you must:

- Be under the regular care of a qualified physician or licensed health care professional appropriate for treating your condition;
- Be actively seeking medical treatment (regular and continuous care); and
- Submit objective medical evidence and proof satisfactory to the claims administrator that you are unable to work at any available job at Honda for which you are qualified.

Qualified Physicians

A qualified physician is a legally licensed physician, surgeon or other practitioner in the field of medicine. This physician cannot be a member of your (or your spouse's) family.

Benefits

STD benefits are paid to you at the rate of 60% of base pay. STD benefits are a taxable benefit when they are paid.

If you have returned to work on a gradual return to work schedule, you may be eligible for pro-rated STD benefits while earning less than 60% of your base pay.

The date benefits begin depends on the type of disability. For disability due to:

- **Bodily injuries.** If you are not absent from work on the day of injury, benefits begin on your first day of absence from work once treated by a physician.

  If you are absent from work due to a bodily injury but do not receive treatment, you will be subject to a waiting period of up to seven calendar days. In this case, benefits begin on the date of treatment or with the end of your waiting period, whichever comes first.

- **Hospitalization or surgery.** Benefits generally begin on the day of hospitalization or surgery. Hospitalization means you are a registered bed patient in a hospital for a 24-hour period, or any part thereof, for which you are charged a full day's rate for room and board.

  If you are not absent from work on the day you are hospitalized or have surgery, benefits begin on your first day of absence from work once you are hospitalized or have surgery.

  If you are absent due to illness/sickness/pregnancy prior to hospitalization or surgery, you will be subject to a waiting period of up to seven calendar days. In this case, benefits begin on the date of hospitalization/surgery or with the end of your waiting period, whichever comes first.

- **Sickness, disease or pregnancy.** Benefits begin on the eighth consecutive calendar day beginning on your first day of absence. However, such waiting period will be waived for any disability that exists for more than 14 days.

If you are disabled for a partial day of absence consecutive to the first full day of absence, and you earned less than 60% of your base pay on that partial day, that partial day of absence will be considered the first day of your waiting period.

The plan pays benefits while you are disabled (determined by the claims administrator) for up to 26 weeks for any one continuous period of disability.

Honda Disability Allowance

Exempt associates and associates classified as Non-Exempt Professional Support Staff on a continuous leave of absence for their own disability are eligible for Honda Disability Allowance. The Honda Disability Allowance is paid for by Honda and provides up to 40% of base pay in addition to short-term disability benefits. The benefit will run concurrently with approved short-term disability leave. The maximum benefit period for this allowance is six months. The amount of the benefit is determined by your years of service as follows:

Honda Disability Allowance Benefits

Years of Service	Benefit Amount
• 0 – 90 days	Not eligible for Honda Disability Allowance
• 91 days through 3 years	1 month at 40% 5 months at 15%
• After 3 years through 4 years	2 months at 40% 4 months at 15%
• After 4 years	3 months at 40% 3 months at 15%

Maximum Benefit for Short-Term Disability

In no event, however, will STD benefits continue beyond the occurrence of any of the following:

- The date following 180 days (Maximum benefits vary in California, Massachusetts, New Jersey, and Washington. If you reside in one of these states, refer to your state plan document at **myhondaconnect.com**.);
- The date of your termination of employment or death;
- A determination by the Plan Administrator that a disability no longer exists with respect to the participant;
- You fail to attend a medical examination required by the Plan Administrator on the date scheduled by Sedgwick's third-party vendor (extenuating circumstances will be considered); or
- You refuse to provide information requested in writing by the Plan Administrator for the purpose of determining whether you are entitled to benefits under the plan; failure to provide such information within 21 days following such request will be considered to constitute a refusal.

What Is Not Covered

You must be actively at work and meet the eligibility criteria for STD benefits to be payable. Benefits will not be paid for any disability:

- That has a first day of absence prior to meeting the eligibility criteria;

- That starts while you are not actively employed;
- That is an intentional self-inflicted injury; and
- That is the result of a work-related illness or injury; however:

  If your claim is denied or contested by Workers' Compensation, you may be eligible for STD; however, if your disability is later approved for Workers' Compensation benefits, any payments you received while on short-term disability will be reimbursed to the claims administrator through deductions from your Workers' Compensation payments.

Circumstances in Which You Will Not Receive Benefits

- If you are incarcerated in any federal, state or municipal institution;
- If you committed a crime and are disabled due to an illness or injury from that crime;
- Illness or injury that is not certified and supported by objective medical evidence;
- If you make false statements or representations or withhold material facts in order to obtain benefits;
- Any period of disability for which benefits are paid under the Unemployment Compensation Act;
- Disabilities resulting from surgery and procedures to mainly improve, alter or enhance appearance (excluding gender change and any weight loss surgery) except where the surgery addresses impairment due to birth effect, accidental injury, disease or surgical treatment of disease or injury;
- Disabilities resulting from surgical procedures for reversal of sterilization; and
- Disabilities resulting from surgery to correct refractive errors (Lasik).

Offsets and Reimbursements

When you file for STD benefits, you are required to complete a reimbursement agreement. Failure to sign and return the agreement to the claims administrator will result in a delay or denial of benefit payments.

Your STD benefit will be reduced by benefits you are entitled to receive from other sources. For example, if you are entitled to state disability, Workers' Compensation, no-fault insurance or Social Security, your STD benefits will be reduced by the payments received.

Example:

- If you are entitled to state disability, no-fault insurance or Social Security, STD benefits will be reduced by the payments received. If any of these payments are received after you have been paid STD, you are required to repay the full amount of the payments.
- If your disability is due to an auto accident and you reside in a no-fault insurance state, the STD program will pay the difference between what you receive under the no-fault insurance and Honda's STD benefits, bringing the total benefit level to the applicable Honda STD benefit amount.

In addition, your STD benefits may be reduced by overpayments that occur as a result of change in claim status or administrative error. You are required to notify the claims administrator of any change in status as well as any award or denial of any other benefits as soon as you receive notice.

If any other payments are received, your claim status changes or an administrative error is discovered that results in an overpayment or discovery of an overpayment after you have been paid STD, you are required to repay the full overpayment. If you fail to reimburse the plan for the overpayment, Honda may make deductions from your paychecks or bonuses, subject to any applicable law, until the plan has been fully reimbursed for any overpayments.

If you have any questions regarding reimbursement or other disability payments that might affect your STD payments, please refer to your reimbursement agreement or contact the claims administrator by calling **1-866-409-2576** (AHM and subsidiaries) or **1-888-538-2732** (HDMA).

Effective Return to Work

An effective return to work after receiving short-term benefits for a disability claim is 60 calendar days. If you become disabled again within the 60-calendar-day period after you return to work on a full-time basis due to the same or related condition, benefits will resume under the prior claim and at the same level you were previously receiving, and no waiting period will apply. However, if after you return to work full time for longer than 60 calendar days you become disabled again, you can file a new claim for benefits. The new claim would be subject to another waiting period.

State disability benefit laws in California, New Jersey and New York require a different period at work to establish an effective return to work for state system benefits. Those differing effective-return-to-work provisions don't alter the requirement that you be back to work for 60 calendar days or longer to establish a new claim under the Honda plan.

Claims

Please request a leave of absence through the claims administrator.

Refer to your *Associate Handbook* for the Leave of Absence Policy and any communication updates.

It is your responsibility to:

- Provide medical documentation within the required timeframe;
- Provide any payment required by your treatment provider in order to furnish medical documentation associated with your claim;
- Provide the claims administrator and your treatment provider with a completed Authorization to Release Information form to allow the claims administrator to contact your treatment provider in order to request or clarify information on your behalf; and
- Notify the claims administrator of any changes in your medical condition or if you change treatment providers for your disability claim.

Requesting a Leave of Absence

Contact the claims administrator at **1-866-409-2576** *(AHM and subsidiaries) or* **1-888-538-2732** *(HDMA) or go to* **mysedgwick.com**. *Please see your* Associate Handbook *for Leave of Absence Policy details.*

The claims administrator will review your claim and determine the length of payment for disability benefits. If your claim is approved, benefit payments will be direct deposited to your bank account on file with Honda.

If your claim is denied and you want to appeal, contact the claims administrator. The claims administrator can provide information on the appeals process. See *Administrative Information* on page 316.

As long as you remain absent from work, you must provide continuing evidence of disability to receive benefits. This may include an Independent Medical Evaluation (IME). If you are required to attend an IME, the cost of the evaluation will be paid by the plan.

When you have been released to return to work, contact the claims administrator (and the In Plant Medical Team, if applicable) to arrange for your return in accordance with Company policy.

Special Situations

If you are on an approved leave of absence, you will be billed directly for benefit deductions to continue coverage. You will receive a monthly invoice from the My Benefits Connect Center. For questions about direct billing, contact the My Benefits Connect Center at **1-866-778-5885**.

When Coverage and Benefits End

STD coverage and benefits end on the earliest of the date:

- Your Honda employment ends;
- Your eligibility ends;
- The plan ends;
- You fail to cooperate with the claims administrator;
- You exhaust 26 weeks of benefits; or
- Your death occurs.

Administrative Details and Appeals

If your claim is denied and you want to appeal, contact the claims administrator. The claims administrator can provide information about the appeals process.

Acts of Third Parties

If a Participant is injured through the acts or omissions of another person or organization, the Plan Administrator will provide the benefits of the plan only on condition that the Participant will agree in writing:

A. That this plan will be subrogated to all rights of recovery that the Participant, his or her heirs, guardians, executors, agents or other representatives (hereafter, individually and collectively "Participant") may have as a result of the injury, including, without limitation rights to recovery pursuant to:

1. Any legal action initiated by this plan;
2. Any action in intervention;
3. Any action, at law or in equity, legally permissible to enforce this plan's rights of recovery against any person or entity that caused, contributed to or is in any way responsible for the injury;

4. Any action, at law or in equity, legally permissible to enforce this plan's rights of recovery against any person, insurance company, healthcare provider or other entity that is in any way responsible for providing indemnification, coverage, compensation or other payment as a result of the injury;
5. Any action, at law or in equity, legally permissible to enforce this plan's rights of recovery against any person who received payment of funds from either (a) a person or entity that caused, contributed to or is in any way responsible for the injury; or (b) any insurance company, healthcare provider or other entity that is in any way responsible for providing indemnification, coverage, compensation or other payment as a result of the injury;
6. Any suit to impose a constructive trust on funds paid by any source as a result of the injury;
7. Any suit to enforce an equitable lien on funds paid by any source as a result of the injury;
8. Under no fault, personal injury protection, financial responsibility, uninsured motorist and underinsured motorist insurance;
9. Under motor vehicle medical and wage loss reimbursement insurance;
10. Under homeowners, renters, premises and owners, landlords and tenants' insurance including medical reimbursement coverage; and
11. Under group accident and health insurance, and athletic team, sporting event, school, club and other specific risk insurance coverages or accident benefit plans.

B. To reimburse the plan for the full amount of payments made under the terms of this plan, immediately upon receipt of the proceeds of any settlement of, or judgment in, an action at law or in equity, arbitration, claim or other proceeding to determine said Participant's rights of recovery arising out of said injury, net of Participant's reasonable expenses in collecting such amount, including reasonable attorney's fees, and net of any amounts which are allocated by terms of any judgment for the payment of unreimbursed medical expenses of the Participant;

C. To provide the Plan Administrator with an equitable lien on the proceeds described above, to the extent of the full amount of payments made under the terms of this plan;

D. To provide the Plan Administrator with a credit against payments to be made in the future under this plan; said credit to be equal to the proceeds above described, less any amount paid to the plan by way of reimbursement;

E. The amount of this plan's subrogation interest will be paid to the plan directly from any recovery by or on behalf of the Participant.

Disability Glossary

Base Pay

Base pay is the regular base pay rate effective as of your last day worked prior to a disability claim. It does not include overtime, shift premium, disability benefits, bonuses, expense allowances or other special compensation. The disability benefit will not increase with wage increases while on disability.

Claims Administrator

The claims administrator for this plan is Sedgwick, an independent claims administrator. Claims should be sent to Sedgwick, P.O. Box 14669, Lexington, KY 40512-4669. Contact Sedgwick at **1-866-409-2576** (AHM and subsidiaries) or **1-888-538-2732** (HDMA).

Hospital/Hospitalization

"Hospital" means an institution with organized facilities for diagnosis and surgery and 24-hour nursing service for the care and treatment of sick and injured persons. Such an institution must be licensed as a hospital pursuant to the statutes or laws of the state or foreign country in which it operates unless such state or foreign country does not have statues or laws concerning requirements for licensing hospitals.

"Hospitalization" means you are a registered bed patient in a hospital for a 24-hour period, or any part thereof, for which you are charged a full day's rate for room and board.

Objective Medical Evidence

Objective medical evidence means demonstration of anatomical, physiological or psychological abnormalities manifested by bodily signs or laboratory findings, apart from the claimant's perception of his or her mental or physical impairments. These signs are observed through medically acceptable clinical techniques such as medical history and physical examination. Laboratory findings are manifestations of anatomical, physiological or psychological phenomena demonstrated by chemical, electrophysiological, roentgen logical or psychological tests.

Observation

Observation services are hospital outpatient services during which a qualified physician decides whether to admit you as an inpatient or discharge you. Observation services are available in the emergency department or other area of the hospital.

Period of Disability

A period of disability is the period during which you cannot work due to injury or illness.

Periods of disability due to the same or related causes count as one period of disability until you return to work at a full schedule for 60 calendar days. If you have previously transitioned from short-term disability (STD) to long-term disability (LTD) and returned back to work while under LTD, you will not be eligible for STD should you relapse during the LTD relapse period of six months. Partial days of disability, such as a gradual return to work schedule, are not considered a return to work at a full schedule. At work time includes PTO and holidays/shutdown periods. Benefits begin on the first day of absence for successive periods of absence that are considered relapses.

If you are released to return to work from your disability leave and become disabled due to a different, unrelated cause, it will be treated as a new period of disability (and may result in a new seven-day waiting period).

Plan

Plan means the Honda North America Short-Term Disability Plan.

Plan Administrator

The Plan Administrator is Honda.

Qualified Physician

A qualified physician means a legally licensed physician, surgeon or other practitioner in the medical profession. This physician cannot be a member of your (or your spouse's) family.

Surgery

The treatment of injuries or disorders of the body by incision or use of general anesthesia.

Company-Paid Long-Term Disability

The Company-paid long-term disability (LTD) plan pays a monthly income benefit when your disability continues beyond 180 days (210 days in California).

Highlights	
Cost	Paid for by Honda
Who Is Covered	Honda associates regularly working at least 16 hours per week
Coverage Begins	First day of the month after six months of employment
Benefits	Provides benefits for disability (occupational or non-occupational) that continues for more than 180 days (210 days in California). Benefit amounts are up to 50% of your base monthly earnings, up to the plan maximum.
Plan Features	Pays a survivor benefit if you die while receiving benefits
Coverage Ends	When your Honda employment or plan eligibility ends
Administered By	New York Life Group Benefit Solutions (formerly Cigna Group Insurance)

Who Is Eligible

You are eligible for the LTD plan if you:

- Are an associate who routinely works at least 16 hours per week; and
- Are actively employed full-time by Honda.

You are not eligible for the LTD plan if you:

- Are an active Honda associate who has a regular work schedule of less than 16 hours per week;
- Are a self-employed person who provides services to Honda through an agreement between Honda and you;
- Are employed by or obtain your employment through a company that provides temporary workers to Honda;
- Are a student or temporary associate; or
- Are an associate of an international affiliate on temporary assignment at Honda.

See the *Voluntary/Supplemental Benefits* section on page 210 for details about associate-paid long-term disability.

When Coverage Begins

Long-term disability coverage begins on the first day of the month after you meet the eligibility criteria described in "Who Is Eligible."

For example: If your hire date is August 2, you will be eligible for LTD benefits on March 1 of the following calendar year, provided you meet the other criteria for eligibility noted above.

How the LTD Plan Works

The LTD plan pays monthly benefits if:

- You become disabled while covered under the plan; and
- Your disability continues for more than 180 days (210 days in California).

Disability

The employee is considered disabled if, solely because of injury and sickness, he or she is:

- Unable to perform the material duties of his or her *regular occupation*; and
- Unable to earn 50% or more of his or her Indexed Earnings from working in his or her *regular occupation*.
- After disability benefits have been payable for 24 months, the associate is considered disabled if, solely due to injury or sickness, he or she is:
- Unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
- Unable to earn 80% or more of his or her Indexed Earnings.

Regular Occupation

The occupation the employee routinely performs at the time the disability begins. In evaluating the disability, the insurance company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

Benefits

The plan pays LTD benefits up to 50% of your *base monthly earnings*, with a maximum benefit of $18,000 per month. Base monthly earnings mean your regular base wage rate in effect the day before your disability began. It does not include overtime, shift premium, expense allowances, bonus or other special compensation.

Your Company-paid LTD benefit (up to 50% of base monthly earnings) is reduced by benefits you may receive for your disability from other sources, such as:

- Honda's Pension Plan, if applicable;
- Honda Disability Allowance and statutory STD, if applicable;
- Any other group disability insurance plan or government retirement system;
- Social Security for your disability and/or your retirement payable to you, your spouse or children; and
- Workers' Compensation (or similar laws) and state disability plans.

Defining Base Monthly Earnings

Base monthly earnings mean your regular base wage rate in effect the day before your disability began.

Note: If you want more than the 50% benefit that the Company-paid LTD plan provides, the associate-paid LTD plan increases your benefit by 10%. See "Associate-Paid Long-Term Disability" in the *Voluntary/Supplemental Benefits* section on page 210.

Your LTD benefit from the plan is adjusted (reduced) by the amount initially payable for these other benefits. Your LTD benefit will not be reduced again for any cost of living increases in these other benefits.

Benefit Example

If your base monthly earnings are $4,368 when you become disabled, you are entitled to a total LTD benefit of $2,184/month (50% × $4,368).

- If you are not entitled to benefits from other sources, the LTD plan will pay $2,184/month.
- If you receive a monthly Social Security benefit of $500/month, the LTD plan will pay $1,684/month, for total benefits of $2,184/month.

How Long Benefits Are Paid

Benefits under the plan continue until the earliest of the date:

- You earn from any occupation, more than the percentage of Indexed Earnings set forth in the definition of disability applicable to you at that time;
- You are determined not to be disabled;
- Your Maximum Benefit Period expires (see the "Maximum Benefit Period" table below);
- You die;
- You refuse, without Good Cause, to fully cooperate in all required phases of the Rehabilitation Plan and assessment;
- You are no longer receiving appropriate care; or
- You fail to cooperate in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Age at Disability	Maximum Benefit Period (includes 6 months of STD benefits)
Under 60	Until age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

If You Return to Limited Work

If you return to limited work, you need to provide proof of your monthly earnings and your benefit is determined as follows:

- **For the first 24 months of LTD payments.** Your benefit will not be reduced by other earnings until the total LTD monthly benefit plus your earnings exceed 100% of your pre-disability earnings. Then, the monthly LTD benefit will be reduced by the excess.
- **If you are still unable to work full-time after 24 months.** You will receive an adjustment to your LTD benefit. The adjusted LTD benefit is as follows:
  - Monthly LTD benefits − 50% of current monthly earnings = adjusted monthly LTD benefits

If Your Disability Recurs

A recurrent disability is treated as part of a prior disability (and subject to the same payment terms) if you:

- Return on a full-time basis to your regular occupation for less than six months; and
- Perform all the key duties of your occupation.

Recurrent Disability
A recurrent disability is related to a prior disability for which you received LTD plan monthly benefits.

If you return to Honda full time for six months or more, your recurrent disability will be treated as a new disability. This means a new 180-day (210-day in California) waiting period will apply before benefits can begin.

In the Event of Your Death

In the event of your death while receiving a monthly benefit, a death benefit will be paid to your eligible survivor. The death benefit is paid in a single lump sum equal to three times your last full month LTD plan net benefit.

The benefit is paid automatically to your surviving spouse if you were married at the time of your death. If there is no surviving spouse at the time of your death, the benefit will automatically be paid in equal shares to your unmarried children under age 25 if they were chiefly dependent upon you for support and maintenance. Payments may be made to a guardian if your children are under age 18. If you have no surviving spouse or unmarried children under the age of 25 at the time of your death, payment of the benefit will be made to your estate.

Mental Health/Chemical Dependency Limitation

Regardless of anything previously stated about plan benefits, all LTD benefits will end after 24 months of payments for disabilities due to mental illness, alcoholism or drug abuse. If you are confined to the hospital for 14 days or more during the 24-month period, for the condition for which benefits are payable, the period of confinement will not count toward the 24-month limit.

In all cases, no benefits are paid after you reach the maximum benefit period described in “How Long Benefits Are Paid” on page 49.

What Is Not Covered

LTD benefits will not be paid for any injury or sickness due to:

- Suicide, attempted suicide or intentional self-inflicted injuries;
- Any act of war, declared or undeclared;
- Active participation in a riot; and
- An illegal act that results in a felony conviction.

LTD benefits will be terminated or are not payable for any period of disability during which you:

- Are incarcerated in a penal or corrections institution;
- Cease to be under the regular care of a qualified physician;
- Fail to cooperate with the administration of your LTD claim;
- Refuse to participate in rehabilitation efforts as required by the LTD carrier; and
- Refuse to participate in a transitional work arrangement or other modified work arrangement required by the LTD carrier.

Claims

You should request an application for LTD benefits through the claims administrator by calling **1-888-842-4462**. **This applies whether you are receiving short-term disability benefits or Workers' Compensation benefits for the first 180 days (210 days in California) of disability.** LTD claim forms will then be sent to you with instructions.

LTD claims are processed by the claims administrator. If your claim is denied, you have the right to appeal in writing to the claims administrator. See *Administrative Information* on page 316.

LTD Claim Forms

*To start the claim process, you should contact the claims administrator at **1-888-842-4462**. LTD claim forms will be mailed to you for completion.*

Proof of Claim

To file your LTD claim, you need to provide proof of your disability within 90 days after the end of the 180-day (210-day in California) waiting period. No proof will be accepted more than one year after the end of the 90-day period (21 months from the start of your disability).

While benefits are paid, you may also need to provide proof of continued disability and regular physician care at your own expense. Proof must be provided within 30 days after it is requested by the claims administrator.

The claims administrator reserves the right to require a physical exam (at their own expense) or an interview with you to determine proof of your claim.

Special Situations

If you are on an approved leave of absence, you will be billed directly for benefit deductions to continue coverage. You will receive a monthly invoice from the My Benefits Connect Center. For questions about direct billing, contact the My Benefits Connect Center at **1-866-778-5885**.

When Coverage Ends

LTD coverage ends on the earliest of the date:

- Your Honda employment ends (if you are receiving LTD benefits, these benefits continue);
- Your eligibility ends; or
- The plan ends.

For more information about how life events impact your LTD coverage, please refer to *Life* on page 8.

Other Income Benefits

If disability benefits are payable to you under this policy, you may be eligible for benefits from Other Income Benefits. If so, we may reduce the Disability Benefits by the amount of such Other Income Benefits.

Other Income Benefits include:

1. Any amounts received (or assumed to be received) by you or your dependents under:
   - The Canada and Quebec Pension Plans;
   - The Railroad Retirement Act;
   - Any local, state, provincial or federal government disability or retirement plan or law payable for injury or sickness provided as a result of employment with the employer;
   - Any sick leave of the employer; or
   - Any work loss provision in mandatory "no-fault" auto insurance.
2. Any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive) on your own behalf or for your dependents—or which your dependents receive (or are assumed to receive) because of your entitlement to such benefits.
3. Any retirement plan benefits funded by the employer. "Retirement plan" means any defined benefit or defined contribution plan sponsored or funded by the employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan; or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 40l(k) savings account.

4. Any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for disability and contains the same or similar provision for reduction because of other insurance, we will pay for our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
5. Any amounts received (or assumed to be received) by you or your dependents under any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law payable for injury or sickness arising out of work with the employer, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
6. Any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

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Life and Accident Insurance

Honda offers basic life and accident insurance and business travel insurance benefits for you or your survivors in the event of your accidental death or serious injury.

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Basic Life and Accident Insurance

Basic life and accident insurance provides financial protection for your family in the event of your death or serious accidental injury.

For More Information
Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

Highlights	
Cost	Paid for by Honda
Who Is Covered	Regular associates working at least 16 hours per week
Coverage Begins	First day of the month after date of hire
Benefits	Two times base annual earnings (up to $1.2 million) if you die; full or partial benefit if you suffer an accidental injury
Special Features	You can request payment of a portion of your basic life insurance benefit if you become terminally ill.
Coverage Ends	When your Honda employment or eligibility ends
Administered By	MetLife

Who Is Eligible

You are eligible for basic life and accident insurance if you:

- Are a regular associate who routinely works at least 16 hours per week; and
- Are employed by Honda on the first day of the month following date of hire.

You are not eligible if you:

- Are an active Honda associate who has a regular work schedule of less than 16 hours per week;
- Are a self-employed person who provides services to Honda through an agreement between Honda and you;
- Are employed by or obtain your employment through a company that provides temporary workers to Honda;
- Are a student, co-op, intern or temporary associate; or
- Are an associate of an international affiliate on temporary assignment at Honda.

When Coverage Begins

Basic life and accident insurance coverage begins on the first day of the month after you meet the eligibility criteria, provided you are actively at work on that day. Otherwise, coverage will be delayed until you return to active work for one full day.

Basic Life and Accident Insurance Coverage

Your coverage amounts under this plan are:

- Basic life insurance of two times your base annual earnings, up to $1.2 million of coverage; and
- Accident insurance of two times your base annual earnings, up to $1.2 million of coverage.

If your base annual earnings are not a multiple of $1,000, they are first rounded up to the next $1,000 multiple for your basic life insurance.

If your base annual earnings are not a multiple of $1,000, they are first rounded up to the next $1,000 multiple for your accident insurance.

Base Annual Earnings
Base annual earnings mean your regular base wage rate, excluding overtime, shift premium, bonus, expense allowances or other special compensation.

The value of basic life insurance coverage of more than $50,000 is taxable and is reported on your Form W-2 each year. Value means what the Internal Revenue Service determines to be the premium cost.

When Coverage Amounts Change

Your basic life and accident insurance coverage amounts change:

- On the date your base annual earnings change, if you are actively at work; and
- On the date you return to work for one full day, if your base annual earnings changed while you were disabled or on an approved leave of absence.

Naming a Beneficiary

You name a beneficiary to receive all death benefits payable from the plans by logging in to **myhondaconnect.com** or calling the My Benefits Connect Center at **1-866-778-5885**. You may elect different beneficiaries for each plan.

You may name a person (or a legal entity, such as a trust) as your beneficiary. You may change your beneficiary selection at any time by calling the My Benefits Connect Center or by changing your beneficiary online.

Beneficiary selections (or changes) are effective when you make the change through a personal service representative at the My Benefits Connect Center at **1-866-778-5885**—or when your selection is saved online at **myhondaconnect.com**.

Benefits

Benefits are paid if you die or have an accidental loss as listed in the chart that follows. The coverage amount in effect on the date of death or accidental loss applies. Benefits for loss of life will be paid to your beneficiary. Benefits for all other losses will be paid to you. See "How Benefits Are Paid" on page 61.

Accidental losses must occur within one year of the accident. In the event of multiple accidental losses, the plan will pay up to 100% of the accident coverage.

Benefit Amount

Loss	Plan Pays This % of Coverage Amount
Life	100% of life benefit
Accidental loss of:	
• Life (subject to review of exclusions)	100% of accident benefit (in addition to life benefit)
• Both hands or both feet	100% of accident benefit
• Entire sight in both eyes	100% of accident benefit
• Total paralysis of both upper and lower limbs (quadriplegia)	100% of accident benefit
• Loss of an arm permanently severed at or above the elbow or loss of a leg permanently severed at or above the knee	75% of accident benefit
• Total paralysis of both lower limbs (paraplegia)	50% of accident benefit
• Total paralysis of the arm and leg on either side of the body (hemiplegia)	50% of accident benefit
• Speech and hearing in both ears	100% of accident benefit
• Speech or hearing in both ears	50% of accident benefit
• One hand, one foot or entire sight in one eye	50% of accident benefit
• Total paralysis of one limb	25% of accident benefit
• Thumb and index finger of same hand	25% of accident benefit
Brain damage	100% of accident benefit
Coma	5% of accident benefit monthly, beginning on the 7th day of the coma for the first 11 months, and 45% of the accident benefit for the 12th month of the coma
Third-degree burn(s)	A percentage of the full amount equal to the percentage of body surface suffering third-degree burns

Additional Benefits

If loss of life results from accidental injuries, the plan pays additional benefits as follows.

Benefit	Plan Pays This % of Coverage Amount
Seat belt	An additional 10% up to a $25,000 maximum, if loss of life results from accidental injuries sustained while driving or riding in a private, four-wheel passenger car with a properly fastened seat belt or child restraint. Seat belt use must be certified by an investigating officer and a police report submitted with the claim. This benefit is not payable if the car is commercially licensed or used for commercial purposes or any vehicle used for recreational or professional racing, or if the covered person was driving under the influence of alcohol or drugs.
Air bag	An additional 5% (minimum $1,000, up to a $10,000 maximum) of accident benefit, if: • Loss of life results from accidental injuries sustained while driving or riding as a passenger in a car equipped with air bags; and • Proof is provided that the deceased was riding in a seat protected by an air bag and was wearing a seat belt properly fastened at the time of the accident.
Child care	Per qualifying child, an additional amount equal to the child care center charges incurred for a period of up to five consecutive years (not to exceed an annual maximum of $2,000 and an overall maximum of 15% of accident benefit) will be paid. The child care center must be a facility that is operated and licensed according to the law of the jurisdiction where it is located and provides care and supervision for children in a group setting on a regularly scheduled and daily basis.
Child education	Per qualifying child, an additional amount equal to the tuition charges incurred for a period of up to four consecutive academic years (not to exceed an academic year maximum of $10,000 and an overall maximum of 20% of accident benefit) will be paid. Proof may be required that the child was enrolled as a full-time student in an accredited college, university or vocational school above the 12th-grade level; or at the 12th-grade level and, within one year after the date of death, enrolls as a full-time student in an accredited college, university or vocational school.
Spouse education	An additional amount equal to the tuition charges incurred for a period of up to four consecutive academic years (not to exceed an academic year maximum of $5,000 and an overall maximum of 5% of accident benefit) will be paid. Proof may be required that the spouse was enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or at the 12th grade level and, within one year after the date of death, enrolls as a full-time student in an accredited college, university or vocational school.
Hospital confinement	An additional amount for each month of hospital confinement equal to the lesser of 1% of accident benefit or $2,500 with the same proof guidelines as shown above.
Common carrier	An additional 100% of accident benefit will be paid if proof is provided that the injury resulting in the deceased's death occurred while traveling in a common carrier.
Repatriation	An additional benefit will be paid if loss of life results from accidental injuries sustained and proof is provided that death incurred at least 100 miles from the deceased's principal place of residence. The benefit (not to exceed $5,000) will be equal to the charges incurred for the preparation and transportation of the deceased's body to the city of the deceased's principal residence.

Covered Losses

Covered losses listed in "Benefit Amount" table above are defined as follows:

- Loss of hand means removal at or above the wrist joint but below the elbow.
- Loss of a foot means removal at or above the ankle joint but below the knee.
- Loss of sight means permanent and uncorrectable loss of sight in the eye. The visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.
- Loss of thumb and index finger on the same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.
- Loss of speech and hearing in both ears means a complete, continuous and irrevocable loss that continues for six consecutive months following the accidental injury.
- Loss of use of limbs (paralysis) means loss of use of a limb, without severance and must be certified by a physician as permanent, complete and irreversible.

Exclusions and Limitations

Accident benefits will not be paid for any loss caused by or contributed to by:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity.
- Infection, other than infection occurring in an external accidental wound or from food poisoning.
- Suicide or attempted suicide (while sane or insane).
- An intentional self-inflicted injury.
- The voluntary intake or use by any means of:
  - Any drug, medication or sedative, unless it is taken or used as prescribed by a physician;
  - An "over-the-counter" drug, medication or sedative taken as directed;
  - Alcohol in combination with any drug, medication or sedative; or
  - Poison, gas or fumes.
- War, whether declared or undeclared, or act of war, insurrection, rebellion or active participation in a riot.
- Service in the armed forces of any country or international authority; however, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision, reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country.
- Commission of or attempt to commit a criminal act.

- Use of alcohol, intoxicants or drugs, medication or sedatives, except as prescribed by a physician. An accident in which the blood alcohol level of the operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the jurisdiction where the accident occurred will be deemed to be caused by the use of alcohol.
- Air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo).
- Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight.
- Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation.
- Travel in an aircraft or device used:
  - For testing or experimental purposes;
  - By or for any military authority; or
  - For travel or designed for travel beyond the earth's atmosphere.

The injury must not be one that is excluded by the terms of this section.

Claims

The My Benefits Connect Center files all basic life and accident insurance claims on behalf of associates. In the event of your death, a family member or beneficiary should notify the My Benefits Connect Center at **1-866-778-5885**. Other accidental losses should be reported within 20 days after the date of the accident (or within a reasonable time period). In both cases, acceptable proof of loss needs to be provided to the insurance company before benefits can be paid. Proof of loss is needed within 90 days of the covered loss.

If a claim is denied in whole or part, you can appeal in writing to MetLife. See *Administrative Information* on page 316.

Basic Life and Accident Claim Forms

Notify the My Benefits Connect Center to file a claim for an active associate's accident or death benefits. Claim forms are submitted directly to the insurance company by the My Benefits Connect Center on your behalf.

How Benefits Are Paid

The full benefit amount may be paid:

- By check;
- By establishing an account that earns interest and provides the beneficiary with immediate access to the full benefit amount; or
- By any other method that provides the beneficiary with immediate access to the full benefit amount.

If your beneficiary dies before receiving the full benefit amount, the remainder will be paid to the person/entity you designate as a contingent or secondary beneficiary on the beneficiary form or online. If no primary or contingent beneficiary is named or still living at your death, payment will be made to one of the following in this order:

- Your surviving spouse;
- Your surviving children in equal amounts (payment to a minor child may be made to an adult who has custody and supports the child, or a legal guardian, when appointed);
- Your surviving parents in equal amounts;
- Your surviving brother(s)/sister(s) in equal amounts; and
- Your estate.

If You or Your Beneficiary Have Questions

If you or your beneficiary have questions about filing claims or completing forms, contact the My Benefits Connect Center at ***1-866-778-5885.***

Benefits During a Terminal Illness

If you are terminally ill with a life expectancy of 12 months or less, you can access a portion of your basic life insurance benefit. You can withdraw a lump sum of up to 80% of your basic life insurance amount (two times annual base earnings). The minimum withdrawal is $10,000, while the maximum is $500,000.

To apply for this benefit, you need to complete an application and provide physician certification of your life expectancy. Forms are available from, and you can return forms to, the My Benefits Connect Center **(1-866-778-5885)**.

The life insurance coverage that remains in force will be reduced by the amount of benefits received.

When Coverage Ends

Basic life and accident insurance coverage will end on the earliest of the date:

- Your Honda employment ends;
- Your plan eligibility ends; or
- The plan ends.

If your employment or eligibility ends, you may convert your Honda coverage to a personal policy.

Coverage During Disability and Leave of Absence

Honda will continue your basic life and accident insurance while:

- **You are disabled.** Coverage continues until your Honda employment ends.
- **You are on an approved leave of absence.** Coverage continues until your Honda employment ends.

Changing to a Personal Policy

When your basic life insurance ends, you can convert your Honda coverage to a personal policy without providing proof of good health, provided you do so within the conversion time frame allowed, which is 31 days from the coverage end date.

If you change to a personal policy:

- MetLife will automatically send you conversion information after they receive your separation/retirement notification. If you have not received your notification within 21 days of your separation/retirement date, contact MetLife at **1-800-638-6420** or the My Benefits Connect Center at **1-866-778-5885**.
- You will need to pay premiums for your coverage. The first premium will need to be paid before your personal policy can take effect.
- Your personal policy will be limited to the amount of Honda coverage you had on the last day it was effective. Other limitations may apply if coverage ended because the plan ended.
- If you die within the 31 days after Honda coverage ends, the insurance company will pay your beneficiary the amount of insurance that would have been available to you under a personal policy subject to plan exclusions. MetLife will still need to determine eligibility. Please consult the full certificates of coverage for complete details.

Business Travel Insurance

Business travel insurance provides financial protection for your family in the event of an injury or death while you are traveling on Company business.

Highlights	
Cost	Paid for by Honda
Who Is Covered	Regular associates working at least 20 hours per week
Coverage Begins	On your date of hire
Pays Benefits of	Up to five times base earnings, rounded to the next higher $1,000 up to a maximum of $500,000, depending on type of loss
Coverage Ends	When your Honda employment or eligibility ends
Administered By	AIG

Who Is Eligible

You are eligible for business travel insurance if you are a regular associate who routinely works at least 20 hours per week.

You are not eligible if you:

- Are an active Honda associate who has a regular work schedule of less than 20 hours per week;
- Are a self-employed person who provides services to Honda through an agreement between Honda and you;
- Are employed by or obtain your employment through a company that provides temporary workers to Honda; or
- Are a student, co-op, intern or temporary associate.

When Coverage Begins

Participation in the plan begins on your hire date.

Business Travel Insurance Coverage

You are automatically protected by the business travel insurance plan, at no cost to you. The plan protects you worldwide, 24 hours a day, while traveling on official Honda business. Plan coverage does not include commuting to your scheduled assigned work location or other personal travel before, during or after work hours.

For an associate who is on a temporary assignment, everyday travel to/from work would not be covered.

Coverage begins when you depart on your trip from your home or work location and ends when you return to either location. However, any period of time you are on an authorized leave of absence or vacation is not covered. The coverage amount is up to five times base annual earnings, rounded to the next higher $1,000 up to a maximum of $500,000, depending on the type of loss. A trip to a location that extends for over 365 days is not covered.

Base Annual Earnings

Base annual earnings mean your regular base wage rate, excluding overtime, shift premium, bonus, expense allowances or other special compensation.

When Coverage Amounts Change

Your business travel insurance coverage amounts will change on the date your base earnings change, if you are actively at work. In the event of a claim, AIG would confirm your base annual earnings on the date of the accident.

Benefits

Plan benefits are paid in a single lump sum if a loss occurs within one year of, and as the result of, an accident.

Benefit Amounts

Accidental loss of life	100%
Loss of both hands, both feet or entire sight in both eyes	100%
Total paralysis of both upper and lower limbs (quadriplegia)	100%
Total paralysis of both lower limbs (paraplegia)	75%
Loss of one hand or one foot	50%
Loss of entire sight in one eye	50%
Loss of speech or hearing in both ears	50%
Loss of one arm or one leg	50%
Total paralysis of upper and lower limbs on one side of body (hemiplegia)	50%
Loss of hearing in one ear	25%
Total paralysis of one limb of the body (uniplegia)	25%

Business travel insurance benefits are payable in addition to all other insurance coverage and in no way affect your coverage under Workers' Compensation insurance. Your beneficiary for business travel insurance is automatically the same beneficiary you named for your basic life insurance.

Covered Losses

The plan covers travel on any type of transportation including automobile (your own, rented or Company-owned, or another person's), taxi, bus, streetcar, train and ship. The plan covers injuries sustained while a passenger in an aircraft that has a current and valid air-worthiness certificate and is piloted by a person holding a valid and current certificate of competency rating authorizing him or her to pilot the aircraft.

This includes any transport type of aircraft operated by the Military Airlift Command of the United States or a similar air transport service of any duly constituted government authority of any other recognized country.

Should more than one associate be injured or killed in the same accident, the maximum benefit payable to *all* associates (or beneficiaries) involved is limited to $5 million. If total losses are more than $5 million, the benefit payable to each associate (or beneficiary) is pro-rated based on the individual loss for each associate as it relates to the total loss.

Exclusions and Limitations

The plan does not cover you as a pilot or crew member in any civilian aircraft.

Claims

All business travel insurance claims are processed by AIG Domestic Accident and Health Claims Department. Contact AIG at **1-800-551-0824** or **ahclaims@aig.com**. In the event of your death, a family member or beneficiary should notify the Honda Risk Management Department at **riskmanagementandinsurance@ahm.honda.com** or **1-937-644-8099**. Other accidental losses should be reported no more than 20 day after the date of the accident. In both cases, acceptable proof of loss must be provided to the insurance company before benefits can be paid. For any questions, contact the Honda Risk Management Department at **riskmanagementandinsurance@ahm.honda.com** or **1-937-644-8099**.

Important Note!
You, a family member or your beneficiary must provide acceptable proof of loss to AIG before benefits can be paid.

The claims payer is AIG. If a claim is appealed in whole or part, you can appeal in writing to AIG. See *Administrative Information* on page 316.

When Coverage Ends

Your coverage will end on the earliest of the date:

- Your Honda employment ends;
- Your plan eligibility ends; or
- The plan ends.

HEALTH BENEFITS

Contents

Health Benefits

The following healthcare benefits are available to you:

- Medical plan
- Prescription drug plan
- Dental plan
- Vision plan

Honda's health benefits provide you with healthcare coverage and the opportunity to choose the coverage levels that meet your personal situation.

Choosing Health Benefits

You elect the medical, dental and vision coverage you want, if any—and the coverage levels you want for your health benefits. You automatically receive prescription drug benefits when you enroll in the medical plan.

Benefits for Honda

You should review your benefits each year to ensure you have the right level of coverage for you and/or your dependents. See *How the Benefits Program Works* on page 22 for details on your options.

Benefits for Honda

Participating in Health Benefits

This section describes how you and your eligible dependents can participate in health benefits.

For More Information

Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

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Who Is Eligible for Health Benefits

You are eligible for the Honda medical, prescription drug, dental and vision plans if you are a regular associate who routinely works at least 16 hours per week.

You are not eligible for this coverage if you:

- Are an active Honda associate who has a regular work schedule of less than 16 hours per week;
- Are a self-employed person who provides services to Honda through an agreement between Honda and you;
- Are employed by or obtain your employment through a company that provides temporary workers to Honda;
- Are a student, co-op, intern or temporary associate; or
- Are an associate of an international affiliate on assignment at Honda.

Part-Time Associates

Part-time associates and their eligible dependents are eligible for healthcare coverage and are responsible for paying an additional portion of the premiums for such coverage. Part-time associates are those associates who are regularly scheduled to work less than 40 hours.

All eligible dependents may only be covered once in each type of benefit (this includes benefits provided by Honda or a Honda affiliate).

You may also cover your eligible dependents. For this purpose, your eligible dependents are:

- Your legally married spouse and not legally separated;
- Children up to age 26; and
- Your child with disabilities of any age who is a tax dependent and who cannot earn a living due to a mental or physical disability that began prior to reaching age 26 and who depends on you for support.

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

Children are your:

- Biological children (your natural children), adopted children and children placed with you for adoption;

  For adoption, eligibility begins on the date of placement or the date of the probate filing for independent adoptions.
- Stepchildren;
- Children for whom you are the legal guardian and who you claimed or could claim as “dependents” on your federal income tax return. These children are not eligible if one of the child’s parents lives with you; and
- Children recognized under a qualified medical child support order (QMCSO).

As a Honda associate, it is your responsibility to provide accurate and up-to-date dependent information. If you wish to add a dependent to coverage, you must verify your dependent is eligible to participate in the Honda healthcare plan. If verification is not completed within 45 days of enrollment, the enrollment will be denied, and the dependent will not be covered. If the status of a dependent you have enrolled in healthcare coverage changes during the year, you must report this to the My Benefits Connect Center within 31 days. Providing false information about your dependent(s) could result in loss of elected benefits and/or in corrective action, up to and including termination.

Honda Associates with the Same Dependent(s)

- If you and your spouse both work for Honda or an affiliate—or if you have the same dependent as another Honda associate—only one of you can cover eligible dependents in each type of benefit. See *How the Benefits Program Works* on page 22 for more details.

Changes in Dependent Eligibility

You need to contact the My Benefits Connect Center to:

- Add coverage for new dependents; and
- Report eligibility changes, such as an adoption or divorce or legal separation.

These changes should be reported no later than 31 days (60 days for birth, adoption or placement for adoption) after the event or benefit election (see *Life* on page 8).

To report a change, contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET.

If your dependent's eligibility ends, he or she may qualify for continued coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For more information about qualifying for and electing COBRA coverage, see *COBRA* on page 204.

Your Responsibilities…

- You are responsible for ensuring that only eligible dependents are covered under the plans offered by Honda—and for providing accurate and up-to-date dependent information. If a dependent's status changes, you *must* report the status change immediately to the My Benefits Connect Center within 31 days of the status change (see *Life Events* on page 8). Failure to do so—or providing false information about your dependents—could result in loss of elected benefits or in corrective action, up to and including termination. You may also be responsible for repaying benefits paid on behalf of an ineligible dependent.
- You may be asked to provide supporting documents for your enrollments.

Qualified Medical Child Support Order (QMCSO)

Under the terms of a qualified medical child support order, an order or a judgment may be made by a state court or through an administrative process under state law directing the plan administrator to provide coverage for a dependent child under Honda's healthcare plans. Coverage will be provided according to federal and applicable state law. However, in general the QMCSO cannot require benefits to be paid in a way that is inconsistent with plan provisions or any other existing order.

If Honda receives such an order, you and your child(ren) will be notified. If the order is issued after your coverage begins, the child's coverage will take effect after Honda reviews and approves the court order. QMCSO procedures are available free of charge from the My Benefits Connect Center.

When Coverage Begins

If you are an eligible new hire and you enroll within 31 days of hire, your medical, prescription drug, dental and vision coverage begins the first day of the month following your date of hire.

For example, if you are eligible for coverage and you are hired on January 20, and you elect coverage on or before February 20, medical, prescription drug, dental and vision coverage begins February 1.

Dependent coverage begins when your coverage starts, or, if later, the date the dependent meets eligibility criteria or the date they are enrolled.

When Coverage Ends

Medical, prescription drug, dental and vision coverages end as follows:

- Coverage for you ends on the earliest of:
  - The last day of the month in which you elect to stop your coverage in connection with a life event (see *Life Events* on page 8);
  - The last day of the month in which your employment ends (see *Life Events* on page 8);
  - The last day of the month in which your eligibility ends;
  - The date the plan ends; or
  - The last paid-through day of the month in which you stop making any required contributions (for example, if you are paid through the month of January and make no further payments, coverage would end on January 31).
- Coverage for your dependents ends on the earliest of:
  - The date your coverage ends;
  - The last day of the month in which the dependent's eligibility ends (for example, your dependent reaches age 26);
  - The date the plan ends all dependent coverage; or
  - The date the plan ends.

In the Event of Your Death

In the event of your death, healthcare coverage will continue, at no cost, for your eligible dependents for up to 12 months after the date of death.

Continuation of Coverage for Your Dependents After Your Death

If you die while covered under any part of this plan, any health expense coverage then in force for your dependents will be continued.

Any dependent's coverage, including your spouse's, will end when any one of the following happens:

- When your spouse remarries;
- The 12-month coverage period ends (unless you enrolled in Survivor Medical Insurance);
- A dependent no longer is a defined dependent;
- A dependent becomes eligible for like coverage under this plan;

- Dependent coverage for your class of eligible associates ceases before your death; or
- Required contributions, if any, stop.

If health expense coverage is being continued for your dependents, your child born after your death will also be covered.

Coverage may be retroactively terminated if you or a family member commits fraud or makes an intentional misrepresentation of a material fact, subject to 30-day advance notice and an opportunity to appeal. Please note that identifying anyone as an eligible dependent when they are not will be treated as an intentional misrepresentation of a material fact and a falsification of employment records subject to disciplinary action up to and including termination of employment.

If coverage for you or your dependents ends, some or all of you may qualify for continued coverage under COBRA. For more information about qualifying for and electing COBRA coverage, see *COBRA* on page 204.

Double Medical, Prescription Drug, Dental Coverage

If you or your dependents are covered under Honda's healthcare plan as secondary and also participate in another non-Honda plan (your spouse's, for example) as primary, the two plans together will not pay more than what Honda would have paid if Honda was primary. Honda's benefits are coordinated with:

- Other group coverage (insured and non-insured); and
- No-fault automobile insurance or other liability insurance, including any type of medical coverage available under any automobile insurance.

When Automobile Insurance Is Primary…

Medical coverage available under any automobile insurance (for example, to cover expenses incurred due to a car accident) is always considered the primary plan.

If you have this double coverage:

- One plan is considered primary and pays benefits first under its provisions.
- The other plan is considered secondary and may pay for remaining expenses second under its provisions.

Medical coverage available under any automobile insurance (for example, to cover expenses incurred due to a car accident) is always considered the primary plan, except in the following situation: Honda's healthcare plan is considered primary to medical coverage available under any automobile insurance on a vehicle owned by Honda.

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

If Honda's 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 Honda's plan to cover any remaining expenses. If the expense is not covered in full by the primary plan, Honda's plan may pay the amount normally reimbursed minus the amount paid or payable by the primary plan. Under the coordination of benefits provision of Honda's plan, the amount normally reimbursed under this plan is reduced to consider payments made by "other plans."

Neither plan will pay more than its plan limits for expenses. A plan without these benefits coordination rules is always primary. If both plans have these rules:

- Your plan is primary for covered expenses for you.
- Your spouse's plan is primary for covered expenses for him or her.

For example, if you and your spouse are covered under each other's plans, the following applies.

If the Claim Is for…	This Plan Is Primary	This Plan Is Secondary
You	Honda's plan	Spouse's plan
Your spouse	Spouse's plan	Honda's plan

If you and your spouse both cover your children, the primary plan for them is determined by the birthday rule. This means that your children's primary coverage is that of the parent whose birthday occurs earlier in the plan year. For example, if your birthday is April 1 and your spouse's birthday is October 1, the Honda plan is primary for your children.

If you are divorced or separated, a court decree may establish financial responsibility for the children's healthcare coverage. If so, the parent who is responsible for healthcare coverage has the primary plan. If it is not specified, coverage is provided in the following order by the plan of the:

1. Parent with custody;
2. Stepparent married to the parent with custody;
3. Parent without custody; and then
4. Stepparent married to the parent without custody.

If it is found that the child(ren) has duplicate Honda coverage (or through an affiliate of Honda), the parent whose birthday falls first in the calendar year will cover the child(ren).

If both parents have the same birthday, the benefits of the plan that covered one parent longer are considered primary and are determined before those of the plan that covered the other parent for a shorter period.

In addition, the other plan's rule will determine the order of benefits if, as a result, the plans do not agree on the order of benefits.

Please note that if you and your spouse are both employed by Honda or an affiliate of Honda, each of you can only be covered by one of each type of benefits plan. In addition, dependents of Honda associates can only be covered by one associate's benefits plan. If it is found that the child(ren) has duplicate Honda coverage, the parent whose birthday falls first in the calendar year will cover the child(ren).

When Honda's plan is secondary and other coverage is primary, Honda's benefits are coordinated with benefits the covered person is eligible to receive. This applies whether or not benefits are actually paid through the other coverage.

Examples

For these examples, let's assume that:

- You participate in the HSA Plan (see *Medical Plan* on page 88 for information) and you have met your deductible.

- Your spouse has an in-network claim for an X-ray.
- The cost of the X-ray is $75.
- The X-ray is covered at 90% (in-network) under Honda's medical plan and 60% under XYZ company's plan.

Example #1

Let's say that you choose to cover your spouse and child under Honda's plan. Your spouse does not have coverage from his or her employer. This means that Honda's plan is primary.

- As the primary plan, Honda's plan pays $67.50, which is 90% of the cost of the X-ray (in-network level of benefits).
- Since your spouse does not have other healthcare coverage, you are responsible for paying the remaining amount, which is $7.50.

Amount Paid by Honda's Plan (Primary)	Amount Paid by Spouse's Plan (Secondary)	Total Paid by Plan(s)	Amount You Are Responsible for Paying
$67.50	N/A	$67.50	$7.50

Example #2

For another example, let's say that your spouse works for XYZ company and has primary coverage. You work for Honda and the Honda plan is your spouse's secondary coverage.

- Since your spouse's plan is primary, it pays benefits first. According to its limits, it pays $45, or 60% of the cost.
- Then, Honda's plan pays $22.50, which brings the total it pays up to its plan limit of 90%.
- The combined total amount paid by both plans is $67.50.

Amount Paid by Spouse's Plan (Primary)	Amount Paid by Honda's Plan (Secondary)	Total Paid by Plan(s)	Amount You Are Responsible for Paying
$45.00	$22.50	$67.50	$7.50

Important Note About Coordination of Benefits

In general, 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, except when the coordination of benefits rules of this plan and any "other plan" both consider this plan primary.

A "processed claim transaction" is a group of actual or prospective charges submitted to your claims administrator for consideration, which have been grouped together for administrative purposes as a "claim transaction" in accordance with your claims administrator's current rules. If the plan includes both medical and dental coverage, those coverages will be considered separate plans. The medical/pharmacy coverage will be coordinated with other medical/pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

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

Coordinating Benefits with Medicare

When you or your dependents are eligible for Medicare, the Honda medical, prescription drug and dental plans are primary for each of you as follows:

- While you are actively employed by Honda; or
- During a covered person's first 30 months of end-stage renal disease treatment.

In these cases, Medicare must be secondary. However, a covered person may elect to end Honda coverage and have Medicare coverage alone. For information, contact Quantum Health at **1-866-778-5885**.

When your active employment ends, Medicare coverage becomes primary for you and any Medicare-eligible dependents. For purposes of coordinating benefits with Medicare, your active employment ends when you retire or terminate employment. Medicare is also primary *after* 30 months of end-stage renal disease treatment. In addition, if you are disabled for more than six months and have Medicare, Medicare is primary.

When Medicare is primary and Honda coverage is secondary, Honda benefits are coordinated with Medicare Part A and Part B benefits that the covered person is eligible to receive. This applies whether or not the benefits are actually paid by Medicare.

Medical, Prescription Drug and Dental Plan Rights

The medical, prescription drug and dental plans have certain rights that allow the plans to be administered properly. All three plans have rights to:

Information. The plans 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 plans may recover payments (from persons, including you, or plans) that exceed Honda plan provisions for benefits provided on your or your dependent's behalf. To recover the payments, the plans will request that funds be returned. The plans reserve the right to deduct or offset any amounts not recovered from pending or future claims. This includes, but is not limited to, situations where the plan has made payments on behalf of your ineligible dependent.

Make direct payment. The plans may directly reimburse other plans or persons (such as service providers) for any amounts payable by the plan.

Set rules for subrogation and right of recovery. These provisions apply when the Honda Health & Welfare Benefits Plan, which includes the medical, prescription drug and dental plans, 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.

Definitions That Apply to Subrogation/Right to Recovery

Responsible Party

This means any party actually, possibly or potentially responsible for making any payment to a covered person because of the covered person's injury, illness or condition. The term "responsible party" includes the liability insurer of the responsible party or any insurance coverage.

Insurance Coverage

This 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.

Covered Person

This 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 benefits under this plan, the plan will be subrogated to (i.e., 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 the covered person because of the 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 that is owed to the plan.

Constructive Trust

By accepting benefits from the plan (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider), 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 constitute 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 will 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, the responsible party, the responsible party's insurer, representative or agent, and/or any other source possessing funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or 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.

First-Priority Claim

By accepting benefits from the plan (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider), 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. This plan will 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 that 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 will 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 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 will 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 will 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 or the institution of court proceedings against the covered person. The covered person will 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 and the claims administrator have the right to conduct an investigation regarding the injury, illness or condition to identify any responsible party. The plan reserves the right to notify the 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 will have the authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the plan (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider), 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.

Medical and Prescription Drug Claims Administrators

For the HSA and PPO Plans, Quantum Health decides medical claims for services that require pre-certification (e.g., pre-service medical claims). UMR or Blue Cross Blue Shield of Alabama (BCBS-AL) decides initial claims when pre-certification is not required. CVS/Caremark decides prescription drug claims. For the HMO Plan, Kaiser Permanente decides medical and prescription drug claims.

Quantum Health, UMR, BCBS-AL, Kaiser and CVS/Caremark (as named fiduciaries) have discretion to determine all questions arising in the administration, interpretation and application of the medical and prescription drug plans. Quantum Health, UMR, BCBS-AL, Kaiser and CVS/Caremark will endeavor to act, whether by general rules or by particular decisions, so as to treat all persons in similar circumstances uniformly. Their interpretations and determinations are final and binding on all persons absent fraud or the arbitrary and capricious abuse of the wide discretion granted to Quantum Health, UMR, BCBS-AL, Kaiser and CVS/Caremark. In interpreting and applying the medical and prescription drug plans, Quantum Health, UMR, BCBS-AL, Kaiser and CVS/Caremark may consider the advice of experts of their own choosing and generally accepted medical practices.

Administrative details and procedures for appealing a claim can be found in *Administrative Information* on page 316.

Medical Care

The following section gives you information about what to do when you need certain types of medical care. Some medical services require pre-certification.

For the HSA and PPO Plans, reference your medical/prescription ID card or call Quantum Health at **1-866-778-5885**. For the HMO Plan, reference your medical/prescription ID card or call the Kaiser Member Service Contact Center:

- Kaiser California: **1-800-464-4000**
- Kaiser Georgia: **1-888-865-5813**
- Kaiser Northwest: **1-800-813-2000**

If You Need to See a Doctor…

In-Network Providers

- Verify the physician you are seeing is an in-network provider by checking **myhondaconnect.com** or the online directory on your claims administrator's website (**umr.com**, **bcbsal.com** or **kp.org**) under either "Find a Provider" or "Find a Doctor." You can also call Quantum Health at **1-866-778-5885**.
- Bring your medical/prescription drug ID card to the doctor's office and show it to the receptionist.
- If you are covered under the HSA Plan, your out-of-pocket expenses (network-negotiated amounts only) will be paid by you (the associate), and you can choose to pay the expenses out of your pocket or using your Health Savings Account.
- If you are covered under the PPO Plan or HMO Plan, your out-of-pocket expenses (network-negotiated amounts only) will be paid by you (the associate).
- Ask for an itemized bill from the provider if you contribute to the Healthcare Flexible Spending Account or Limited Purpose Flexible Spending Account and have chosen to opt out of auto-adjudication during enrollment.
- Receive further treatment from an in-network specialist, if necessary.

When you receive care from an in-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 (if the provider does not file the claim for you).
- File your claim promptly so you will not lose track of expenses. **You have up to 12 months (one year) after the date of service to file a claim.**
- If you are enrolled in the HSA Plan or PPO Plan, your out-of-pocket expenses will include the difference between the allowed amount and the billed charge (i.e., the balance bill), which may be significant. If you are enrolled in the HSA Plan, you can choose to pay the expenses out of your pocket or using your Health Savings Account.
- If you are covered under the HMO Plan, care received outside your plan's network will not be covered, except in a medical emergency.
- If you participate in the Healthcare Flexible Spending Account (FSA) and have elected to opt out of streamlined submission, file your claim after you receive an Explanation of Benefits (EOB) for the claim. You have until March 31 of the following year to submit claims for eligible expenses incurred in the prior calendar year.

If You Need Surgery…

Always ask your doctor about outpatient surgery or other alternatives to treat your condition before you undergo surgery. Then, notify Sedgwick (your Company-paid short-term disability claims administrator) and your supervisor if you are going to be away from work.

In-Network Providers

- If you are covered under the HSA Plan or PPO Plan, call Quantum Health at **1-866-778-5885**. Failure to pre-certify non-emergency surgery will result in penalties and/or non-payment of claims.
- If you are covered under the HMO Plan, call
  - Kaiser California: **1-800-464-4000**
  - Kaiser Georgia: **1-888-865-5813**
  - Kaiser Northwest: **1-800-813-2000**
- Reduce your costs by using an in-network surgeon.

Out-of-Network Providers

- If you are covered under the HSA Plan or PPO Plan, call Quantum Health at **1-866-778-5885** to pre-certify your care in advance. Failure to pre-certify non-emergency surgery will result in penalties and/or non-payment of claims.
- If you are covered under the HMO Plan, care received outside your plan's network will not be covered, except in a medical emergency.
- File medical and Healthcare FSA claims promptly.

If You Need Hospitalization…

Notify Sedgwick (your Company-paid short-term disability claims administrator) and your supervisor that you are going to be away from work and for how long. Also, bring your medical/prescription ID card to the hospital. The hospital will usually file a claim directly with UMR, BCBS-AL or Kaiser for your hospital expenses. Then, you will receive a bill for your share of the costs, if applicable.

In-Network Providers

- Confirm that your hospital is an in-network hospital. This way, you will reduce your costs.
- If you are covered under the HSA Plan or PPO Plan, call Quantum Health at **1-866-778-5885** to certify your hospital admission and length of stay.
- If you are covered under the HMO Plan, call the Kaiser Member Service Contact Center for the complete list of services that require pre-certification and the criteria that are used to make authorization decisions:
  - Kaiser California: **1-800-464-4000**
  - Kaiser Georgia: **1-888-865-5813**
  - Kaiser Northwest: **1-800-813-2000**
- Remember, if you do not go to an in-network hospital, your benefits will be paid at the out-of-network level unless it is an emergency.

Out-of-Network Providers

- If you are covered under the HSA Plan or PPO Plan, call Quantum Health at **1-866-778-5885** to certify your hospital admission and length of stay.

- If you are covered under the HMO Plan, care received outside your plan's network will not be covered, except in a medical emergency.

If You Have a Medical Emergency…

- If you have a medical emergency, go to the nearest emergency room.
- Bring your medical/prescription drug ID card to the hospital whenever possible. The hospital will usually file a claim directly with your 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.

Keep in Mind

- A "medical emergency" is defined as an acute and severe medical condition, including, but not limited to, severe pain that 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;
- Serious impairment to bodily function;
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

If You Have an Urgent Medical Issue…

- If you are unsure of the best source for care, call your family physician.
- If you cannot reach your physician, you can contact Teladoc at **1-800-Teladoc (1-800-835-2362)** or seek care at a retail clinic or urgent care facility.

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Connect to Your Wellbeing

The *Connect to Your Wellbeing* Program provides you and your eligible spouse with the tools and resources needed to help you improve your total wellbeing—physically, financially and emotionally. This program includes a number of activities that, when completed, enable you to earn the medical plan incentive as well as additional rewards. The *Connect to Your Wellbeing* Program is part of your benefits package. There is no cost for you to participate and participation is voluntary. What you may gain is invaluable: enhanced wellbeing for you and your family.

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Eligibility

Associates

All active U.S. Honda associates are eligible to participate in the *Connect to Your Wellbeing* Program. If an associate is on assignment outside of the U.S., he or she is not eligible to participate in the program.

Spouses

All spouses covered as primary or secondary on Honda's medical plan are eligible to participate in the *Connect to Your Wellbeing* Program.

How the Program Works

Complete Challenges for Points

You and your covered spouse (if applicable) can complete wellbeing challenges that encourage a healthy lifestyle. They range from general physical activities to important health checks (like a health assessment or biometric screening). For each challenge you complete, you can earn points. The more challenges you complete, the more points you earn, which leads to rewards. A full list of challenges can be found on the *Connect to Your Wellbeing* website at **wellbeing.honda.com**.

Achieve Rewards for Continued Participation

There are three levels through continuous participation with which you can achieve rewards in the *Connect to Your Wellbeing* Program. You will receive rewards as you progress in the program. Don't forget that if your spouse is covered on your medical plan, he or she can also earn points and rewards, too.

Level*	Activities	Rewards
Level 1 – Seek	Required activities communicated annually. May include items such as a: • Health assessment • Biometric screening • Preventative exam	Medical plan incentive for the following calendar year
Level 2 – Strive	Complete additional wellbeing challenges to earn points	Reward
Level 3 – Soar	Complete additional wellbeing challenges to earn points	Reward

*The number of points needed to complete each level may change periodically. Visit **wellbeing.honda.com** for the current numbers.

Health Assessment

A health assessment is a great first step toward being a better you because it provides you with a personalized overview of your total wellbeing based on your responses. It identifies your areas of strength, as well as areas that you could focus on—giving you a solid starting road map to better yourself.

Your results are for your information and do not affect your eligibility for healthcare benefits. Honda does not receive associate and/or spouse personal information through the *Connect to Your Wellbeing* Program. See "Access to Personal Health Information" on page 87 for more details.

Preventive Exam

Regular health exams can prevent diseases, detect problems in their early stages and increase your chances of living a healthy and happy life. A preventive exam could be anything from a physical, a mammogram, a vision checkup, or a dental exam. Choose an exam that is appropriate based on your age and gender and aligns with your doctor's recommendations. Age- and gender-appropriate preventive care is covered at 100% under the Honda medical plan.

See the covered preventive exams under your medical, dental or vision plan and/or talk to your primary care physician to schedule the exam that best meets your needs.

Biometric Screenings

Getting a biometric screening is a great way to get a picture of your current health and identify potential problems before they start. There are only three ways to get credit for the biometric screening:

- Attend a free on-site biometric screening at your location;
- Visit your doctor and submit the Physician Fax Form; or
- Visit a LabCorp Patient Center with your printed voucher.

Complete details, forms and vouchers are available on **wellbeing.honda.com**.

Additional Wellbeing Challenges

Connect to Your Wellbeing offers a variety of wellbeing challenges to help you improve your physical, financial and emotional wellbeing. Each tile that you will see on the **wellbeing.honda.com** home page is what we call a wellbeing challenge. The wellbeing challenges are a great way for you to achieve your goals and earn points along the way. Some are available all year long, while some change on a quarterly basis.

Lifestyle Management and Coaching

You can participate in weekly webinars or one-on-one coaching sessions. You can earn points by participating in any of the coaching programs. Topics vary from nutrition to learning how to make positive life changes. Learn more at **wellbeing.honda.com**.

Learn More in Wellbeing Mailers

- Wellbeing mailers are sent out to provide updated information about the *Connect to Your Wellbeing* Program. The mailers include information such as:
- Since on-site screenings are limited due to COVID-19, new ways to earn points are described.
- Covered spouses are required to participate and achieve **Level 1 – Seek** to earn the medical plan incentive. Spouses who do not have a Social Security number can use their Tax Identification Number to participate in the program.

Programs to Help Manage Diabetes and Weight Loss

Honda offers you access to Livongo, a company dedicated to helping its qualified participants manage their diabetes by providing a free smart glucometer, unlimited testing supplies (such as test strips) and smart monitoring analytics. On-call coaching is available 24 hours a day, 365 days a year.

To help you lose weight, you also have access to Omada, a digital behavior change program. Omada can help qualified participants lose weight and reduce their risk for chronic disease using a smart scale, food tracking and step counting, as well as coaching from a registered dietitian.

Note: HMO participants have access to Omada but must request access through their primary care physician. They can also enroll in Kaiser's care management programs.

Visit the *Connect to Your Wellbeing* website at **wellbeing.honda.com** to find out if you're eligible. You can also visit **myhondaconnect.com** and click the "Connect to Your Wellbeing" tile.

Wellbeing Rewards

Medical Plan Incentives—Reduced Medical Plan Contributions

If you complete **Level 1 – Seek** by the program deadline, you can lower your medical plan contributions for the following calendar year's medical plan. If your spouse is covered under your medical plan (as either primary or secondary), he or she must also complete **Level 1 – Seek** by the program deadline in order for you to earn the medical plan incentive for the following year.

New hires are automatically eligible for the medical plan incentive during the calendar year in which they are hired.

Medical Plan Incentive Impact When Adding a Spouse to the Plan Mid-Year

Scenario	Current Calendar Year Incentive	Following Calendar Year Incentive
Add a spouse to your medical plan prior to October 1	No impact	Spouse must participate in the wellbeing program to earn the medical plan incentive
Add a spouse to your medical plan on or after October 1	No impact	No impact (spouse can participate to earn the incentive in following years)
Add a spouse during Benefits Enrollment	N/A	No impact

If you add your spouse to your medical plan with an effective date of coverage before October 1, both you and your spouse must complete **Level 1 – Seek** to earn the medical plan incentive for the following calendar year. There is no impact on the medical plan incentive for the current year. If you were already receiving the medical plan incentive for the current year, that will continue through the duration of the current year.

If you add your spouse to your medical plan with an effective date of coverage after October 1, only the associate needs to complete **Level 1 – Seek** to earn the medical plan incentive for the following year. There is no impact on the current year.

If you add a spouse to your medical plan during Benefits Enrollment, it will not impact your medical plan incentive for that plan year. However, your spouse will need to participate in order to earn the incentive in following years.

For current medical plan incentive information, visit **myhondaconnect.com** and click the "Health & Insurance" tile.

Additional Rewards

Additional rewards are offered at the completion of **Level 2 – Strive** and **Level 3 – Soar**. All rewards outside of the medical plan incentive are considered taxable income. As the associate, you are responsible for taxes owed on your rewards, as well as your spouse's rewards (if applicable).

Access to Personal Health Information

All personally identifiable information shared with the *Connect to Your Wellbeing* Program provider is private, secure and not provided to Honda.

The *Connect to Your Wellbeing* Program is managed by a third-party provider. The provider offers services on behalf of Honda's group health plans. Therefore, any information provided becomes legally protected health information under the Health Insurance Portability and Accountability Act (HIPAA) and is not shared with Honda.

Levels completed and points earned will be reported to Honda for purposes of administering the medical plan incentive and processing taxes on the additional rewards. Other than that, Honda will only receive summary data from the provider and its other healthcare providers to better understand the health status of associates and eligible spouses.

Honda is committed to helping you achieve your best health. Rewards for participating in the wellbeing program are available to all associates. If you think you might be unable to meet a standard for a reward under the wellbeing program, you might qualify for an opportunity to earn the same reward by different means. Contact the vendor through ***wellbeing.honda.com*** *and the provider will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status*.

Medical Plan

The medical plan helps you pay for covered medical care and protects you from the financial impact of catastrophic expenses.

For More Information
Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

Highlights

Options	Honda offers you up to three medical options: • The Health Savings Account (HSA) Plan • The Preferred Provider Organization (PPO) Plan • The Health Maintenance Organization (HMO) Plan You also have the option to waive coverage. **Note:** As of January 1, 2021, the HMO Plan has become a grandfathered plan and is available only if you were enrolled in the HMO Plan in 2020. If you enroll in a different plan after 2020, the HMO Plan will no longer be available to you in the future. The HMO Plan is not available to new participants.
Cost Per Pay	Honda pays for the majority of the cost of coverage, and you share a portion of the cost through convenient payroll deductions.
Who Is Covered	Eligible associates and their eligible dependents
Coverage Begins	First day of the month following your date of hire, if you are eligible for coverage
About This Benefit	The HSA Plan and PPO Plan are administered by either UMR (a division of UnitedHealthcare company) or Blue Cross Blue Shield of Alabama (BCBS-AL), depending on your home zip code. The HMO Plan is administered by Kaiser Permanente. • You can receive care from in-network or out-of-network providers under the HSA and PPO Plans. Your share of the costs will generally be lower if you use in-network providers. • You generally receive care only from in-network providers with the HMO Plan. There is generally no out-of-network coverage with the HMO Plan, except in a medical emergency.

Highlights

Plan Features	• The **HSA Plan** offers a network of healthcare providers and a higher level of coverage when you see an in-network provider. It also gives you the opportunity to open a tax-advantaged Health Savings Account (HSA), which offers more control over how you spend and save your healthcare dollars. Honda makes a contribution to your Health Savings Account. You also have the option to contribute. You own your HSA and the funds roll over year to year. • The **PPO Plan** offers a network of healthcare providers and a higher level of coverage when you see an in-network provider. • The **HMO Plan** offers coverage only through HMO providers and hospitals. You must choose a primary care physician, who manages all your healthcare services. Except in a medical emergency, you will need a referral from your primary care physician before you can see any other healthcare professional. The plans also include the following: • **Annual deductible.** You must satisfy the annual deductible before you begin paying coinsurance. • **Coinsurance (not applicable to the HMO Plan).** Once you have met the deductible, both you and Honda share the cost of your eligible medical expenses. • **Copay (not applicable to the HSA Plan).** You pay a "copay," a flat dollar amount, for some covered expenses. • **Out-of-pocket maximum.** When you reach the out-of-pocket maximum, Honda pays 100% of any eligible medical expenses for the remainder of the calendar year.
Coverage Ends	Last day of the month your Honda employment ends or eligibility ends
Administered By	• The HSA and PPO Plans are administered by either UMR (a division of UnitedHealthcare company) or Blue Cross Blue Shield of Alabama (BCBS-AL), depending on your home zip code. • The Health Savings Account (HSA) is administered by Optum Bank. • The HMO Plan is administered by Kaiser Permanente.

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Who Is Eligible

Eligibility for you and your dependents is defined in *Participating in Health Benefits* on page 68.

Your Cost

Honda pays for the majority of the cost of coverage, and you share a portion of the cost through convenient payroll deductions. You can lower your medical plan contributions by participating in the *Connect to Your Wellbeing* Program. If you choose to cover a spouse who is eligible for coverage through his or her employer, you may also pay an additional spousal contribution. Associates are responsible for any required copay, deductible and/or coinsurance amounts.

Save on Medical Contributions
Read Connect to Your Wellbeing *on page 83 for more information about steps you can take to reduce your medical plan contributions for the following year.*

Spousal Contribution for the Medical Plan

If you choose to cover an eligible spouse* under *primary* coverage through Honda's medical plan and your spouse has access to coverage through his or her employer, you may be responsible for a spousal contribution (subject to change in future plan years). If your spouse obtains medical/prescription coverage from his or her employer as his or her primary plan, you may continue coverage for him or her under the Honda plan with secondary medical/prescription coverage. Please see *Participating in Health Benefits* on page 68 for more information about medical/prescription drug benefits for spouses under secondary coverage.

If you choose to cover your spouse as primary under Honda's plan, this contribution will be deducted from your paycheck unless you are eligible to *waive* the contribution because your spouse is:

- Covered under Honda's plan as secondary and his or her employer's plan as primary;
- Not eligible for coverage through his or her employer;**
- Not employed;
- Self-employed with no access to coverage as a result of the business; or
- A Honda associate*** covered under Honda's plan as a dependent.

*Spouse is defined as a legally married spouse and not legally separated.

**When a spouse is considered "not eligible," it means that based on his or her status as an employee (e.g., part-time/seasonal), he or she is not eligible for healthcare coverage. When the company offers coverage to the spouse but there are restrictions that define when he or she can enroll, the spouse is still considered eligible for healthcare coverage and you do not have a reason to waive the spousal contribution.

***Honda associate: Someone who is directly employed by a Honda company or Honda affiliate in the U.S. Control Group. If you need to verify whether your spouse's employer is a Honda affiliate, please contact the My Benefits Connect Center at **1-866-778-5885**.

This will be a pre-tax deduction, and it will apply regardless of the cost for coverage or type of coverage that is offered to your spouse by his or her employer. This type of contribution provides you with a choice of where to obtain primary coverage for your spouse and ensures that Honda can continue to provide valuable and affordable coverage for all associates and spouses who need it.

What Is Primary Versus Secondary Medical Coverage?

- If your spouse has access to coverage through his or her employer, he or she can enroll in the employer plan as primary and maintain Honda's plan as secondary. This means you can waive the spousal contribution. Primary coverage simply means that claims for medical services are submitted to that plan first. If he or she also has Honda's plan as secondary coverage, claims are submitted to Honda's plan after the primary plan has processed the claim. Honda's plan will pay up to its plan limits.

When Coverage Begins

When coverage begins is described in *Participating in Health Benefits* on page 68.

How the Medical Plans Work

Honda offers eligible associates the medical plans described in this section of the Summary Plan Description (SPD).

- The Health Savings Account (HSA) Plan
- The Preferred Provider Organization (PPO) Plan
- The Health Maintenance Organization (HMO) Plan (available through Kaiser Permanente in California, Georgia and Oregon)

Can you Enroll in the HMO Plan?

The HMO Plan is not available to new participants. You can only enroll in the HMO Plan if you were enrolled in it in 2020. If the HMO Plan is available to you but you enroll in a different plan, the HMO Plan will not be available to you in the future.

Or, you can waive coverage. Please note that if you waive coverage, generally, you will not be able to elect coverage until the next Benefits Enrollment period or within 31 days (or 60 days for birth, adoption or placement for adoption) of a qualified life event (see *Life Events* on page 8). **Honda assumes that if you waive coverage, you have other coverage elsewhere.**

You will receive a new medical/prescription drug ID card only when you change medical plan options or provider networks. If you stay in the same medical plan year over year, you can use the same ID card you used during the previous year(s).

Your Choice: In-Network and Out-of-Network Providers

Depending on your home zip code, the HSA and PPO Plans are administered by either UMR or Blue Cross Blue Shield of Alabama (BCBS-AL), which manages the provider network, monitors how care is delivered and negotiates special rates for care. You have a choice each time you need care:

- You can receive care from in-network providers; or
- You can receive care from out-of-network providers.

With the HSA and PPO Plans, your share of the costs will generally be lower if you use in-network providers because your costs are based on lower, negotiated rates and you pay a smaller percentage of the costs. An out-of-network provider may balance bill you for the difference between a billed charge and the allowed amount and the difference can be significant. However, for most services, you are free to use out-of-network providers if you choose.

In addition, while there are many benefits to choosing a regular family doctor who can coordinate all your healthcare needs, the plans allow you to receive care from any in-network provider without a referral and receive the negotiated rates.

Network Provider Information

For information about in-network providers, if you are enrolled in the HSA Plan or PPO Plan, contact Quantum Health at ***1-866-778-5885*** *or* ***myhondaconnect.com****.*

If you are enrolled in the Kaiser HMO Plan, call:

- *Kaiser California:* ***1-800-464-4000***
- *Kaiser Georgia:* ***1-800-865-5813***
- Kaiser Northwest: **1-800-813-2000**

Note: If your plan is administered by BCBS-AL, not all providers participating in the BlueCard PPO Program will be recognized by Blue Cross Blue Shield of Alabama as approved providers for the type of service or supply being furnished. Call Quantum Health at **1-866-778-5885** if you have any question whether your provider is approved for the services or supplies you plan on receiving.

The Health Savings Account (HSA) Plan

The Health Savings Account (HSA) Plan provides comprehensive healthcare coverage, as well as a Health Savings Account, which allows you to set aside tax-free money for eligible expenses (see more details in “Eligible Expenses” on page 98), while also receiving a contribution from Honda. Money in your Health Saving Account rolls over from year to year, allowing you to save for future healthcare expenses.

How the HSA Plan Works

The following chart shows how the plan *generally* works. For specific details about deductibles, coinsurance amounts and out-of-pocket maximums, see “HSA Plan Structure” on page 94.

Health Savings Account	• Honda makes an annual contribution to your Health Savings Account. • The amount of Honda’s contribution depends on your level of coverage (individual or family). If you are hired after January 1 of a given year, Honda’s regular annual contribution will be prorated based on your date of hire.

	• If you enroll as a new hire after January 1, you may still be able to contribute the maximum HSA contribution set by federal regulations. See "How the Health Savings Account Works" on page 95 for more information. • Your Health Savings Account balance will roll over year to year.
Healthcare Utilization	• During the calendar year, you and your family choose how to use the dollars in your Health Savings Account. • As you incur medical and prescription drug expenses, you can choose to either pay for the expenses with the money in your Health Savings Account or pay out of pocket.
Deductible*	• Before the plan begins to pay a percentage of the cost of care, you must pay a deductible. • This means you pay 100% of your non-preventive medical and prescription drug expenses until you have reached your deductible amount.* • The amount of your deductible depends on your coverage level (individual or family) and whether service was received in-network or out of network. • The total family deductible must be met before the plan covers any expenses. No one family member's expenses are capped at an individual deductible amount.
Coinsurance	• After you have met the deductible, both you and Honda share the cost of your eligible medical and prescription drug expenses, until the total you have paid for eligible medical and prescription drug expenses for the year reaches an out-of-pocket maximum amount. • The coinsurance amount depends on in-network versus out-of-network care.
Out-of-Pocket Maximum	• The out-of-pocket maximum depends on your coverage level (Associate Only or Family) and whether the service was received in-network or out-of-network and *includes* your deductible.
After Out-of-Pocket Maximum Reached, Honda Pays 100% of Costs	• After you reach the out-of-pocket maximum, Honda pays 100% of any eligible medical and prescription drug expenses for the remainder of the calendar year. • The out-of-pocket maximum provides a limit to what you pay for eligible medical and prescription drug expenses during the year and safeguards you against a catastrophic claim.

*The deductible may be waived for some drugs. Some exclusions apply. Please see *Prescription Drug Plan* on page 169.

HSA Plan Structure

Your annual deductible, out-of-pocket maximum and Health Savings Account contribution depend on your coverage level (Associate Only or Family). If enrolled under family coverage, the family deductible and out-of-pocket maximum can be satisfied by an individual or any combination of family members. Deductible and out-of-pocket amounts are applied to both the in-network and out-of-network deductible and out-of-pocket maximum accumulation.

Coverage Level	Annual Health Savings Account Contribution (paid by Honda)*	Deductible (paid by associate)—Applies to Medical and Prescription Drug		Coinsurance (paid by Honda and associate)		Out-of-Pocket Maximum (includes deductible)—Applies to Medical and Prescription Drug	
		In-Network	*Out-of-Network***	*In-Network*	*Out-of-Network***	*In-Network*	*Out-of-Network***
Individual	$900	$1,500	$3,000	90% Honda; 10% associate	70% Honda; 30% associate	$3,000	$6,000
Family	$1,800	$3,000	$6,000			$6,000	$12,000

*If you are hired after January 1 of a given year, Honda's regular annual contribution will be prorated based on your medical plan eligibility date.

**Based on the allowed amount. If an out-of-network provider bills more than the allowed amount, you are responsible for paying the difference, which may be significant.

How the Health Savings Account Works

Additional Health Coverage
Honda pays 100% for annual routine preventive care provided by an in-network provider.

The Health Savings Account is a tax-advantaged savings account that can be used to pay for certain qualified healthcare (medical, prescription drug, dental and vision) expenses on a pre-tax basis. Honda encourages associates and family members to get annual physicals, immunizations and recommended preventive tests as a way to stay healthy. Honda pays 100% for annual routine preventive care services when you use an in-network provider.

With a Health Savings Account, you can save taxes by:

- Making pre-tax contributions to your Health Savings Account (which lowers your taxable income);
- Earning tax-free interest on the money in your Health Savings Account; and
- Withdrawing funds that are free of federal and, in most areas, state income tax, to pay for eligible healthcare expenses.

Administered by Optum Bank, the Health Savings Account is only available to associates enrolled in the HSA Plan and who meet eligibility requirements.

Highlights of the Health Savings Account:

- Honda will deposit money into your Health Savings Account. This is money you can use to pay for eligible healthcare expenses.
- You also have the option to contribute to your Health Savings Account with before-tax deductions from each paycheck (lowering your taxable income).
- You can use the money now to pay for eligible healthcare expenses tax-free, or you can save your money to cover future eligible healthcare expenses because money in the account rolls over from year to year.
- You own the account—all the money in your Health Savings Account is yours to keep, including any interest or earnings. This means you take the account with you, including any contributions from

Honda, if you leave or retire from Honda. The remaining funds are available for all qualified healthcare expenses regardless of your plan choice.

- Once you reach a balance of $2,100 ($2,000 minimum cash account balance plus $100 minimum investment amount), you have the option to invest some of your balance and potentially grow your account with tax-free earnings. You must maintain a minimum cash account balance of $2,000 to continue investing. When you access your HSA account online at **optumbank.com**, Optum Bank will notify you when you log in if you have reached the threshold and are eligible to invest funds. For any questions about your HSA, contact Optum Bank Customer Service Support at **1-866-234-8913** or the My Benefits Connect Center at **1-866-778-5885**.

Health Savings Account Contributions

Honda will make a contribution to your Health Savings Account upon enrollment and activation of your account provided you are an eligible associate. The Honda contribution amount will vary based on your coverage tier as follows:

	Associate Only Coverage	Family Coverage
Annual Contribution	$900	$1,800

Note: Amount and timing of Honda's contributions may change in future years.

If you are newly hired after January 1, the Honda annual contribution is prorated and deposited as soon as is administratively possible after you are eligible for the medical plan.

All benefits-eligible associates can enroll in the HSA Plan. However, you ***are not eligible to make or receive Health Savings Account contributions if you are***:

- Enrolled in another medical plan (such as your spouse's/domestic partner's plan), unless it is a qualified high deductible health plan;
- Enrolled in Medicare or Tricare;
- Eligible to be claimed as a dependent on another individual's tax return;
- Not a U.S. resident;
- A veteran and have received veterans' benefits within the last three months;
- Active military; or
- Enrolled in a general purpose Healthcare FSA (enrollment in a Limited Purpose FSA is permissible).

There are limits on how much you and Honda, together, can contribute to your Health Savings Account. **Please refer to irs.gov to see current IRS limits.**

All funds placed into your Health Savings Account are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee. Honda does not sponsor or maintain your Health Savings Account.

If you enroll in your Health Savings Account within the year (not on January 1), you will still be allowed to contribute the maximum amount set by federal regulations based on the coverage tier you are enrolled in on December 1. However, you must remain enrolled in a high deductible health plan from December 1 through December 31 of the following year (13 months) or you will be subject to tax implications and an additional tax of 10%.

For example, if you are enrolled in a high deductible health plan with Associate Only coverage on December 1, 2020, and you enroll in your Health Savings Account on February 1, 2021, you can still contribute the maximum amount to your Health Savings Account for 2020. However, you must remain

enrolled in the high deductible health plan from December 1, 2020 through December 31, 2021, to avoid being subject to tax implications, as well as to avoid the additional 10% tax.

Note: Amounts that exceed the contribution maximum are not considered tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15 of the following year.

Contributions for Mid-Year Enrollees

The amount that you can contribute in a calendar year is dependent on whether or not you will remain eligible for a Health Savings Account and enrolled in a Health Savings Account-compatible plan (e.g., a high deductible health plan) for the 13 months measured from the December for the year in which the election is made through the end of the following December.

- You are eligible to contribute the full IRS maximum for the current tax year if you are enrolled by December 1 and remain eligible for Health Savings Account contributions for the next 13 months. This means you have to remain covered by a high deductible health plan for the next 13 months. If you become ineligible during the 13-month period (e.g., enroll in a non-Health Savings Account-compatible health plan, such as a Preferred Provider Organization Plan (PPO) or any non-high deductible health plan through your spouse), the prorated portion of the contributions that you made for the months that you were not covered by a qualified high deductible health plan will become taxable and you may be subject to an additional penalty tax.
- If you will not be enrolled in a Health Savings Account-compatible plan for the 13 months following December 1 of a given year, you will be eligible to contribute to your Health Savings Account on a prorated basis for the months that you are eligible to contribute within the current tax year. Remember that this prorated maximum includes both the Honda contribution and your personal contribution. Example: Sal has single HSA coverage for the first eight months of the calendar year. At age 45, Sal's maximum annual HSA contribution is $2,400 ($3,600 / 12 x 8).
- Eligible individuals enrolling in a Health Savings Account-compatible plan between December 2 and December 31 are not eligible to make Health Savings Account contributions on a tax-advantaged basis for the current tax year. Employees hired between December 2 and December 31 are not eligible for the Honda contribution for the plan year in which they are hired.

Eligible expenses include those that occur on or after the date your medical plan is effective, which occurs on the first of the month following your date of hire. For example, if you are hired on April 15 and enroll in the HSA Plan, the date of service for the eligible claims must be on or after May 1 of the same calendar year.

If Optum Bank is unable to establish the Health Savings Account for you, they will contact you to request additional information required in accordance with the U.S. Patriot Act. If they have not received anything after 45 days, they will send you a follow-up notice.

If your account is not successfully opened after approximately 60 days from the date you originally elected it, the employer funding will be returned to Honda and any future payroll deductions will be stopped. If the required documentation is not received by Optum Bank within 75 days, your pending enrollment will expire.

If your enrollment expires and you still wish to establish an Optum HSA and start payroll deductions, you must contact the My Benefits Connect Center to begin a new enrollment process.

For more information, visit **irs.gov** and see Publication 969 or contact the My Benefits Connect Center.

Flexible Spending Account Participation

- Keep in mind that IRS rules prohibit you from participating in both a Health Savings Account and a Healthcare Flexible Spending Account. Therefore, you are not eligible to participate in the Healthcare FSA if you are enrolled in the HSA Plan. You can, however, participate in the Limited Purpose FSA and Dependent Care FSA. See *Flexible Spending Accounts* on page 212 for more details.

Eligible Expenses

The funds in your Health Savings Account will be available to help you pay your or your eligible dependents' out-of-pocket costs under the HSA Plan, including annual deductibles and coinsurance. You may also use your Health Savings Account funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are considered "qualified healthcare expenses."

Please see "Additional Healthcare Expense Coverage Available with Your Health Savings Account" on page 100 for additional information. Health Savings Account funds used for such purposes are not subject to income or excise taxes.

Qualified healthcare expenses only include the medical, prescription drug, dental and vision expenses for you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to claim as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

Health Savings Account funds may also be used to pay for non-qualified healthcare expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability or your attainment of age 65).

The following are examples of qualified healthcare expenses that are covered by Internal Revenue Code Sections 213(d) and 223:

- Charges for medically necessary services not covered by another plan, including but not limited to the following:
  - Deductibles;
  - Out-of-pocket expenses;
  - Coinsurance;
  - Charges exceeding allowed amounts or usual and customary amounts;
  - Charges exceeding plan limits;
  - Prescription drug charges;
  - Other non-covered charges for qualified medical care;
  - All medically necessary prescription drugs and certain other prescription drugs permitted by the IRS (e.g., contraceptives and prenatal vitamins);
  - Eye exams, glasses (frames and lenses), contact lenses and solutions for contact lenses, lubricant eye drops, eye patches and reading glasses;
  - LASIK eye surgery;

- Dental implants;
- Dental treatment, routine dental care (cleaning, X-rays, fillings, etc.), and over-the-counter products such as toothache relief, temporary filling, denture adhesive;
- Orthodontia (braces);
- Mouth guards;
- Hearing exams, hearing aids;
- Cost differences between semi-private and private hospital rooms;
- Costs for special medical equipment installed in your home or for home improvements for purposes of medical care (e.g., ramps, support bars, railings);
- Fees for special schools on the recommendation of a physician, including schools for individuals with mental impairment, physical disabilities or severe learning disabilities;
- Transportation (amounts paid for travel primarily for, and essential to, medical care);
- Personal use items if primarily used to prevent or alleviate a physical or mental defect or illness (e.g., wigs, Braille books, hearing aids);
- Nursing services in a hospital, nursing home or your home;
- Smoking cessation programs;
- Weight loss programs (if you have a letter from your treating physician indicating medical necessity);
- Alternative medicine;
- Christian Science practitioners;
- Long-term care insurance premiums (**Note:** The tax-free reimbursement cannot exceed the annually adjusted "eligible long-term care premiums" in the Internal Revenue Code. This amount is based on age.);
- COBRA premiums;
- Medicare premiums;
- Health premiums while you are receiving unemployment insurance; and
- Retiree medical plan premiums other than for Medigap insurance.

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals;
- Routine prenatal and well-child care;
- Flu shots (if not covered by your medical plan);
- Vaccinations; and
- Child and adult immunizations.

- Screenings for conditions such as:
  - Cancer;
  - Heart and vascular diseases;
  - Infectious diseases;
  - Mental health conditions;
  - Substance abuse;
  - Metabolic, nutritional and endocrine conditions;
  - Musculoskeletal disorders;
  - Obstetric and gynecological conditions;
  - Pediatric conditions; and
  - Vision and hearing disorders.
- Over-the-counter medications, menstrual products and medical supplies (e.g., ibuprofen, tampons and bandages).

Additional Healthcare Expense Coverage Available with Your Health Savings Account

A complete description of, and a definitive and current list of what constitutes eligible healthcare expenses, is available in IRS Publication 502, which is available from any regional IRS office or at **irs.gov**.

If you receive any additional health services that are not covered under your medical plan and you have funds in your Health Savings Account, you may use the funds in your Health Savings Account to pay for the eligible healthcare expenses. If you choose not to use your Health Savings Account funds to pay for any Section 213(d) expenses that are not covered health services, you will still be required to pay the provider for services.

The monies paid for these additional healthcare expenses will not count toward your annual deductible or out-of-pocket maximum.

Using the Health Savings Account for Non-Qualified Expenses

You have the option of using funds in your Health Savings Account to pay for non-qualified healthcare expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your Health Savings Account to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability or your attainment of age 65).

In general, you may not use your Health Savings Account to pay for other health insurance, including Medicare Supplemental Plans, without incurring a tax; however, you may use your Health Savings Account to pay for COBRA premiums and Medicare Part A, B or D premiums (but only if the account holder and Medicare enrollee are age 65 or older).

The following are examples of expenses that would not qualify for a tax-free withdrawal from your Health Savings Account:

- Contributions to other employer-sponsored dental, vision and medical plans, including plans sponsored by your spouse's employer (contributions to the Company's dental, vision and medical plans are already made on a before-tax basis);

  Exceptions: COBRA premiums, Medicare premiums, health premiums while you are receiving unemployment insurance, retiree medical plan premiums other than for Medigap insurance, and certain long-term care insurance premium amounts are considered qualified expenses.

- Costs you deduct as qualified medical expenses on your federal income tax return;
- Expenses not eligible to be deducted under federal tax law;
- Expenses reimbursed by any other health plan;
- Health club membership dues;
- Cosmetic surgery (such as electrolysis, hair removal or transplants, liposuction, etc.);
- Vitamins and other dietary supplements, toiletries and cosmetics that are not medically necessary;
- Medications purchased merely to maintain you or your family's health;
- Prescription drugs that are not medically necessary and not permitted by the IRS (such as Rogaine);
- Cosmetic dental work (including bleaching, bonding and veneers);
- Undocumented travel to or from your physician's office or other medical facility; and
- Weight loss programs (unless you have a letter from your treating physician indicating medical necessity).

Portability Feature

If you do not use all of the funds in your Health Savings Account during the calendar year, you do not lose the balance remaining in your Health Savings Account. If your employment terminates for any reason, the funds in your Health Savings Account will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan.

If you elect COBRA, the Health Savings Account funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

Keep Your Receipts

- Be sure to keep your receipts and medical records. If these records verify that you paid qualified healthcare expenses using your Health Savings Account, you do not need to include the distribution from your Health Savings Account in your taxable income when filing your tax return. However, if you cannot demonstrate that you used your Health Savings Account to pay qualified healthcare expenses, you may need to report the distribution as taxable income on your tax return. Honda and Optum Bank will not verify that distributions from your Health Savings Account are for qualified healthcare expenses. Consult your tax advisor to determine how your Health Savings Account affects your unique tax situation.

- The IRS may request receipts during a tax audit. Honda and Optum Bank are not responsible or liable for the misuse by associates of Health Savings Account funds by, or for the use by associates of Health Savings Account funds for non-qualified healthcare expenses.

Investment Options

Investment options are available to those with account balances in excess of $2,100. You can learn about available investment options by calling Optum Bank customer service at **1-866-234-8913** and following the voice prompts or by visiting **optumbank.com**.

Additional Information About the Health Savings Account

It is important for you to know the amount in your Health Savings Account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a healthcare professional, Optum Bank and/or the financial institution holding your Health Savings Account funds may provide the healthcare professional with information regarding the balance in your Health Savings Account. At no time will Optum Bank provide the actual dollar amount in your Health Savings Account, but they may confirm that there are funds sufficient to cover an obligation owed by you to that healthcare professional. If you do not want this information disclosed, you must notify Optum Bank in writing.

When you enroll in the Health Savings Account for the first time, you will receive an HSA debit card with which to pay for eligible healthcare costs. Use the same card even if you change medical provider networks (e.g., UMR to BCBS-AL).

You can obtain additional information about your Health Savings Account online at **irs.gov**. You may also contact your tax advisor. Please note that additional rules may apply to a spouse's (who is an eligible individual) intent to opening a Health Savings Account.

Note: You will be charged a small administrative fee by Optum Bank if you have a balance in your Health Savings Account but are not enrolled in the HSA Plan. You can use the funds in the savings account to pay for qualified out-of-pocket expenses even if you are no longer enrolled in the HSA Plan.

The Preferred Provider Organization (PPO) Plan

The Preferred Provider Organization (PPO) Plan provides comprehensive healthcare coverage. You can receive care from an in-network or out-of-network provider.

How the PPO Plan Works

The following chart summarizes how the PPO Plan pays benefits. Some benefits from the plan are paid after you pay a calendar year deductible. You pay a specified coinsurance amount for covered expenses after you meet your deductible, which depends on whether you receive care from an in-network or an out-of-network provider. The plan also includes an annual out-of-pocket maximum. Once you meet this out-of-pocket maximum, covered expenses will be paid at 100% of the allowed amount.

For more information about coverage and plan exclusions or limits, see "Benefits/Covered Expenses" on page 105 and "Expenses Not Covered by the Plan" on page 150.

Deductible	• For some care, such as emergency room visits, you will pay the cost of care until you meet the deductible. • The amount of your deductible depends on your coverage level (Associate Only or Family) and whether service was received in-network or out-of-network.
Copay	• For some care, such as office visits, you will pay a flat dollar amount copay for a covered expense.
Coinsurance	• After you have met the deductible, both you and Honda share the cost of your eligible medical expenses, until the total you have paid for eligible medical and prescription drug expenses for the year reaches an out-of-pocket maximum amount. • The coinsurance amount depends on in-network versus out-of-network care.
Out-of-Pocket Maximum	• The out-of-pocket maximum depends on your coverage level (Associate Only or Family), whether the service was received in-network or out-of-network and *includes* your deductible and copays.
After Out-of-Pocket Maximum, Honda Pays 100% of Costs	• After you reach the out-of-pocket maximum, Honda pays 100% of any eligible medical and prescription drug expenses for the remainder of the calendar year. • The out-of-pocket maximum provides a limit to what you pay for eligible medical and prescription drug expenses during the year and safeguards you against a catastrophic claim.

PPO Plan Structure

Your annual deductible and out-of-pocket maximum depend on your coverage level (Associate Only or Family) and the provider network status where care was received. The Family amount can be satisfied by any combination of family members, but an individual would never need to satisfy more than his or her own individual amount. Deductible and out-of-pocket amounts are applied to both the in-network and out-of-network accumulation.

Coverage Level	**Deductible (paid by associate)**		**Coinsurance (paid by Honda and associate)**		**Out-of-Pocket Maximum (includes deductible and prescription drug expenses)**	
	In-Network	***Out-of-Network****	***In-Network***	***Out-of-Network****	***In-Network***	***Out-of-Network****
Associate Only	$400	$800	80% Honda; 20% associate	60% Honda; 40% associate	$3,500	$7,000
Family	$800	$1,600			$7,000	$14,000

*Based on the allowed amount. If an out-of-network provider bills more than the allowed amount, you are responsible for paying the difference, which may be significant.

The Health Maintenance Organization (HMO) Plan

The Health Maintenance Organization (HMO) Plan was grandfathered effective January 1, 2021. The current HMO Plan enrollees may continue to remain in this plan. There will be no new entrants into this plan in the future. The HMO Plan provides comprehensive healthcare coverage from the Kaiser

Permanente network of participating healthcare providers. The HMO Plan is available through Kaiser in California, Georgia and Oregon. Under the HMO Plan, you must choose a primary care physician, who manages all your healthcare services. Except in a medical emergency, you will need a referral from your primary care physician before you can see any other healthcare professional.

You have the right to designate any primary care provider who participates in the Kaiser network and who is available to accept you or your family members. If you need a specialist, you will need a referral from your primary care physician. For children, you may designate a pediatrician as the primary care provider. For information about how to select a primary care provider, and for a list of the participating primary care providers, call:

- Kaiser California: **1-800-464-4000**
- Kaiser Georgia: **1-888-865-5813**
- Kaiser Northwest: **1-800-813-2000**

You do not need pre-certification from the Kaiser HMO Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the Kaiser network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining pre-certification for certain services, following a pre-approved treatment plan or following procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the Kaiser HMO Plan.

How the HMO Plan Works

The following chart summarizes how the HMO Plan pays benefits. The HMO Plan has a small annual deductible. Once you have met your deductible, you pay a copay for specific services and/or doctor visits. Except in a medical emergency, any care received outside of the HMO network will not be covered. Therefore, it is important to know who participates in your HMO Plan's network. For example, if you go to a doctor or hospital that doesn't accept your plan, you will pay all costs. But, all covered care received at or from Kaiser-designated providers and facilities will be covered by the HMO Plan.

The plan also includes an annual out-of-pocket maximum. Once you meet this out-of-pocket maximum, covered expenses will be paid at 100% of the allowed amount.

For more information about coverage and plan exclusions or limits, see "Benefits/Covered Expenses" on page 105 and "Expenses Not Covered by the Plan" on page 150.

Deductible	• The amount of your deductible depends on your coverage level (Associate Only or Family).
Copay	• A copay is a flat dollar amount for a covered expense.
Out-of-Pocket Maximum	• The out-of-pocket maximum depends on your coverage level (Associate Only or Family).
After Out-of-Pocket Maximum, Honda Pays 100% of Costs	• After you reach the out-of-pocket maximum, Honda pays 100% of any eligible medical and prescription drug expenses for the remainder of the calendar year. • The out-of-pocket maximum provides a limit to what you pay for eligible medical and prescription drug expenses during the year and safeguards you against a catastrophic claim.

HMO Plan Structure

Your out-of-pocket maximum depends on your coverage level (Associate Only or Family). The amounts are shown below. The Family amount can be satisfied by any combination of family members, but an individual would never need to satisfy more than his or her own individual amount.

Coverage Level	Deductible (paid by associate)	Out-of-Pocket Maximum of Eligible Charges (includes prescription drug expenses)
	In-Network	***In-Network***
Associate Only	$250	$2,500
Family	$500	$5,000

Benefits/Covered Expenses

Some benefits may be processed at in-network benefit levels when provided by out-of-network providers. When out-of-network charges are covered in accordance with in-network benefits, the charges are still limited to the allowed amount.

The following exceptions may apply if you are in a plan administered by UMR:

- Covered services provided by a radiologist, anesthesiologist, certified registered nurse anesthetist or pathologist will be payable at the in-network level of benefits when rendered by an out-of-network provider.
- Covered services (including preventive services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist or pathologist will be payable at the in-network level of benefits when services are provided at an in-network facility.
- Covered services provided by a physician during an inpatient stay will be payable at the in-network level of benefits when provided at an in-network hospital.
- If there is no in-network provider, or no in-network provider is willing or able to provide the necessary service(s) to the covered person within a 50-mile radius of the covered person's residence, the covered person may be eligible to receive in-network benefits from an out-of-network provider. In this situation, your in-network physician will notify Quantum Health. Quantum Health will work with you and your in-network physician to coordinate care through an out-of-network provider.
- Diagnostic lab and pathology tests performed by an out-of-network provider will be subject to the in-network level of benefits when referred by an in-network provider.
- The in-network level of benefits may be applied when an out-of-network provider is used during a medical emergency, provided a transfer to an in-network provider occurs as soon as such transfer is medically appropriate.

If you are in a plan covered by Blue Cross Blue Shield of Alabama, medical expenses must be:

- For care requiring pre-certification, as determined by Quantum Health;
- For in-network-level benefits, for services and supplies furnished by a provider recognized by Blue Cross Blue Shield of Alabama as an in-network provider at the time services are provided; and

- For services and supplies furnished by a provider recognized by Blue Cross Blue Shield of Alabama as an *approved* provider for the type of service being furnished, whether an in-network provider or not. For example, if you receive services from someone other than an M.D., benefits may not be payable, even if the services provided are within the scope of that person's license. You should check with Quantum Health at **1-866-778-5885** if you are uncertain if a person is an approved provider.

The following sections show the benefits and services covered by the medical plan.

Routine Preventive Care

Honda's plan generally follows the recommendations of the U.S. Preventive Services Task Force (**uspreventiveservicestaskforce.org/uspstf/recommendation-topics**), the Advisory Committee on Immunization Practices and the Health Resources and Services Administration (available at **hrsa.gov/womens-guidelines/index.html**). Honda's plan will implement changes to the recommendations and guidelines no later than the first year starting after the one-year anniversary of the change.

Services covered in-network at 100% include but are not limited to:

- Abdominal aortic aneurysm screening;
- Alcohol misuse screening and behavioral counseling interventions;
- Anemia screening;
- Aspirin use counseling for cardiovascular disease prevention;
- Autism screening;
- Bacteriuria screening;
- Behavioral counseling to prevent skin cancer;
- Blood pressure screening;
- Breast cancer mammography screenings, including 3D mammography;
- Breast feeding interventions;
- Breast pumps;
- Breast cancer counseling about genetic testing for women at a higher risk;
- Cervical cancer screening (Pap smear);
- Chlamydia screening;
- Cholesterol screening;
- Colorectal cancer screening, including fecal occult blood testing, sigmoidoscopy, colonoscopy and bowel prep;
- Depression screening;
- Diabetes screening;
- Diet counseling;

- Fall prevention screening;
- Folic acid supplements;
- Gonorrhea screening;
- Hepatitis B screening;
- Hepatitis C screening;
- HIV screening;
- HPV screening;
- Immunizations;
- Obesity screening and counseling;
- Osteoporosis screening;
- Prenatal care;
- Prenatal conference;
- Preventive services and vaccines for COVID-19 as of 15 days after such service or vaccine is given an "A" or "B" rating by the U.S. Centers for Disease Control and Prevention (CDC) or U.S. Preventive Services Task Force;
- Prostate cancer screening (PSA testing);
- Rh incompatibility screening;
- Routine diagnostic testing, labs and X-rays;
- Routine hearing exams;
- Routine physical exams and well-child exams;
- Sexually transmitted infection prevention counseling;
- Sterilization for women;
- Syphilis screening;
- Tobacco use screening and interventions; and
- Well-women exams.

The age and visit limits recommended by the U.S. Preventive Services Task Force will apply to your plan unless those limits provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration would result in greater benefits. If you find it necessary to make this determination, contact your physician or call Quantum Health at **1-866-778-5885** if you are enrolled in the HSA or PPO Plan. If you are enrolled in the Kaiser HMO Plan, call:

- Kaiser California: **1-800-464-4000**
- Kaiser Georgia: **1-888-865-5813**
- Kaiser Northwest: **1-800-813-2000**

Women's Preventive Health Benefits

The department of Health and Human Services (HHS) adopted additional Guidelines for Women's Preventive Services—including well-woman visits, gestational diabetes screening, HPV DNA testing, STI counseling, HIV screening and counseling, breastfeeding support, supplies and counseling and domestic violence screening and counseling—that are covered without cost sharing to members in health plans.

The plan covers all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. The plan also provides benefits for prescription contraceptives, regardless of purpose. Prescription contraceptives that require that a physician administer a hormone shot or insert a device will be processed as a covered medical benefit.

Benefits include:

- $0 cost for most generic birth control medication and certain brand-name medications when no generic version is available;
- $0 cost for certain birth control devices, including emergency contraception, injectable, transdermal and implantable contraception, vaginal rings and barrier methods (such as diaphragms and cervical caps);
- $0 cost folic acid tabs;
- $0 cost for routine prenatal visits and services explicitly identified in the Department of Health and Human Service rules; and
- $0 cost for sterilization.

For more specific details about these benefits:

- If you are enrolled in the HSA or PPO Plan, call Quantum Health at **1-866-778-5885**.
- If you are enrolled in the Kaiser HMO Plan, call:
  - Kaiser California: **1-800-464-4000**
  - Kaiser Georgia: **1-888-865-5813**
  - Kaiser Northwest: **1-800-813-2000**

Screening and Counseling Services

Covered expenses include charges made by your primary care physician in an individual or group setting for the following screening and counseling services.

Obesity

Screening and counseling services to aid in weight reduction due to obesity. You are not required to use a bariatric Centers of Excellence (COE) for bariatric screening services. See "Bariatric Surgery for the HSA and PPO Plans" on page 138 or "Bariatric Surgery for Kaiser HMO Plan" on page 138 for more information.

Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention;
- Medical nutrition therapy;

- Nutrition counseling; and
- Healthy diet counseling visits provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Misuse of Alcohol and/or Drugs

Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Use of Tobacco Products

Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine, including cigarettes; cigars; smoking tobacco; snuff; smokeless tobacco and candy-like products that contain tobacco. Coverage includes:

- Preventive counseling visits;
- Treatment visits; and
- Class visits to aid in the cessation of the use of tobacco products.

Limitations

The plan does *not* consider or cover the following services as preventive care:

- Services that are covered to any extent under any other part of this plan;
- Services for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given while the person is confined in a hospital or other place for medical care;
- Services not given by a physician or under his or her direction;
- Medicines, drugs (please refer to *Prescription Drug Plan* on page 169);
- Appliances, equipment or supplies (Some appliances, equipment and supplies (e.g., breast pumps) are covered under preventive care. Contact Quantum Health at **1-866-778-5885** for covered items.);
- Exams in any way related to employment;
- Premarital exams;
- Vision, hearing or dental exams (Children's vision and hearing screenings are included under preventive health.); and
- A physician's office visit in connection with immunization or testing for tuberculosis.

Teladoc

Teladoc allows you and your enrolled family members to consult a doctor online or by phone for non-emergency medical issues. You can also use Teladoc to consult with a licensed therapist, psychiatrist or dermatologist. Teladoc has a national network of U.S. board-certified doctors, and you can use Teladoc at any time, 24 hours a day, 365 days a year. You can call from anywhere—whether you're at home, at work or even on vacation—and calling Teladoc costs less than urgent care or emergency room visits for non-emergency medical care. To register, go to **teladoc.com/Honda**.

Teladoc Service

	HSA Plan	PPO Plan
Expense	**Teladoc provider**	**Teladoc provider**
Consultation	$45 per visit; then 90% after calendar year deductible	$10 copay per visit for general medical and behavioral health $20 copay per visit for dermatology

Kaiser members can contact nurses and clinicians by phone 24 hours a day, 7 days a week. These medical professionals will help members assess their symptoms and determine the level of care needed. Video visits are available by appointment. Call the phone number on the back of your ID card.

Physician Services

The plan covers charges made by a legally qualified physician for surgery (including pre- and post-operative care, as well as administering anesthesia), second surgical opinion services, obstetrical care and other services, including:

- Inpatient visits while you are a hospital patient for reasons other than surgery, obstetrical care or radiation therapy (except for an unrelated condition);
- Specialist consultation for a medical, surgical or maternity condition, but only one for each hospital visit;
- Diagnostic lab, X-ray and pathology services in a provider's office, when related to covered services other than allergy testing;
- Radiation therapy and chemotherapy;
- Emergency room care for other than surgery or maternity; and
- Exams, diagnosis and treatment for an illness or injury, other than routine office visits and allergy testing.

Physician Service

	HSA Plan		PPO Plan		HMO Plan
Expense	**In-Network Provider***	**Out-of-Network Provider****	**In-Network Provider***	**Out-of-Network Provider****	**HMO Provider**
Inpatient visits, second surgical opinions and inpatient consultations	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	100%, no calendar year deductible
*Surgery and anesthesia****	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	$250 per admission, after calendar year deductible

Physician Service

	HSA Plan		PPO Plan		HMO Plan
Expense	***In-Network Provider****	***Out-of-Network Provider*** **	***In-Network Provider****	***Out-of-Network Provider*** **	***HMO Provider***
Diagnostic X-rays and lab exams	90%, after calendar year deductible	70%, after calendar year deductible	100%, no calendar year deductible for basic X-rays and labs in office setting; 80%, after calendar year deductible in outpatient facility and for PET/CT/MRI/MRA imaging and ultrasound	60%, after calendar year deductible	100%, after calendar year deductible
Office visit	90%, after calendar year deductible	70%, after calendar year deductible	100%, after $30 copay for PCP; $50 copay for specialist	60%, after calendar year deductible	100%, no calendar year deductible after $30 copay for PCP; $50 copay for specialist
Emergency room services	90%, after calendar year deductible (if not a medical emergency, paid at 50% after in-network calendar year deductible)		80%, after calendar year deductible (if not a medical emergency, paid at 50% after in-network calendar year deductible)		100%, no calendar year deductible after $200 facility copay
Outpatient consultations	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	100%, no calendar year deductible after $30 copay for PCP; $50 copay for specialist
Allergy testing	90%, after calendar year deductible	70%, after calendar year deductible	100%, no calendar year deductible after applicable office visit copay	60%, after calendar year deductible	100%, no calendar year deductible after $50 facility copay
Allergy treatment	90%, after calendar year deductible	70%, after calendar year deductible	100%, no calendar year deductible	60%, after calendar year deductible	100%, no calendar year deductible after $50 copay
Maternity care	100%, no deductible for routine prenatal service; 90%, after calendar year deductible for non-routine prenatal services and postnatal care	70%, after calendar year deductible	100%, no deductible for routine prenatal service; 80%, after calendar year deductible for non-routine prenatal services and postnatal care **BCBS-AL PPO:** 100%, no calendar year deductible, initial visit subject to $30 copay	60%, after calendar year deductible	100%, covered for prenatal care exams; $30 office visit copay applies for non-routine prenatal services and postnatal care

Physician Service

	HSA Plan		PPO Plan		HMO Plan
Expense	***In-Network Provider****	***Out-of-Network Provider*****	***In-Network Provider****	***Out-of-Network Provider*****	***HMO Provider***
Pre-certification	Required for MRIs, MRAs and PET scans. HSA Plan and PPO Plan members, call Quantum Health at **1-866-778-5885**; Kaiser HMO Plan members, call Kaiser California at **1-800-464-4000**; Kaiser Georgia at **1-888-865-5813**; or Kaiser Northwest at **1-800-813-2000**. There is a $400 penalty if pre-certification is not obtained when required. For more information, HSA Plan and PPO Plan members, see "Pre-Certification for HSA and PPO Plans" on page 145; Kaiser HMO Plan members, see "Pre-Certification for Kaiser HMO Plan" on page 149.				

*Up to negotiated rate.

**Up to allowed amount. The allowed amount for emergency room services in a medical emergency is the greatest of the negotiated rate, the amount Medicare would have paid, or the normal allowed amount.

***Anesthesia services provided at an in-network facility by an out-of-network doctor are paid at in-network levels; however, out-of-network allowable amounts and balance billing may still apply.

Spinal, Jaw Joint and Foot Disorders

The plan covers the following expenses for medically necessary treatment of spinal, jaw joint and foot disorders:

- Office visits for manipulation and adjustments (maximums do not apply to hospital care or surgery);
- Expenses for treatment of jaw joint disorders such as temporomandibular joint dysfunction (TMJ), including charges for a temporary appliance and installation by a dentist or physician; there is a $1,500 calendar year maximum for TMJ expenses; and
- Office visits for foot care including:
  - Treatment of weak, strained, flat, unstable or imbalanced feet;
  - Treatment of bunions or toenails;
  - Treatment of ingrown toenails or when at least part of the nail root is removed; and
  - Treatment needed for metabolic or peripheral vascular disease.

Spine, Jaw Joint and Foot Disorders

	HSA Plan		PPO Plan		HMO Plan
Expense	***In-Network Provider****	***Out-of-Network Provider*** **	***In-Network Provider****	***Out-of-Network Provider*** **	***HMO Provider***
Manipulations	90%, after calendar year deductible	70%, after calendar year deductible	$50 copay per visit	60%, after calendar year deductible	Kaiser California: $15 copay Kaiser Georgia and Kaiser Northwest: $50 copay
Calendar year maximum	26 visits including acupuncture treatment per calendar year, combined for in-network and out-of-network care				26 visits including acupuncture treatment per calendar year

*Up to negotiated rate.

**Up to allowed amount.

Treatment of Mouth, Jaws and Teeth

The plan covers charges by a physician or dentist only for:

- Surgical treatment to treat a fracture, dislocation or wound; cut out cysts, tumors or diseased tissues; or alter the jaw or bite relationship when orthodontics alone cannot improve function;
- Non-surgical treatment of infections or diseases unrelated to the teeth;
- Surgery or orthodontia needed to remove, repair, replace or reposition natural, healthy teeth damaged due to an accidental injury. In this case, the plan covers only the initial crowns, dentures or other appliances that may be required for care or treatment before the later of one year from the accidental injury or the enrollment in the plan. Other expenses may be eligible under the dental plan (see *Dental Plan* on page 179 for details);
- Lingual frenectomy; and
- Labial frenectomy (for children under the age of five).

The plan covers the following expenses *only* in case of accidental injury:

- 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;
- Root canal therapy; and
- Tooth removal.

The plan does *not* cover the following expenses:

- 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;
- Periodontal treatment;
- Dental cleaning, in-mouth scaling, planing or scraping;
- Myofunctional therapy (i.e., muscle training therapy or training to correct or control harmful habits);
- Oral surgery that is dental in nature; and
- Dental implants, except in the case of accidental injury.

Outpatient Hospital

The 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 doctor's office; and
- Diagnostic lab and X-ray expenses (including physician fees for interpretation) provided in a doctor's office, lab facility or on an outpatient basis in a hospital.

The following types of service/supplies are covered:

- Emergency treatment of an accidental injury;
- Chemotherapy and radiation therapy;
- IV therapy;
- Hemodialysis;
- X-rays, lab and pathology services;
- Medical emergencies; and
- Surgery.

Outpatient Hospital Service*

	HSA Plan		***PPO Plan***		***HMO Plan***
Expense	***In-Network Provider****	***Out-of-Network Provider******	***In-Network Provider****	***Out-of-Network Provider******	***HMO Provider***
Accidental injury	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	$150 per procedure
Surgery	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	$150 per procedure
Diagnostic lab and PET, CT and MRI/MRA scans, IV therapy, radiation therapy and chemotherapy	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	100% covered
Hemodialysis	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	100%, no deductible after $50 facility copay
Pre-certification	Outpatient surgeries, PET, CT and MRI/MRA scans require certification by a Quantum Health Care Coordinator by the next business day after admission. There is a $400 penalty if pre-certification is not obtained when required. For more information, HSA Plan and PPO Plan members, see "Pre-Certification for HSA and PPO Plans" on page 145; Kaiser HMO Plan members, see "Pre-Certification for Kaiser HMO Plan" on page 149.				

*Outpatient hospital services will be processed as other covered services if the facility bills for an emergency room visit but the patient's condition does not satisfy UMR's or BCBS-AL's definition of medical emergency. This includes any lab and X-ray exams, diagnostic tests and other services and supplies (including those not listed above) associated with the emergency room visit.

**Up to negotiated rate.

***Up to allowed amount.

Inpatient Hospital

The plan covers semi-private room and board, other services and supplies for full-time inpatient hospital care. If Quantum Health determines it is medically necessary, the plan will cover private room and board.

You must be admitted to an approved in-network hospital to receive in-network benefits for the hospitalization.

Prior to admission, you are responsible for making sure care is certified with Quantum Health. You will pay a $400 penalty for inpatient admissions that are not certified.

Inpatient Hospital Service

	HSA Plan		***PPO Plan***		***HMO Plan***
Expense	***In-Network Provider****	***Out-of-Network Provider*** **	***In-Network Provider****	***Out-of-Network Provider*** **	***HMO Provider***
Inpatient hospital (no limit on number of days for inpatient hospital care)	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60% after calendar year deductible	$250 copay per admission, after calendar year deductible
Pre-certification	Required for all inpatient admission; emergency admissions require certification by a Quantum Health Care Coordinator by the next business day after admission. There is a $400 penalty if pre-certification is not obtained when required. For more information, HSA Plan and PPO Plan members, see "Pre-Certification for HSA and PPO Plans" on page 145; Kaiser HMO Plan members, see "Pre-Certification for Kaiser HMO Plan" on page 149				

*Up to negotiated rate.

**Up to allowed amount.

Important reminder: The plan will only pay for nursing services provided by the hospital as part of its charges. The plan does *not* cover private duty nursing services as part of an inpatient hospital stay.

Important Note—Post-Mastectomy Services

The Women's Health and Cancer Rights Act became effective on October 21, 1998. This law requires group health plans that provide mastectomies to also cover reconstructive surgery and prostheses following mastectomies.

As the Act requires, Honda provides the following information about the Act and its provisions.

If you have a mastectomy, the plan will cover:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications related to the mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have questions about coverage for mastectomies and reconstructive surgery, please contact Quantum Health at **1-866-778-5885**.

Pre-Certification of Services (for HSA and PPO Plans)

One of the several requirements for hospital benefits is that Quantum Health certifies the medical necessity of your hospital stay in advance. You *must* notify Quantum Health by the next business day after an emergency hospital admission using the number on the back of your medical/prescription drug ID card. Emergency admissions then must be certified as medically necessary. **Failure to obtain a certificate of medical necessity will result in penalties,** as described in "Pre-Certification for HSA and PPO Plans" on page 145.

In addition, for benefits to be paid, you must be a plan participant at the time services are provided *and* the service or supply must be covered under the plan.

Maternity Care Exception—Length of Stay

A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to the expected delivery date. The plan and the Care Coordination process comply with all federal regulations regarding utilization review for maternity admissions. The plan will not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require prior notification or certification for prescribing a length of stay not in excess of these periods. If the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the plan will only consider benefits for the actual length of the stay. The plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48- or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Emergency Care and Ambulance

The plan covers emergency room treatment for injury, illness or disease in in-network and out-of-network facilities. Benefits are paid based on whether emergency room care was used for a true medical emergency or non-emergency. For non-emergencies, you pay a coinsurance of 50%, after deductible.

Ambulance service is also covered:

- In an emergency situation; and
- When an ambulance is required to safely transport the patient to or from home or an appropriate treatment facility.

For a true medical emergency condition, you should seek care immediately at the nearest emergency facility.

What Is an Emergency?

An emergency condition means an acute and severe medical condition, including, but not limited to, severe pain that 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;
- Serious impairment to bodily function;
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Care and Ambulance

	HSA Plan		PPO Plan		HMO Plan
Expense	***In-Network Provider****	***Out-of-Network Provider*** **	***In-Network Provider****	***Out-of-Network Provider*** **	***HMO Provider***
Emergency room—medical emergencies	90%, after calendar year deductible (if not a medical emergency, paid at 50%, after in-network calendar year deductible)		80%, after calendar year deductible (if not a medical emergency, paid at 50%, after in-network calendar year deductible)		$200, after calendar year deductible
Ambulance service—medical emergencies only	90%, after calendar year deductible		80%, after calendar year deductible		100% covered**

*Up to negotiated rate.

**Up to allowed amount. The allowed amount for emergency room services in a medical emergency is the greatest of the negotiated rate, the amount Medicare would have paid, or the normal allowed amount.

Maternity and Family Planning

The plan covers the following:

- Pregnancy-related expenses for associates and dependents, including delivery at a hospital or birthing center.
- Family planning expenses including:
  - Voluntary sterilization by vasectomy or tubal ligation (reversals are not covered); and
  - Elective abortions performed because of possible danger to the mother's life or that of the unborn child (where death of the baby during the pregnancy is unavoidable) or in situations involving incest or rape.
- Fertility expenses—including in vitro fertilization, GIFT and artificial insemination—up to a $25,000 lifetime maximum for medical expenses and $10,000 lifetime maximum for prescription drug expenses. Infertility cannot be the result of a voluntary sterilization. For specific coverage provisions, contact Quantum Health at **1-866-778-5885**. Coverage for Kaiser HMO Plan members varies by region. For details, refer to your Evidence of Coverage (EOC).

  Program utilization criteria include:

  - The member must enroll in the Optum Fertility Program and use a Centers of Excellence (COE) facility for services to be covered. Services with any other provider will not be covered. If there is no COE within 60 miles, a gap exception is allowed for a member to go to a non-COE and have

claims paid at the COE benefit level. Members must still use an in-network provider even when seeking a gap exception.

- Age requirements:
  - Age 44 or under, if female and using own eggs/oocytes; or
  - Age 50 or under if female and using donor eggs/oocytes. As long as treatment is initiated prior to the age indicated, then the person can complete that cycle.
- All authorization information and enrollment for fertility services must be initiated and approved through the Optum Fertility Program. If you have questions about coverage for fertility services or to initiate enrollment in the Optum Fertility Program, please contact Quantum Health at **1-866-778-5885**.
- Dependent children are not included in this benefit.

These procedures must be performed at a medical facility conforming to generally accepted medical standards as defined by UMR or BCBS-AL.

The plan does *not* cover the following expenses:

- Expenses involving surrogates and storage of sperm, eggs and embryos;
- Purchase of donor sperm or storage of sperm;
- Care of donor egg retrievals or transfers;
- Cryopreservation or storage of cryopreserved embryos beyond the allowed period up to 12 months;
- Gestational carrier programs; and
- Home ovulation prediction kits.

Expenses Covered by the Prescription Drug Plan

*The prescription drug plan covers contraceptive drugs. For information on applicable copays/coinsurance, please see Prescription Drug Plan on page 169 or **caremark.com**, or call Quantum Health at **1-866-778-5885**. Some contraceptive drugs may be covered at 100%, as mandated by the Affordable Care Act (ACA).*

Contraception Expenses

The plan covers the following expenses:

- Charges incurred for prescription contraceptives (including injectable medications, such as Depo-Provera) and insertion and removal of contraceptive devices (such as IUDs and implants) that are FDA approved; and
- Related outpatient contraceptive services, such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

The plan does *not* cover:

- Charges for services covered to any extent under any other part of this plan or any other group plan sponsored by Honda; and
- Charges incurred for contraceptive services while confined as part of an inpatient stay.

Maternity and Family Planning

	HSA Plan		PPO Plan		HMO Plan
Expense	**In-Network Provider***	**Out-of-Network Provider****	**In-Network Provider***	**Out-of-Network Provider****	**HMO Provider**
Pregnancy	100%, no deductible for routine prenatal services; 90%, after calendar year deductible for non-routine prenatal services and postnatal care	70%, after calendar year deductible for both routine and non-routine prenatal services and postnatal care	100%, no deductible for routine prenatal services; 80%, after calendar year deductible for non-routine prenatal services and postnatal care	60%, after calendar year deductible	100% covered for prenatal care exams; office visit copay applies for non-routine prenatal services and postnatal care
Birthing center/hospital (delivery)	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	$250, after calendar year deductible
Fertility, up to $35,000 lifetime maximum benefit ($25,000 medical and $10,000 Rx)—see "Infertility Services and Fertility Solutions (FS) Program" on page 120 for details on Centers of Excellence (COE) rules	90%, after calendar year deductible	Not covered	80%, after calendar year deductible	Not covered	Copays may apply depending on where service is performed. See EOC for coverage limits for Kaiser.
Family planning	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	Copays may apply depending on where service is performed. See EOC for coverage limits for Kaiser.

*Up to negotiated rate.

**Up to allowed amount.

Important Note—Length of Stay

Under federal law, group health plans and issuers of group health coverage may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than

48 hours following a vaginal delivery (or 96 hours following a caesarean section). However, federal law generally does not prohibit an attending physician, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours (or 96 hours), if appropriate. In either case, plans and issuers may not require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of the minimums described above.

Infertility Services and Fertility Solutions (FS) Program

The Infertility Services and Fertility Solutions (FS) Program is available to HSA Plan and PPO Plan members. Services for Kaiser members will vary by region. For details, please consult with member services or refer to your Evidence of Coverage (EOC).

Therapeutic services for the treatment of infertility are covered when provided by or under the direction of a physician. The plan pays benefits for infertility when provided by a Centers of Excellence (COE) facility.

Services with any other provider will not be covered. If there is no COE within 60 miles, a gap exception is allowed for a member to go to a non-COE and have claims paid at the COE benefit level. Members must still use an in-network provider even when seeking a gap exception.

Note: Diagnostic services benefits are covered as described under “

Kaiser members can contact nurses and clinicians by phone 24 hours a day, 7 days a week. These medical professionals will help members assess their symptoms and determine the level of care needed. Video visits are available by appointment. Call the phone number on the back of your ID card.

Physician Services” on page 110 in this document.

Benefits under this section are limited to the following procedures:

- Ovulation induction and controlled ovarian stimulation;
- Insemination procedures, artificial insemination (AI) and intrauterine insemination (IUI);
- Assisted reproductive technologies (ART): In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), intra cytoplasmic sperm injection (ICSI);
- Testicular sperm aspiration/microsurgical epididymal sperm aspiration (TESA/MESA): Male factor associated procedures for retrieval of sperm;
- Cryopreservation and storage of embryos (storage is limited to 12 months);

  Note: Long-term storage costs (anything longer than 12 months) are not covered under the plan.
- Pre-implantation genetic diagnosis (PGD) for diagnosis of genetic disorders only;
- Pre-implantation genetic screening (PGS) used to select embryos for transfer in order to increase the chance of conception;
- Embryo transportation related network disruption;
- Donor coverage-associated donor medical expenses, including collection and preparation of oocyte (egg) and/or sperm, and the medications associated with the collection and preparation of ovum and/or sperm;

Note: The plan does not cover donor charges associated with compensation or administrative services.

- Fertility preservation: When planned cancer or other medical treatment is likely to produce infertility/sterility, the plan covers the collection of sperm, cryopreservation of sperm, ovulation, induction and retrieval of oocyte (egg), oocyte preservation, ovarian tissue cryopreservation, in-vitro fertilization, and embryo cryopreservation;

  Note: Long-term storage costs (anything longer than 12 months) are not covered

- Surgical procedures: Laparoscopy, lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty (Strassman type);
- Electroejaculation; and
- Female member without a male partner (reciprocal or partner IVF): The plan will cover the transfer of any resulting embryos to an individual from whom the oocytes were not derived.

To be eligible for benefits, the covered person must:

- Have failed to achieve pregnancy after a year of regular, unprotected heterosexual intercourse if the woman is under age 35, or after six months, if the woman is over age 35;
- Have failed to achieve or maintain a pregnancy following six to 12 treatment cycles, depending on age, of medically supervised donor insemination;
- Have failed to achieve pregnancy due to impotence/sexual dysfunction;
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization;
- Have diagnosis of a male factor causing infertility (e.g., treatment of sperm abnormalities, including the surgical recovery of sperm);
- Be under age 44, if female and using own oocytes (eggs); and
- Be under age 50, if female and using donor oocytes (eggs).

Note: For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

The waiting period may be waived when the covered person has a known infertility factor, including but not limited to: Congenital malformations, known male factor, known ovulatory disorders, diminished ovarian reserve, impotence/sexual dysfunction, moderate or severe endometriosis, or documented compromise of the fallopian tubes.

Benefits are limited to $35,000 per covered person during the entire period you are covered under the plan. This is a combined $25,000 medical and $10,000 prescription drug lifetime maximum benefit.

Member notification (enrollment) requirement: Enrollment in the Optum Fertility Program is required prior to receiving services in order to receive coverage. If you do not enroll, your claim will not be paid, even if your healthcare provider or clinic is part of the Centers of Excellence network.

Fertility Solutions (FS) Program

The plan pays benefits for the infertility services described above when provided by designated providers participating in the Fertility Solutions (FS) Program. The program provides education, counseling, infertility management and access to a national network of premier infertility treatment clinics.

You or your covered spouse may be referred to the FS Program by Quantum Health.

Exclusions

- Administrative costs or obstetrical costs associated with insemination of surrogate or transfer to gestational carrier;
- Infertility treatment with voluntary sterilization currently in place;
- Infertility treatment following successful reversal;
- Infertility treatment following the reversal of voluntary sterilization;
- Dependent child;
- Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic purposes; and
- Social preservation.

Short-Term Rehabilitation

The plan covers charges from a physician or a licensed or certified physical, occupational or speech therapist for short-term rehabilitation services furnished to a person who is not confined as an inpatient in a hospital or facility. Short-term rehabilitation therapy includes physical, occupational and speech therapy that is expected to improve body function lost or impaired due to:

- Accidental injury or stroke;
- Surgical operation;
- Disease; and
- Defects present at birth for a covered child or delayed development.

Short-term rehabilitation does not include expenses for special education to function without speech, such as sign language or elocution lessons.

Cardiac pulmonary rehabilitation programs are covered when medically necessary, if referred by a physician, for patients who have certain cardiac conditions.

Covered services include:

- Phase I cardiac rehabilitation, while the covered person is an inpatient; and
- Phase II cardiac rehabilitation, while the covered person is in a physician-supervised outpatient, monitored, low-intensity exercise program. Services generally will be provided in a hospital rehabilitation facility and include monitoring of the covered person's heart rate and rhythm, blood pressure and symptoms by a healthcare professional. Phase II generally begins within 30 days after discharge from the hospital.

Short-Term Rehabilitation Services

	HSA Plan		PPO Plan		HMO Plan
Expense	***In-Network Provider****	***Out-of-Network Provider***	***In-Network Provider****	***Out-of-Network Provider***	***HMO Provider***
Physical, occupational and speech therapy (60 visits combined for physical, occupational or speech therapy per calendar year)	90%, after calendar year deductible	70%, after calendar year deductible	100%, no deductible, after $50 copay	60%, after calendar year deductible	Kaiser California: $30 copay and unlimited visits; Kaiser Georgia and Kaiser Northwest: $50 copay per visit
Cardiac and pulmonary rehabilitation (limited number of treatments of reversible pulmonary diseases, up to 36 hours in a six-week period)	90%, after calendar year deductible	70%, after calendar year deductible	100%, no deductible, after $50 copay	60%, after calendar year deductible	100%, no calendar year deductible, after $50 copay

*Up to negotiated rate.

**Up to allowed amount.

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

The plan covers the following services:

- 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.

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.

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

- Any services that 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 provided during a stay in a hospital, extended care facility or hospice facility except as stated above;
- Services not performed by a physician or under the direct supervision of a physician;
- 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; and
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability (this includes lessons in sign language).

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

	HSA Plan		PPO Plan		HMO Plan
Expense	**In-Network Provider***	**Out-of-Network Provider****	**In-Network Provider***	**Out-of-Network Provider****	**HMO Provider**
Outpatient cognitive therapy	90%, after calendar year deductible	70%, after calendar year deductible	$50 copay per visit	60%, after calendar year deductible	$50 copay per visit
Physical therapy, occupational therapy and speech therapy (up to a combined maximum of 60 visits per calendar year)	90%, after calendar year deductible	70%, after calendar year deductible	$50 copay per visit	60%, after calendar year deductible	Kaiser California: $30 copay and unlimited visits; Kaiser Georgia and Kaiser Northwest: $50 copay per visit

*Up to negotiated rate.

**Up to allowed amount.

Extended Care Facility

The plan covers charges made by an extended care facility, including facility charges for room, board and routine nursing care, if you are recovering from a serious illness or injury, are confined to a bed with a long-term illness or injury or have a terminal condition. Extended care facility benefits will only be paid if authorized by Quantum Health if you are enrolled in the HSA Plan or PPO Plan (or Kaiser if you are enrolled in the HMO Plan).

For the HSA Plan and PPO Plan, you can request authorization by calling **1-866-778-5885**. For the HMO Plan, you can request authorization by calling:

- Kaiser California: **1-800-464-4000**
- Kaiser Georgia: **1-888-865-5813**
- Kaiser Northwest: **1-800-813-2000**

Also, see “Pre-Certification for HSA and PPO Plans” on page 145 or “Pre-Certification for Kaiser HMO Plan” on page 149.

An extended care facility includes any Medicare participating extended care facility that provides non-acute care for patients needing skilled nursing services 24 hours a day. The facility must be staffed and equipped to perform skilled nursing care and other related health services. An extended care facility does not provide custodial or part-time care.

Extended Care Facility

	HSA Plan		PPO Plan		HMO Plan
Expense	**In-Network Provider***	**Out-of-Network Provider****	**In-Network Provider***	**Out-of-Network Provider****	**HMO Provider**
Extended care facility	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	100%, after calendar year deductible
Calendar year maximum	120 days per person per calendar year, combined for in-network and out-of-network care				120 days
Pre-certification	Pre-certification required; call Quantum Health at **1-866-788-5885** (see "Pre-Certification for HSA and PPO Plans" on page 145 for more information)				Pre-certification required; call: • Kaiser California: **1-800-464-4000** • Kaiser Georgia: **1-888-865-5813** • Kaiser Northwest: **1-800-813-2000** (see "Pre-Certification for Kaiser HMO Plan" on page 149 for more information)

*Up to negotiated rate.

**Up to allowed amount.

Home Healthcare

To be covered, home healthcare agency charges must be made for care and treatment of disease or injury that is:

- Prescribed in writing by a physician;
- Provided in the patient's home in lieu of hospital or convalescent facility care; and
- Provided to you in your home while you are homebound.

Treatment is limited to a maximum of 120 visits per calendar year.

Home healthcare expenses includes 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.; and
- Medical supplies, prescription drugs and lab services provided by or for a home healthcare agency to the extent they would have been covered under this plan if you had continued your hospital stay.

Benefits for home healthcare visits are payable up to the home healthcare maximum. Each visit by a nurse or therapist is one visit.

In figuring the Plan Year Maximum Visits, each visit of up to four 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 extended care facility as a full-time inpatient; and
- Care is needed to transition from the hospital or extended care facility to home healthcare.

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 healthcare 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 healthcare 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 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; and
- 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 members or other caretakers cannot provide the necessary care.

Pre-certification requirements apply as described in "Pre-Certification for HSA and PPO Plans" on page 145 and "Pre-Certification for Kaiser HMO Plan" on page 149. Benefits payable for each covered person are subject to a calendar-year maximum for visits, as described in the following table. Home healthcare expenses do not include transportation, services of a social worker or services provided by a member of your/your spouse's family or a resident of your home.

Home Healthcare

	HSA Plan		PPO Plan		HMO Plan
Expense	***In-Network Provider****	***Out-of-Network Provider*** **	***In-Network Provider****	***Out-of-Network Provider*** **	***HMO Provider***
Home healthcare	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	100% covered
Calendar year maximum	120 visits per person per calendar year, combined for in-network and out-of-network care				120 visits
Pre-certification	Pre-certification required; call Quantum Health at **1-866-788-5885** (see "Pre-Certification for HSA and PPO Plans" on page 145 for more information)				Pre-certification required; call: • Kaiser California: **1-800-464-4000** • Kaiser Georgia: **1-888-865-5813** • Kaiser Northwest: **1-800-813-2000** (see "Pre-Certification for Kaiser HMO Plan" on page 149 for more information)

*Up to negotiated rate.

**Up to allowed amount.

Hospice Care

Hospice care is care arranged under a hospice care agency (as defined in the "Glossary" on page 156) for terminally ill patients with a terminal diagnosis and who are no longer seeking treatment of any kind. For Kaiser HMO Plan members, services are provided in your service area.

The care must be designed to provide pain control or palliative treatment for the patient as well as supportive services to the patient and family. In addition, the attending physician and hospice care agency must write and review a treatment plan that assesses and describes care.

Covered hospice care expenses include:

- **Inpatient.** Semi-private room and board, services and supplies provided in a hospital, skilled nursing or hospice facility (as defined in the "Glossary" on page 156) for pain control and other symptom management; and
- **Outpatient.** Hospice care agency charges for:
  - Part-time or intermittent R.N. or L.P.N. nursing care and home health aide services, up to eight hours a day;
  - Physician consultation or case management services;
  - Medical social services under the direction of a physician;
  - Psychological and dietary counseling;

- Physical and occupational therapy; and
- Prescribed medical supplies and medicine.

Benefits for each covered person are paid as described in the following table. In addition, pre-certification requirements apply as described in "Pre-Certification for HSA and PPO Plans" on page 145 and "Pre-Certification for Kaiser HMO Plan" on page 149.

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

Hospice Care

	HSA Plan		***PPO Plan***		***HMO Plan***
Expense	***In-Network Provider****	***Out-of-Network Provider*** **	***In-Network Provider****	***Out-of-Network Provider*** **	***HMO Provider***
Hospice Care	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	100% covered
Pre-certification	Pre-certification required; call Quantum Health at **1-866-788-5885** ("Pre-Certification for HSA and PPO Plans" on page 145 for more information)				Pre-certification required; call: • Kaiser California: **1-800-464-4000** • Kaiser Georgia: **1-888-865-5813** • Kaiser Northwest: **1-800-813-2000** (see "Pre-Certification for Kaiser HMO Plan" on page 149 for more information)

*Up to negotiated rate.

**Up to allowed amount.

Medical Supplies and Equipment

The plan also covers the following medical supplies and equipment:

- Anesthetics, oxygen, X-rays, radium and radioactive isotope therapy;
- Artificial limbs and eyes;
- Medically necessary orthotics. This includes, but is not limited to, foot orthotics 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 36 months) if prescribed by an otolaryngologist; subject to the maximum for each covered person described in the below; and
- 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. Repair of purchased equipment may be covered.

For Network Benefits

- *To receive network benefits, find the nearest network provider of durable medical equipment.*
- *If you are enrolled in the HSA Plan or PPO Plan, contact Quantum Health at* **1 866 778 5885** or **myhondaconnect.com**.
- *If you are enrolled in the Kaiser HMO Plan, call:*
  - *Kaiser California:* **1 800 464 4000**
  - *Kaiser Georgia:* **1 800 865 5813**
  - *Kaiser Northwest:* **1 800 813 2000**

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

Medical Supplies and Equipment

	HSA Plan		***PPO Plan***		***HMO Plan***
Expense	***In-Network Provider****	***Out-of-Network Provider*****	***In-Network Provider****	***Out-of-Network Provider*****	***HMO Provider***
Medical supplies and durable medical equipment (DME)	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	100% covered
Pre-certification	Pre-certification required for all rentals and any purchases of supplies and equipment over $1,500; call Quantum Health at **1-866-788-5885** ("Pre-Certification for HSA and PPO Plans" on page 145 for more information)				Pre-certification required; call: • Kaiser California: **1-800-464-4000** • Kaiser Georgia: **1-888-865-5813** • Kaiser Northwest: **1-800-813-2000** (see "Pre-Certification for Kaiser HMO Plan" on page 149 for more information)

*Up to negotiated rate.

**Up to allowed amount.

Hearing Aids

Expenses incurred for hearing aids within 30 days of termination of the person's coverage under this benefit section will be deemed to be covered hearing care expenses only if the following steps are completed before the date coverage ends:

- The prescription for the hearing aid was written; and
- The hearing aid was ordered.

Coverage for services provided after the person's termination date will be denied. The hearing aid maximum is $2,000 (one or both ears) every 36 months for the HSA and PPO Plans, and $1,000 per ear every 36 months for the HMO Plan.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by illness, injury or congenital defect. Covered expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition or normal growth or wear and tear;
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes, but is not limited to:

- An artificial arm, leg, hip, knee, eye or larynx;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- A speech-generating device, including Cochlear implants and processor replacement;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes or other devices to support the feet, unless the orthopedic shoe is an integral part of a covered leg brace;
- Trusses, corsets and other support items; or
- Any item listed in "Expenses Not Covered by the Plan" on page 149.

Mental and Behavioral Health Treatment

The plan covers inpatient and outpatient treatment of mental and behavioral health disorders where treatment is provided by or under the direction of a psychiatrist, psychologist or psychiatric social worker.

For Network Benefits

To receive network benefits for this type of treatment, you must use a network provider; no referral is necessary. If you are in the HSA Plan or PPO Plan, Quantum Health's Care Coordinators must certify all inpatient, intensive outpatient and partial hospitalization/residential treatment center treatments. Call Quantum Health at **1 866 778 5885** *for questions about your claims. If you are enrolled in the Kaiser HMO Plan, call:*

- *Kaiser California:* **1 800 464 4000**
- *Kaiser Georgia:* **1 800 865 5813**
- *Kaiser Northwest:* **1 800 813 2000**

Inpatient Treatment

For inpatient treatment at a hospital, the plan covers treatment of mental and behavioral health disorders received while a person is a full-time inpatient.

Examples of mental and/or behavioral health disorders include schizophrenia, panic disorder, major depressive disorder, psychotic depression, obsessive compulsive disorder, autism and bipolar disorder.

For treatment at a residential treatment facility, the plan covers certain expenses for the treatment of mental and behavioral health disorders while a person is a full-time inpatient. These expenses include:

- Daily board and room charges. Board and room charges for a private room are covered up to a semi-private room limit; and
- Other necessary services and supplies.

See the "Glossary" on page 156 for definitions of "mental disorder" and "residential treatment facility."

Partial Confinement Treatment

Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

Outpatient Treatment

The plan covers outpatient treatment charges for the treatment of mental and behavioral health disorders when the person is not a full-time inpatient at a hospital or residential treatment facility.

Mental Health Treatment

	HSA Plan		PPO Plan		HMO Plan
Expense	***In-Network Provider****	***Out-of-Network Provider*** **	***In-Network Provider****	***Out-of-Network Provider*** **	***HMO Provider***
Inpatient facility services for mental health treatment	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	100%, no calendar year deductible after $250 facility copay per admission
Physician charges for inpatient mental health treatment	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60%, after calendar year deductible	100% covered
Outpatient mental health treatment	90% after calendar year deductible	70%, after calendar year deductible	$30 copay per visit, no deductible; 80%, after calendar year deductible for other outpatient services	60%, after calendar year deductible	$30 copay per individual visit; $15 copay per group visit
Pre-certification	Inpatient, intensive outpatient and partial hospitalization/ residential treatment facility treatments services require pre-certification by a Quantum Health Care Coordinator (**1-866-778-5885**) by the next business day after admission (see "Pre-Certification for HSA and PPO Plans" on page 145 for more information)				Pre-certification required; call: • Kaiser California: **1-800-464-4000** • Kaiser Georgia: **1-888-865-5813** • Kaiser Northwest: **1-800-813-2000** (see "Pre-Certification for Kaiser HMO Plan" on page 149 for more information)

*Up to negotiated rate.

**Up to allowed amount.

Substance Abuse Treatment

The plan covers alcohol and substance abuse treatment prescribed and supervised by a physician.

Inpatient Treatment

Inpatient treatment refers to services provided when a person is a full-time inpatient at a hospital or residential treatment facility.

For inpatient services in a hospital, the plan covers the following expenses:

- Treatment of the medical complications of alcoholism or substance abuse, such as cirrhosis of the liver, delirium tremens or hepatitis;
- Treatment of alcoholism or substance abuse; and

- Treatment of mental disorders.

For inpatient services at a residential treatment facility, the plan covers the following expenses for the treatment of alcoholism or substance abuse:

- Daily board and room charges. Board and room charges for a private room are covered up to a semi-private room limit; and
- Other necessary services and supplies.

Outpatient Treatment

The plan covers outpatient treatment charges for the treatment of alcoholism or substance abuse when the person is not a full-time inpatient at a hospital or residential treatment facility.

This plan covers partial hospitalization services (more than four hours but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically directed intensive treatment of alcohol or substance abuse. The partial hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Partial Confinement Treatment

Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically directed intensive treatment of substance abuse.

Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

Associate Assistance Program

Your Associate Assistance Program services include:

Confidential Counseling

Life can be stressful. Your Associate Assistance Program is designed to provide short-term counseling services for you and your dependents to help you handle concerns constructively, before they become major issues. Call anytime about concerns such as:

- Marital, relationship or family problems;
- Divorce or separation;
- Child care or parenting issues;
- Grief and loss;
- Substance abuse;
- Elder care; and
- Maintaining work-life balance.

Counselors are master's degree or Ph.D. credentialed. Telephonic and face-to-face counseling is available for you and your dependents/household. Face-to-face counseling will be made available in your local community and provided by a credentialed counselor. If your problem cannot be resolved in a short-term period (six visits), your counselor may refer you to another qualified professional. You and your dependents/household are eligible for six visits per incident per year. All calls are voluntary and strictly confidential. Honda pays this benefit entirely.

GuidanceResources

Go online to access timely, expert information on thousands of topics, including relationships, work, school, children, wellness, legal, financial and free time. You can search for qualified child and elder care, attorneys and financial planners, as well as ask questions, take self-assessments and more.

GuidanceResources is available to you 24 hours a day, 7 days a week.

- Call **1-800-232-6357** or **1-866-778-5885**. You can speak to a counseling professional who will listen to your concerns and can guide you to the appropriate services you require.
- Visit GuidanceResources Online at **guidanceresources.com** and enter company ID: HONDA.

Remember, your GuidanceResources benefits are strictly confidential. To view the HIPAA privacy notice, please go to **guidanceresources.com/privacy**.

Substance Abuse Treatment

	HSA Plan		***PPO Plan***		***HMO Plan***
Expense	***In-Network Provider****	***Out-of-Network Provider*** **	***In-Network Provider****	***Out-of-Network Provider*** **	***HMO Provider***
Inpatient facility services for substance abuse treatment	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60% after calendar year deductible	100%, no calendar year deductible after $250 facility copay per admission
Physician charges for inpatient substance abuse treatment	90%, after calendar year deductible	70%, after calendar year deductible	80%, after calendar year deductible	60% after calendar year deductible	100% covered, after calendar year deductible
Outpatient substance abuse treatment	90%, after calendar year deductible	70%, after calendar year deductible	$30 copay per visit, no deductible; 80%, after calendar year deductible for other outpatient services	60%, after calendar year deductible	$30 copay per individual visit; $15 copay per group visit
Pre-certification	Inpatient, intensive outpatient and partial hospitalization/ residential treatment facility treatments services require pre-certification by a Quantum Health Care Coordinator (**1-866-778-5885**) by the next business day after admission (see "Pre-Certification for HSA and PPO Plans" on page 145 for more information)				Pre-certification required; call: • Kaiser California: **1-800-464-4000** • Kaiser Georgia: **1-888-865-5813** • Kaiser Northwest: **1-800-813-2000** (see "Pre-Certification for Kaiser HMO Plan" on page 149 for more information)

*Up to negotiated rate.

**Up to allowed amount.

Organ Transplants

UMR provides access to Optum Transplant Centers of Excellence and Blue Cross Blue Shield of Alabama provides access to Blue Distinction Transplant Centers of Excellence—healthcare 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; and
  - 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); and
- Inpatient and outpatient expenses directly related to a transplant.

If you are a participant in a 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 in-network care expenses. There is no coverage for non-COE transplant providers.

What Is Covered

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; and
- 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 benefit amount (see the next page).

For In-Network Level Coverage…

Any covered expenses you incur from a COE facility will be considered in-network care expenses. Services received at a non-COE facility, even if received from an in-network provider, are not covered.

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 benefit	$10,000 total for patient and companion per transplant performed in a 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.

Transplant Services for Kaiser HMO Plan Members

Kaiser covers transplants of organs, tissue or bone marrow if you satisfy the medical criteria developed by the medical group and the medical group provides a written referral for care to a transplant facility as described in the Kaiser Evidence of Coverage (EOC).

Kaiser Travel and Lodging for Certain Referrals

Kaiser will arrange or provide reimbursement for certain travel and lodging expenses at a distant location in accordance with their policy. For more information about Kaiser organ transplant coverage, see your EOC or contact Kaiser directly.

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 *Prescription Drug Plan* on page 169);
- 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, without the expectation of transplantation within 12 months for an existing illness; and
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Quantum Health.

Gender Reassignment Services

Honda covers gender reassignment/transition services for those diagnosed with gender dysphoria, including pre-surgery and post-surgery treatment, along with the necessary ongoing prescription treatment. Cosmetic services are excluded.

Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between an individual's gender identity and the gender assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). A diagnosis of gender dysphoria requires a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must

continue for at least six months. This condition may cause clinically significant distress or impairment in social, occupational or other important areas of functioning. To qualify for benefits, the following requirements may be requested (for a full listing or instructions, please contact Quantum Health at **1-866-778-5885**):

- Single letter of referral from a qualified mental health professional;
- Persistent, well-documented gender dysphoria;
- Capacity to make a fully informed decision and to consent for treatment;
- Age of majority (18 years of age or older); and
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

Gender reassignment surgery is performed to change primary and/or secondary sex characteristics. In addition to hormone therapy and gender reassignment surgery, psychological adjustments are necessary in affirming sex. Treatment should focus on psychological adjustment, with hormone therapy and gender reassignment surgery being viewed as confirmatory procedures dependent on adequate psychological adjustment. Mental healthcare may need to be continued after gender reassignment surgery.

Bariatric Surgery for the HSA and PPO Plans

The plan covers surgical treatment of morbid obesity provided all of 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 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.
- You have 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 BRS Program. Members can initiate this by contacting Quantum Health.

Bariatric Surgery for Kaiser HMO Plan

Kaiser covers hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the medical group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long-term bariatric surgery success.

- A Plan Physician, who is a specialist in bariatric care, determines that the surgery is medically necessary.

For details, please consult with member services or refer to your Evidence of Coverage (EOC).

Bariatric Resources Services (BRS)

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. The 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.

Other Covered Services for the HSA and PPO Plans

The plans also cover the following services, subject to the applicable deductible, coinsurance and/or copay.

Additional covered services include:

Augmentation Communication Devices

The plan covers augmentation communication devices and related instruction or therapy.

Autism Spectrum Disorder (ASD) Treatment

Autism spectrum disorder treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric and pharmaceutical (medication management) care; speech therapy, occupational therapy and physical therapy; or applied behavioral analysis (ABA) therapy.

Treatment is subject to all other plan provisions as applicable (such as prescription benefit coverage, behavioral/mental health coverage and/or coverage of therapy services).

Coverage does not include services or treatment identified elsewhere in the plan as non-covered or excluded (such as experimental, investigational or unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).

Breast Reductions

The plan covers breast reductions determined to be medically necessary.

Cataract or Aphakia Surgery

The plan covers cataract or aphakia surgery as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal lenses are not allowable.

Circumcision

The plan covers circumcision and related expenses when care and treatment meet the definition of medical necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

Cleft Palate and Cleft Lip

Cleft palate and cleft lip benefits will be provided for initial and staged reconstruction of cleft palate or cleft lip. Such coverage includes medically necessary oral surgery and pre-graft palatal expander.

Cornea Transplants

The plan covers cornea transplants.

Dental Services

In addition to the services described under "Treatment of Mouth, Jaws and Teeth" on page 113, covered dental services include:

- Inpatient or outpatient hospital charges, including professional services for X-rays, laboratory services and anesthesia while in the hospital, if medically necessary; and
- Removal of all teeth at an inpatient or outpatient hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the covered person can undergo radiation therapy for a covered medical condition.

Extended Care Facility Services

The plan covers extended care facility services for both mental and physical health diagnoses. Charges will be paid under the applicable diagnostic code. Extended care facilities include skilled nursing facilities and residential treatment facilities. The following services are covered:

- Room and board; and
- Miscellaneous services, supplies and treatments provided by an extended care facility, including inpatient rehabilitation.

Foot Care (Podiatry)

The plan covers foot care (podiatry) that is recommended by a physician as a result of infection. The following charges for foot care will also be covered:

- Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet when surgery is performed;
- Treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease; and
- Physician office visit for diagnosis of bunions. The plan also covers treatment of bunions when an open-cutting operation or arthroscopy is performed.

Genetic Counseling

The plan covers genetic counseling based on medical necessity.

Infant Formula

The plan covers infant formula administered through a tube as the sole source of nutrition for the covered person.

Learning Disability

The plan covers special education, remedial reading, school system testing and other rehabilitation treatment for a learning disability, except when such services are provided by a school.

Massage Therapy

The plan covers massage therapy performed in conjunction with manipulations by a qualified chiropractor, a qualified massage therapist (MT), a qualified physical therapist (PT) or other qualified provider, if applicable.

Medical and/or Routine Services Provided in a Foreign Country

The plan covers medical and/or routine services provided in a foreign country; however, no coverage is provided if the sole purpose of travel to that country is to obtain medical services and/or supplies.

Nursery and Newborn Expenses, Including Circumcision

The plan covers nursery and newborn expenses, including circumcision, for the following children of the covered employee or covered spouse: natural (biological) children and newborn children who are adopted or placed for adoption at the time of birth.

Nutritional Counseling

The plan covers nutritional counseling, if medically necessary.

Nutritional Supplements, Enteral Feedings, Vitamins and Electrolytes

The plan covers nutritional supplements, enteral feedings, vitamins and electrolytes that are prescribed by a physician and administered through a tube, provided they are the sole source of nutrition or are part of a chemotherapy regimen. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings), provided the feedings are prescribed by a physician and are the sole source of nutrition or are part of a chemotherapy regimen.

Oral Surgery

The plan covers oral surgery, including:

- Excision of partially or completely impacted teeth in the hospital only;
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations;
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Reduction of fractures and dislocations of the jaw;
- External incision and drainage of cellulitis;
- Incision of accessory sinuses, salivary glands or ducts; and
- Excision of exostosis of jaws and hard palate.

Orthognathic, Prognathic, and Maxillofacial Surgery

The plan covers orthognathic, prognathic and maxillofacial surgery, when medically necessary.

Oxygen and Administration of Oxygen

The plan covers oxygen and its administration.

Pharmacological Medical Case Management

The plan covers pharmacological medical case management (medication management and lab charges).

Pre-Admission Testing

The plan covers pre-admission testing if necessary and consistent with the diagnosis and treatment of the condition for which the covered person is being admitted to the hospital.

Qualifying Clinical Trials

The plan covers qualifying clinical trials as defined below, including routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening diseases or conditions. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

  Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

  Benefits are available only when the covered person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

  Routine patient care costs for qualifying clinical trials may include:

  - Covered health services (e.g., physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
  - Covered health services required solely for the administration of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
  - Covered health services needed for reasonable and necessary care arising from the provision of an investigational item or service.

  Routine costs for clinical trials do not include:

  - The experimental or investigational service or item as it is typically provided to the patient through the clinical trial;
  - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
  - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
  - Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening diseases or conditions and that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH), including the National Cancer Institute (NCI);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or Veterans Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or
  - The Department of Veterans Affairs, the DOD or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - It is comparable to the system of peer review of studies and investigations used by the NIH; and
    - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
  - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
  - The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
  - The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The plan sponsor may, at any time, request documentation about the trial; or
  - The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the plan.

Radiology and Interpretation Charges

The plan covers radiology and interpretation charges.

Respiratory Therapy

The plan covers respiratory therapy by a qualified respiratory therapist or other qualified provider.

Sleep Disorders

The plan covers sleep disorders, if medically necessary.

Sleep Studies

The plan covers sleep studies.

Urgent Care Facility

The plan covers urgent care—the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have injuries or illnesses that require immediate care but are not serious enough to warrant a visit to an emergency room.

Walk-In Retail Health Clinics

The plan covers charges associated with medical services provided at walk-in retail health clinics.

In addition, if your worksite has an on-site clinic, you may visit the on-site clinic for minor illnesses and injuries. Services include the diagnosis and treatment (including prescription drugs) of illnesses and/or injuries such as strep throat, bladder infections, pink eye, infections of the ears, nose and throat, and some types of physical therapy. Charges are comparable to walk-in retail health clinics. For additional details about available services, please contact your local on-site clinic.

COVID-19 Services

Effective March 18, 2020 and until the end of the COVID-19 public health emergency, the plan will provide for the following without imposing any requirements for cost-sharing, pre-certification or medical management:

- Diagnostic testing for COVID-19 and certain items and services that result in an order for, or administration of, the testing;
- COVID-19 antibody tests; and
- The provision of COVID-19 services described above is subject to amendment by federal law or regulation; in such event, the plan will administer COVID-19 testing and/or services as required by federal law and/or regulation.

Care Coordination for HSA and PPO Plans

Quantum Health provides a care coordination process to ensure you obtain high-quality healthcare and services in the most appropriate setting, reduce unnecessary costs and promote early identification of complex medical conditions. In some cases, failure to follow this process of care can result in significant benefit reductions, penalties or even loss of benefits for specific services.

Care coordination generally includes:

- Designating a primary care physician (PCP);
- The review and coordination process, including:
  - Pre-certification of certain procedures;
  - Utilization review;
  - Concurrent review of hospitalization and courses of care; and
  - Case management.

Care Coordination
*Contact a Quantum Health Care Coordinator at **1-866-778-5885**.*

Designating a Primary Care Physician (PCP)

A PCP is responsible for providing general healthcare guidance, evaluation and management. Choosing a PCP is strongly recommended but is not mandatory. To ensure the highest level of benefits, and the best coordination of your care, your PCP should be an in-network provider.

A PCP can be a:

- General or family practitioner;
- Internist;
- Pediatrician (for children);
- Physician's assistant;
- Nurse practitioner;
- OB/GYN; and
- Mental health/substance abuse provider.

You are encouraged to contact your PCP first whenever you need care. In addition to providing care coordination and submitting referral and pre-certification requests, your PCP may also receive notices regarding your plan's healthcare services.

If you have trouble obtaining access to a PCP, the Quantum Health Care Coordinators may be able to assist you by providing a list of available PCPs and even contacting PCP offices on your behalf. Please contact the Care Coordinators at **1-866-778-5885**.

Pre-Certification for HSA and PPO Plans

To receive the highest level of benefits and ensure complete care coordination, you must have certain care, services and procedures pre-certified in advance. Your PCP, specialty physician or other provider may submit a pre-certification request to Quantum Health's Care Coordinators. You are ultimately responsible for ensuring that all pre-certifications are approved and in place prior to the time of service.

Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the need for the pre-certification request and to ensure that the care, service and/or procedure meet plan criteria.

If a pre-certification request does not meet your plan's criteria, the Care Coordinator will contact you and your healthcare provider and assist in redirecting care if appropriate.

The following services require pre-certification:

- Inpatient hospital, residential treatment facility and extended care facility admissions;
- Outpatient surgeries;
- MRI/MRA and PET scans;
- Oncology care and services (chemotherapy and radiation therapy);
- Genetic testing;
- Home healthcare;

- Hospice care;
- DME—all rentals and any purchase over $1,500;
- Organ, tissue and bone marrow transplants;
- Dialysis;
- Fertility; and
- Partial hospitalization and intensive outpatient for mental health/substance abuse.

Penalties for Not Obtaining Pre-Certification

You will be charged a $400 non-notification penalty if pre-certification is not obtained prior to the following services:

- Inpatient admissions;
- MRI/MRA and PET scans;
- Extended care facility; and
- Residential treatment facility admission.

In addition, certain services, such as outpatient surgeries, oncology care and services, home healthcare and hospice care, require you to comply with the care coordination "process of care" for services to be covered.

Utilization Review

The Quantum Health Care Coordinators review each pre-certification request to evaluate whether the care, requested procedures and requested care setting all meet the plan's utilization criteria. If a pre-certification request does not meet these criteria, the request will be reviewed by one of the medical directors for Quantum Health, who will review all available information and, if needed, consult with the requesting provider. If required, the medical director will also consult with other professionals and medical experts with knowledge in the appropriate field. The medical directors will then provide a recommendation to the Quantum Health Care Coordinators whether the request should be approved or denied. Through this process, the Care Coordinators will ensure that pre-certification requests are reviewed according to nationally accepted standards of medical care, based on community healthcare resources and practices.

Concurrent Review

The Care Coordinators will regularly monitor a hospital stay, other institutional admission, or ongoing course of care for any covered member, and examine the possible use of alternate facilities or forms of care. The Care Coordinators will communicate regularly with attending physicians, the utilization management staff of such facilities, and the covered member and/or family (when appropriate) to monitor the patient's progress and anticipate and initiate planning for future needs (discharge planning). This concurrent review, and authorization for plan coverage of hospital days, is conducted in accordance with the utilization criteria adopted by the plan and Quantum Health.

Case Management

Case management is the ongoing, proactive coordination of care in cases where the medical condition is, or is expected to become, catastrophic or chronic or when the cost of treatment is expected to be significant. Examples of conditions that could prompt case management intervention include, but are not limited to:

- Cancer;
- Chronic obstructive pulmonary disease;
- Multiple trauma;
- Spinal cord injury;
- Stroke;
- Head injury;
- AIDS;
- Multiple sclerosis;
- Severe burns;
- Severe psychiatric disorders;
- High-risk pregnancy; and
- Premature birth.

Case management is a collaborative process designed to meet your healthcare needs and maximize your health potential, while effectively managing the cost of care. The case manager will consult with you, your attending physician and other members of your treatment team to assist in facilitating/implementing proactive plans of care, which will provide the most appropriate healthcare and services in a timely, efficient and cost-effective manner.

If you, your case manager and the Plan Administrator all agree on alternative care that can reasonably be expected to achieve the desired results without sacrificing the quality of care provided, the Plan Administrator may alter or waive the plan's normal provisions to cover such alternative care, at the benefit level determined by the Plan Administrator.

In developing an alternative plan of treatment, the case manager will consider:

- Your current medical status;
- The current treatment plan;
- The potential impact of the alternative plan of treatment;
- The effectiveness of such care; and
- The short-term and long-term implications this treatment plan could have.

If an alternative plan of treatment is warranted, the Care Coordinators will submit this plan to the claims administrator for prior review and approval.

Quantum Health retains the right to review your medical status while the alternative plan of treatment is in process and to discontinue the alternative plan of treatment with respect to medical services and supplies that are not covered charges under the plan if:

- The attending physician does not provide medical records or information necessary to determine the effectiveness of the alternative plan of treatment.

- The goal of the alternative care of treatment has been met.
- The alternative plan of care is not achieving the desired results or is no longer beneficial to you.

Chronic Condition Management

Chronic condition management (also referred to as disease management) is specialized support and coordination for members with lifelong, chronic conditions such as diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and asthma. Chronic condition management is a collaborative process that supports disease management by helping the member understand the care pathway, set goals, have a discussion with his or her attending physician about complications or conflicts with care, evaluate how to eliminate barriers to successful self-management, and generally maximize his or her health. Members who are identified from claims, biometrics or other sources will be assessed for level of risk for each disease state and may be contacted proactively by a Chronic Condition Case Manager (also referred to as Disease Manager). Members whose information indicates they are at high risk will be contacted by a Chronic Condition Case Manager for an assessment and ongoing assistance and will be asked to update their care pathway information bi-annually. Members who are at low or moderate risk may request assistance of a Chronic Condition Case Manager and will also be asked to update their care pathway information on a bi-annual basis. Participation in chronic condition care management is voluntary, but participants may receive various prescription medications and/or supplies at a reduced cost or may be entitled to benefits that non-participants do not receive.

General Provisions for Care Coordination

Authorized Representative

You are ultimately responsible for ensuring that all pre-certifications are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual referral and pre-certification process will be executed by your physician or other providers. As a covered member, you authorize the plan and its designated service providers (including Quantum Health, the third-party administrator and others) to accept your healthcare providers making referral and pre-certification submissions as your authorized representatives in care coordination matters. Communications with and notifications to such healthcare providers will be considered as notification to you.

Time of Notice

The pre-certification notifications should be made to the Care Coordinators within the following timeframe:

- At least three business days before a scheduled (elective) inpatient admission;
- By the next business day after an emergency admission;
- Upon being identified as a potential organ or tissue transplant recipient; and
- At least three business days before receiving any other services requiring pre-certification.

Emergency Admissions and Procedures

Any hospital admission or outpatient procedure that has not been previously scheduled and cannot be delayed without harming the patient's health is considered an emergency for purposes of the utilization review notification.

Maternity Admissions

A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to expected delivery. The plan and the care coordination process comply with all federal regulations regarding utilization review for maternity admissions. The plan will not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require prior notification or certification for prescribing a length of stay not in excess of these periods. If the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the plan will only consider benefits for the actual length of the stay. The plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48- or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Care Coordination Does Not Guarantee Payment of Benefits

The care coordination process does not provide a guarantee of payment of benefits. Approvals of pre-certification notices for specialty visits, procedures, hospitalizations and other services indicate that the medical condition, services and care settings meet the utilization criteria established by the plan. Care coordination approvals do not indicate that you are eligible for such benefits, or that other benefit conditions such as copay, deductible, coinsurance, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the plan.

Failure to Comply with Care Coordination Process of Care

You will be charged a $400 non-notification penalty if you fail to comply with the care coordination "process of care" for extended care facility or residential treatment facility inpatient admission and MRI/MRA and PET scans. Charges paid due to any penalty for failure to follow the care coordination process do not count toward satisfying any deductible, coinsurance or out-of-pocket limits of the plan. In addition, certain services, such as outpatient surgeries, oncology care and services, home healthcare and hospice care, require you to comply with the care coordination "process of care" for services to be covered.

Appeal of Care Coordination Determinations

You have certain appeal rights regarding adverse determinations in the care coordination process, including reduction of benefits and penalties. For more information, see *Administrative Information* on page 316.

Pre-Certification for Kaiser HMO Plan

The following are examples of services that require pre-certification by the medical group for the services to be covered ("pre-certification" means that the medical group must approve the services in advance):

- Durable medical equipment;
- Services not available from plan providers; and
- Transplants.

Utilization management (UM) is a process that determines whether a service recommended by your treating provider is medically necessary for you. Pre-certification is a UM process that determines whether the requested services are medically necessary before care is provided. If it is medically

necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of services that require pre-certification and the criteria that are used to make authorization decisions, please call the Kaiser Member Service Contact Center to request a printed copy:

- Kaiser California: **1-800-464-4000**
- Kaiser Georgia: **1-888-865-5813**
- Kaiser Northwest: **1-800-813-2000**

Expenses Not Covered by the Plan

The plan does not pay benefits for the following:

- Abortions, unless the physician states in writing that the fetus' or mother's life would be in danger if the fetus were carried to term, or unless the pregnancy is the result of incest or rape;
- Acts of war: injury or illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared;
- Alternative/complementary treatment, including services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the plan;
- Amounts above the allowable charge or network negotiated charge as determined by your claims administrator;
- Any benefits that are prohibited by law in your local area;
- Appointment missed—an appointment the covered person did not attend;
- Assistance with activities of daily living;
- Assistant surgeon, co-surgeons or surgical team services, unless determined to be medically necessary by the plan;
- Before enrollment and after termination: services, supplies or treatment rendered before coverage begins or after coverage ends under the plan;
- Bereavement counseling;
- Biofeedback services;
- Blood donor expenses;
- Blood pressure cuffs/monitors;
- 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);
- Cardiac rehabilitation beyond Phase II, including self-regulated physical activity that the covered person performs to maintain health that is not considered to be a treatment program;
- Care provided to prevent a surrounding area from exposure to disease or injury;

- Charges covered under any governmental law or coverage you qualify for due to past or present service in the armed forces (except Medicaid or as specifically required by law);
- Charges for in-mouth appliances or related adjustments or fitting services except as provided for injury or temporomandibular joint dysfunction;
- Charges for surgery to correct refractive errors;
- 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;
- Charges made only because there is healthcare coverage or that a covered person is not legally responsible for (see note in box at right);
- Claims received later than 12 months from the date of service;
- Cosmetic treatment, cosmetic surgery or any portion thereof, unless the procedure is otherwise listed as a covered benefit;
- Court-ordered—any treatment or therapy that is court-ordered or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by the plan. The plan does not cover the cost of classes ordered after a driving-while-intoxicated conviction or other classes ordered by the court;
- Custodial care—non-medical care given to a covered person, such as administering medication and assisting with personal hygiene or other activities of daily living, rather than providing therapeutic treatment and services;
- Dental implants, except as otherwise outlined in the SPD;
- Duplicate services and charges or inappropriate billing, including the preparation of medical reports and itemized bills;
- Education—charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics;
- Environmental devices, including environmental items such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers and vacuum devices;
- Examinations for employment, insurance, licensing or litigation purposes;

Note

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.

- Excess charges—charges or the portion thereof that are in excess of the allowed amount, the usual and customary charge, the negotiated rate or the fee schedule;
- Experimental, investigational or unproven—services, supplies, medicines, treatment, facilities or equipment that the plan determines are experimental, investigational or unproven, including administrative services associated with experimental, investigational or unproven treatment. This exclusion does not apply to qualifying clinical trials as described in of this SPD;
- Extended care facility services that exceed the appropriate level of skill required for treatment as determined by the plan;
- Fitness programs, including fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or bodybuilding;
- Foot care (podiatry) consisting of routine foot care;
- Genetic counseling other than based on medical necessity, unless covered elsewhere in this SPD;
- Genetic testing, unless covered elsewhere in this SPD;
- Glasses, child;
- Growth hormones;
- Home births and associated costs;
- Home modifications, including modifications to your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts or ramps;
- Infant formula not administered through a tube as the sole source of nutrition for the covered person;
- Intraocular lenses other than conventional intraocular cataract lenses;
- Lamaze classes or other childbirth classes;
- Liposuction**,** unless covered elsewhere in this SPD;
- Long-term care;
- Maintenance therapy if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve a condition, or if clinical evidence indicates that a plateau has been reached in terms of improvement from such services;
- Mammoplasty or breast augmentation, unless covered elsewhere in this SPD;
- Marriage, family, child, career, social adjustment, pastoral or financial counseling, except through Associate Assistance Program services;
- Military-related illness of or injury to a covered person on active military duty, unless payment is legally required;
- Nocturnal enuresis alarm (bed wetting);
- Non-custom-molded shoe inserts;
- Non-emergency care when traveling outside the U.S. (Kaiser HMO Plan);

- Nutrition counseling, unless covered elsewhere in this SPD;
- Nutritional supplements, enteral feedings, vitamins and electrolytes unless covered elsewhere in this SPD;
- Occupational illness and injury;
- Over-the-counter medication, products, supplies or devices**,** unless covered elsewhere in this SPD;
- Palliative foot care;
- Panniculectomy/abdominoplasty, unless determined by the plan to be medically necessary;
- Pharmacy consultations charges for or related to consultative information provided by a pharmacist regarding a prescription order, including, but not limited to, information related to dosage instruction, drug interactions, side effects, and the like;
- Private duty nursing services;
- Reconstructive surgery when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the plan, unless covered elsewhere in this SPD;
- Return to work/school—telephone or Internet services;
- Reversal of sterilization procedure;
- Room and board fees when surgery is performed other than at a hospital or surgical center;
- Routine dental and vision care;
- Routine foot care unless otherwise specified;
- Self-administered services or procedures that can be performed by the covered person without the presence of medical supervision;
- Services at no charge or cost—services for which the covered person would not be obligated to pay in the absence of this plan or that are available to the covered person at no cost, or for which the plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law;
- Services provided by a close relative, meaning a member of the immediate family;
- Services provided by a school;
- Services related to oral surgery and dental care, except to the extent coverage for such services is specifically provided in this SPD;
- Services/supplies that are not medically necessary, as determined by Quantum Health, even if prescribed by a physician; includes services/supplies:
  - That do not require the technical skills of a medical, mental health or dental professional;
  - Provided mainly for the comfort or convenience of you, the caregiver, your family or healthcare provider; and
  - 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;
- Sex therapy;
- Standby surgeon charges;
- Subrogation—charges for an illness or injury suffered by a covered person due to the action or inaction of any third party if the covered person fails to provide information as specified in this SPD;
- Surrogate parenting and gestational carrier services, including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges incurred by a covered person acting as a surrogate parent;
- Taxes, including sales taxes and shipping and handling charges, unless covered elsewhere in this SPD;
- Telemedicine—telephone or Internet consultations made by a covered person's treating physician to another physician (this exclusion does not apply to Teladoc services);
- Transportation services that are solely for the convenience of the covered person, the covered person's close relative or the covered person's physician;
- Treatment of covered mental healthcare providers who receive such treatment as part of their training;
- Treatment, therapy or supplies for:
  - Primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetics therapy, vision perception training or carbon dioxide therapy; and
  - Sexual dysfunctions without a physiological or organic basis.
- Vitamins, minerals and supplements, even if prescribed by a physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a physician for medically necessary purposes;
- Vocational and educational services rendered primarily for training or education purposes. The plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for injury prevention education or return-to-work programs;
- Weekend admissions to hospital confinement (admissions taking place after 3 p.m. on Fridays or before noon on Sundays) unless the admission is deemed an emergency or is for care related to pregnancy that is expected to result in childbirth;
- Weight control services (except as included as routine preventive care) 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 comorbid conditions; use of Centers of Excellence required for surgery, but not for diagnostic services or nutritional counseling;
- Workers' Compensation charges related to illnesses or injuries covered by Workers' Compensation or similar law; and

- Wrong surgeries additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

Claims

If you receive care from an in-network provider, the provider will file the claims.

In all other cases, you need to file claims 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. In-network providers may have less time depending on their contract.

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. The plan does not permit the assignment of rights or benefits.

If You Have Questions

If you are enrolled in the HSA Plan or PPO Plan, call Quantum Health at **1-866-778-5885** *for questions about your claims. If you are enrolled in the Kaiser HMO Plan, call:*

- *Kaiser California:* **1-800-464-4000**
- *Kaiser Georgia:* **1-800-865-5813**
- *Kaiser Northwest:* **1-800-813-2000**

When Coverage Ends

When medical plan coverage ends is described in *Participating in Health Benefits* on page 68.

In certain cases, you or your covered dependent(s) may continue coverage for a limited time by paying the full cost. See *COBRA* on page 204.

Disability, Layoff and Leave of Absence

Normally, your employment ends when you cease active work. However, if you are not at work due to disability, layoff or certain leaves of absence, your employment—and medical coverage—may continue for a stated period. For details, refer to your Associate Handbook or contact your local HR.

At the end of any extended coverage period, you may be entitled to continue your coverage, at your expense, under COBRA. See *COBRA* on page 204 for details.

Survivor Medical Insurance

Coverage will continue for your dependents for more than 12 months if you elected the Survivor Medical Insurance Program. See "Survivor Medical Insurance Program" on page 240 under Supplemental Insurance Plans.

In the Event of Your Death

In the event of your death while covered under the medical plan, Honda will continue medical plan coverage for your covered dependents for up to 12 months after the end of the month of your death.

Coverage will end prior to this date if a dependent:

- No longer meets the eligibility definition (for your spouse, this includes remarriage); or
- Becomes eligible for similar coverage under this plan.

At the end of the 12-month period, your dependents may be entitled to continue their coverage, at their expense, under COBRA. See *COBRA* on page 204.

If you elected to participate in the Survivor Medical Insurance Program, your coverage will continue for your dependents beyond the 12 months. See "Survivor Medical Insurance Program" on page 240 under *Supplemental Insurance Plans* for more information.

Glossary

The following definitions are provided to help you understand your medical coverage. UMR and Blue Cross Blue Shield of Alabama (BCBS-AL) define some of these terms differently, and some terms are not defined at all by one claims administrator or the other. Follow the definition of the claims administrator to which you are aligned. If you are covered by an HMO, see Kaiser's Evidence of Coverage (EOC).

Important Note!
The rate that has been negotiated for in-network providers is generally called "negotiated rate" in this SPD. The allowable amount under the plan for services/supplies that are provided by out-of-network providers is called the "allowed amount."

Allowed Amount

UMR: When UMR receives a claim for a service that has been provided to a covered person, it will determine if the service is a covered benefit under this group health plan. If the service 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 is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

The maximum allowable charge is the highest fee the plan will consider for payment for a particular service. If you use an out-of-network provider and his or her fee is more than the plan's maximum allowable charge, you are responsible for paying the difference in addition to any deductibles or coinsurance amounts applied to your claim. Charges that exceed the maximum allowable charges do not count toward your annual deductible or out-of-pocket maximum. Please note, if you use an out-of-network provider, the difference between the maximum allowable charge and the provider's actual charges can be significant.

The maximum allowable charge 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, the maximum allowable charges will be based on 50% of billed charges. Charges that exceed the maximum allowable charge do not count towards the annual deductible or the out-of-pocket maximum.

BCBS-AL: Benefit payments are covered based on the amount of the provider's charge that Blue Cross Blue Shield of Alabama (BCBS-AL) 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 BCBS-AL to be allowable depending on the type of provider and the state in which the services are rendered.

- ***In-network providers.*** Blue Cross 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 copays, 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 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 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 Blue Shield plan does not provide pricing data or when BCBS-AL 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 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; and
  - Out-of-network providers include providers that have not signed a contract with a Blue Cross Blue Shield plan where services are rendered as well as participating or contracting providers who have not been designated by the local Blue Cross 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.

Ambulatory Surgical Center

BCBS-AL: A facility that provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed. To be considered an ambulatory surgical facility under the plan, the facility must meet the conditions for participation in Medicare.

Behavioral Health Provider

UMR: The services must be provided by a qualified provider. If outside the United States, outpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located or a therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry. The attending physician, psychiatrist or counselor must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of substance use disorder and chemical dependency disorders.

Custodial Care

BCBS-AL: Care primarily to provide room and board for a person who is mentally or physically disabled.

Deductible

An amount of money paid once per plan year by the covered person (up to a family limit, if applicable) before any covered expenses are paid by the plan. “How the Medical Plans Work” on page 92 shows the amount of the applicable deductible (if any) and the healthcare benefits to which it applies.

Diagnostic

BCBS-AL: Services performed in response to signs or symptoms of illness, condition or disease or in some cases where there is family history of illness, condition or disease.

Durable Medical and Surgical Equipment (DME)

UMR: Equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an illness or injury.
- It is generally not useful to a person in the absence of an illness or injury.
- It is appropriate for use in the covered person’s home.

A cochlear implant is not considered durable medical equipment.

BCBS-AL: Equipment the claims administrator approves as medically necessary to diagnose or treat an illness or injury or to prevent a condition from becoming worse. To be considered durable medical equipment, an item must be made to withstand repeated use, be for a medical purpose rather than for comfort or convenience, be useful only if you are sick or injured, and be related to your condition and prescribed by your physician to use in your home.

Eligible Charge

For the HMO Plan, “eligible charge” means the following:

- For services provided by the health plan or medical group or Kaiser hospitals, the amount in the health plan’s schedule of medical group and health plan or Kaiser hospitals charges for services provided to members;
- For services for which a provider (other than the medical group or Kaiser Foundation hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider;
- For items covered under “pharmacy services” and obtained at a pharmacy owned and operated by the health plan, “eligible charge” means the amount the pharmacy would charge a member for the item if a member’s benefits plan did not cover the item. This amount is an estimate of the cost of acquiring, storing and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy services to members, and the pharmacy program’s contribution to the net revenue requirements of the health plan;
- For all other services, the payments that Kaiser Permanente makes for the services or, if Kaiser Permanente subtracts your cost share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your cost share;
- For services received from plan providers or other contracted providers, the amount the provider has agreed to accept as payment;
- For emergency services received from non-plan providers, the greater of (a) the amount paid by the health plan to plan providers; (b) the usual, reasonable and customary rate for

those services in the area where the treatment is provided, based on objective criteria utilized by the health plan (such as the fee schedule of the Georgia State Board of Workers' Compensation); or (c) the amount in the Medicare fee schedule; and

- For all other services received from non-plan providers (including post-stabilization services), the amount agreed upon with the provider, or, absent an agreement, the usual, customary and reasonable rate for those services in the area where the treatment is provided, based on objective criteria (such as the fee schedule for the Georgia State Board of Workers' Compensation).

Extended Care Facility

UMR: A facility including, but not limited to, a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a physician or registered nurse. In addition, the plan requires that the facility provide 24-hours-per-day service to include skilled nursing care and medically necessary therapies for the recovery of health or physical strength; not be a place primarily for custodial care; require compensation from its patients; admit patients only upon physician orders; have an agreement to have a physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one hospital, be licensed by the state in which it operates, and provide the services to which the licensure applies.

Experimental, Investigational or Unproven

UMR: Any drug, service, supply, care or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, investigational or experimental stage of development or performed within or restricted to use in phase I, II or III clinical trials (unless identified as a covered service elsewhere); and
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought).

Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials **or** at least one or more large, controlled, national, multi-center, population-based studies:

- Items based on anecdotal and unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established; and
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care or treatment is considered experimental, investigational or unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in

Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies and/or independent review organizations to evaluate the scientific quality of supporting evidence.

BCBS-AL: Any treatment, procedure, facility, equipment, drugs, drug usage or supplies that either Blue Cross Blue Shield of Alabama has not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, Blue Cross Blue Shield of Alabama develops written criteria (called medical criteria) concerning services or supplies it considers investigational. These criteria are based on peer-reviewed literature, recognized standards of medical practice and technology assessments. Blue Cross Blue Shield of Alabama puts these medical criteria in policies that are made available to the medical community and you. This is done so that you and your providers will know in advance, when possible, what the plan will pay for. If a service or supply is considered investigational, Blue Cross Blue Shield of Alabama will not pay for it. If the investigational nature of a service or supply is not addressed by one of the published medical criteria policies, it will be considered non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the investigational setting.

You must remember that when Blue Cross Blue Shield of Alabama makes determinations about the investigational nature of a service or supply, they are made solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Explanation of Benefits (EOB)

Your EOB is a statement sent by your medical plan claims administrator explaining what your plan paid and what you owe for any medical procedures and/or services you received. Your EOB process differs depending on your medical plan claims administrator.

- **UMR:** You will receive an EOB only if you have an out-of-pocket cost. If there is no cost to you, or if there was only a flat copay, no EOB will be sent. You can opt to receive your EOB electronically instead of by mail. All EOBs are available at **umr.com**.
- **BCBS-AL:** An EOB will be mailed for all services. You can opt out of receiving paper EOBs at **bcbsal.com**.

- **Kaiser:** After you receive services, you will be sent an Explanation of Benefits statement. The Explanation of Benefits is not a bill. It shows your total accumulation toward the plan deductible and plan out-of-pocket maximum. You can also view a copy of your Explanation of Benefits on **kp.org** or you may request a copy by calling the Member Service Contact Center at **1-800-464-4000** (California), **1-888-865-5813** (Georgia) or **1-800-813-2000** (Northwest) (TTY users call **711**), Monday through Friday, 7 a.m. to 7 p.m.

Health Maintenance Organization (HMO)

An HMO plan typically has a closed network of physicians and other healthcare providers, and hospitals. With an HMO, you will need to choose a primary care physician, who will manage all your healthcare services. If you need a specialist, you will need a referral from your primary care physician. You do not receive benefits if you receive care outside the network, except in a medical emergency.

Health Savings Account (HSA)

This is a type of savings account that allows you to set aside money on a pre-tax basis to pay for qualified healthcare expenses.

High Deductible Health Plan (HDHP)

This is a health plan with a deductible that is equal to or exceeds the minimum levels set by the IRS for the year. All benefits, other than preventive care, must be subject to the deductible.

Home Healthcare Agency

UMR: A formal program of care and intermittent treatment that is performed in the home; prescribed by a physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a hospital or an extended care facility stay or results in a shorter hospital or extended care facility stay; organized, administered and supervised by a hospital or qualified licensed providers under the medical direction of a physician; and appropriate when it is not reasonable to expect the covered person to obtain medically indicated services or supplies outside the home.

BCBS-AL: An organization that provides care at home for homebound patients who need skilled nursing or skilled therapy. To be considered a home healthcare agency under the terms of the plan, the organization must meet the conditions for participation in Medicare.

Hospice

BCBS-AL: An organization whose primary purpose is the provision of palliative care. Palliative care means the care of patients whose disease is not responsive to curative treatments or interventions. Palliative care consists of relief of pain and nausea and psychological, social and spiritual support services. For an organization to be considered a hospice under this plan, it must meet the conditions for participation in Medicare.

Hospice Care Agency

UMR: This is a licensed agency that provides terminally ill patients with hospice care services (e.g., private nursing services, medical social services, psychological and dietary counseling and bereavement counseling, physical or occupation therapy, home health aide services, 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. A

hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Facility

UMR: This is a licensed facility (or part of a hospital) run by a staff of physicians with established quality procedures and review, which 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. It must also keep complete medical records on all patients. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospital

UMR: A facility that:

- Is a licensed institution authorized to operate as a hospital by the state in which it is operating;
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment and care of injured and sick persons at the patient's expense;
- Has a staff of licensed physicians available at all times;
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country;
- Continuously provides on-premises, 24-hour nursing services by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or custodial care.

For purposes of this plan, the term "hospital" also includes surgical centers and birthing centers licensed by the states in which they operate.

In-Network Hospital, In-Network Physician

UMR: Any organization that has contracted with various providers to provide healthcare services to covered persons at a negotiated rate. Providers who participate in a network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the covered person must pay due to the deductible, plan participation amounts or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the negotiated rates in the network contract.

BCBS-AL: In-network providers are hospitals, physicians, pharmacies and other healthcare providers or suppliers that contract with any Blue Cross Blue Shield plan (directly or indirectly; for example, a pharmacy benefit manager) for furnishing healthcare services or supplies at a reduced rate.

Medical Emergency

An acute 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, serious impairment to bodily function, serious dysfunction of a body part or organ, or, in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Medically Necessary or Medical Necessity

UMR: Healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, mental illness, substance use disorder, condition or disease or its symptoms, that are all of the following as determined by the claims administrator or its designee, within its sole discretion:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for your illness, injury, mental illness, substance use disorder or disease or its symptoms;
- Not mainly for your convenience or that of your doctor or other healthcare provider; and
- Not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, disease or symptoms.

The fact that a physician has performed, prescribed, recommended, ordered or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility medically necessary.

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

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. The claims administrator reserves the right to consult expert opinion in determining whether healthcare services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within the claims administrator’s sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting the claims administrator’s determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to covered persons by calling UMR at the telephone number on the plan ID card, and to physicians and other healthcare professionals on **UnitedHealthcareOnline.com**.

BCBS-AL: Blue Cross Blue Shield of Alabama uses these terms to help determine whether a particular service or supply will be covered. When possible, written criteria (called medical criteria) are developed to help determine medical necessity. BCBS-AL bases these criteria on peer-reviewed literature, recognized standards of medical practice and technology assessments. These medical criteria are put in policies that BCBS-AL makes available to the medical community and its members, so that you and your providers will know in advance, when possible, what BCBS-AL will pay for. If a service or supply is not considered medically

necessary according to one of BCBS-AL's published medical criteria policies, BCBS-AL will not pay for it. If a service or supply is not addressed by one of BCBS-AL's published medical criteria policies, it will be considered to be medically necessary only if BCBS-AL determines that it is:

- Appropriate and necessary for the symptoms, diagnosis or treatment of your medical condition;
- Provided for the diagnosis or direct care and treatment of your medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of you, your family, your physician or another provider of services;
- Not investigational; and
- Performed in the least costly setting, method or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

You must remember that when medical necessity determinations are made, BCBS-AL is making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Kaiser: A service is medically necessary if it is (i) medically required to prevent, diagnose or treat your condition or clinical symptoms; (ii) in accordance with generally accepted standards of medical practice; (iii) not solely for the convenience of you, your family and/or your provider; and (iv) the most appropriate level of service that can safely be provided to you.

Mental Health Disorder

UMR: A syndrome that is present in an individual and that involves clinically significant disturbance in behavior, emotion regulation or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological or developmental processes that are necessary for mental functioning.

BCBS-AL: These are mental disorders, mental illness, psychiatric illness, mental conditions and psychiatric conditions. These disorders, illnesses and conditions are considered mental health disorders whether they are of organic, biological, chemical or genetic origin. They are considered mental health disorders regardless of how they are caused, based or brought on. Mental health disorders include, but are not limited to, psychoses, neuroses, schizophrenic-affective disorders, personality disorders and psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or related system of hormones controlled by nerves. They are generally intended to include disorders, conditions and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

Kaiser: This is a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases (ICD) or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This also applies to what the DSM and ICD define as substance use disorders.

Negotiated Rate

UMR: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service, such as transplant services, durable medical equipment, extended care facility treatment or other services. The negotiated rate is what the plan will pay to the provider, minus any copay, deductible, plan participation rate or penalties that the covered person is responsible for paying. If a network contract is in place, the network contract determines the plan's negotiated rate.

BCBS-AL: The discounted rate that an in-network provider normally accepts (subject to any applicable copays, 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 Blue Shield plan determines which of its participating or contracting providers will be considered in-network providers.

Out-of-Network Hospital, Out-of-Network Physician

A provider who is not an in-network provider.

Physician

UMR: Any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this plan: a doctor of medicine (MD), doctor of medical dentistry, including an oral surgeon (DMD), doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the term "physician" also includes the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this plan.

BCBS-AL: Any healthcare provider when licensed and acting within the scope of that license or certification at the time and place you are treated or receive services.

Kaiser: Any licensed physician who is a partner or employee of the medical group, or any licensed physician who contracts to provide services to members (but not including physicians who contract only to provide referral services).

Plan Provider

Kaiser: A plan physician, practitioner, medical center, medical office, plan hospital or other licensed provider of services, except for designated specialist providers, with whom the medical group, Kaiser Foundation hospitals or health plan contracts to provide services to members, listed in the physician directory.

Pre-certification

The process by which a patient is pre-approved for coverage of a specific medical procedure or prescription drug.

Preferred Provider Organization (PPO)

Hospitals, physicians or other providers who have agreements with any UMR or BCBS-AL plan to provide surgical and medical services to participants entitled to benefits under this plan.

Provider Network

UMR: The word "network" means an organization that has contracted with various providers to provide healthcare services to covered persons at a negotiated rate. Providers who participate in a network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the covered person must pay due to the deductible, plan participation amounts or other out-of-pocket expenses.

The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the negotiated rates in the network contract. A provider who does not participate in a network may bill covered persons for additional fees over and above what the plan pays.

Knowing to which network a provider belongs will help a covered person determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this plan, covered persons should receive services from in-network providers. However, the plan does not limit a covered person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a covered expense under this plan or is subject to a limitation or exclusion.

To find out to which network a provider belongs, please refer to the provider website, or call the toll-free number that is listed on the back of the plan's identification card. The participation status of providers may change from time to time.

If a provider belongs to one of the following networks, claims for covered expenses will normally be processed in accordance with the in-network benefit levels that are listed in "How the Medical Plans Work" on page 92. Claims from providers who do not participate in the Choice Plus network (or Optum network for transplant) will be processed at the out-of-network benefit level.

- UnitedHealthcare Choice Plus: If a provider belongs to the UnitedHealthcare Choice Plus or First Health networks, claims for covered expenses will normally be processed in accordance with the in-network benefit levels that are listed in "How the Medical Plans Work" on page 92.
- First Health Shared Savings: For services received from any other provider, claims for covered expenses will normally be processed in accordance with the out-of-network benefit levels that are listed in "How the Medical Plans Work" on page 92. These providers charge their normal rates for services, so covered persons may need to pay more. Covered persons are responsible for paying the balance of these claims after the plan pays its portion, if any.

Exceptions to the Provider In-Network Benefits

Some benefits may be processed at in-network benefit levels when provided by out-of-network providers. When out-of-network charges are covered in accordance with in-network benefits, services are considered at billed charges. The following exceptions may apply:

- Covered services (including preventive services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist or pathologist will be payable at the in-network level of

benefits when services are provided at an in-network facility even if the provider is an out-of-network provider.

- Covered services provided by a physician during an inpatient stay will be payable at the in-network level of benefits when provided at an in-network hospital.
- The out-of-network provider may bill you for the difference between the recognized and the billed charge. The difference may be significant.

Residential Treatment Facility

A sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hours-per-day, 7-days-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Semi-Private Rate

UMR: For network charges, this rate is based on network re-pricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only if determined by the plan to be medically necessary. If the hospital has no semi-private rooms, the plan will allow the private room rate, subject to the Maximum Non-Network Reimbursement Plan or the negotiated rate, whichever is applicable.

Skilled Nursing Facility

BCBS-AL: A facility including, but not limited to, a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a physician or registered nurse. In addition, the plan requires that the facility provide 24-hours-per-day service to include skilled nursing care and medically necessary therapies for the recovery of health or physical strength; not be a place primarily for custodial care; require compensation from its patients; admit patients only upon physician orders; have an agreement to have a physician's services available when needed; maintain adequate medical records for all patients; have a written transfer agreement with at least one hospital; be licensed by the state in which it operates; and provide the services to which the licensure applies.

Additional Information

- For help determining the cost of a service or supply, contact Quantum Health at **1-866-778-5885**.

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Prescription Drug Plan

The prescription drug plan helps you pay for prescribed medications using either a retail pharmacy or the mail order program. Prescription drug benefits provided through Kaiser may be different from those described here; check with Kaiser for details.

For More Information

Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

Highlights

Options	Prescription drug benefits are automatically provided when you are enrolled in the medical plan.
Cost Per Pay	Paid for primarily by Honda. You will share the cost of coverage for yourself and your dependents.
Who Is Covered	Eligible associates and their eligible dependents
Coverage Begins	First day of the month following your date of hire, if you are eligible for coverage
About This Benefit	Benefits are administered by CVS/Caremark, which offers three types of pharmacy services: • Retail (or pharmacy) for short-term prescriptions; • Mail order or Maintenance Choice for long-term medications; and/or • Specialty medications for chronic or genetic conditions. Your prescription drug costs are determined by the type of prescription drugs you receive (generic, preferred formulary or non-preferred formulary) and how you have them filled (retail or mail order).
Plan Features	For maximum benefits: • Use your medical/prescription drug ID card at network pharmacy for short-term prescriptions For long-term medications, use the mail order program and 90-day Maintenance Choice at a CVS retail pharmacy
Coverage Ends	Last day of medical plan coverage
Administered By	CVS/Caremark

Table of Contents

Who Is Eligible

Eligibility for you and your dependents is defined in *Participating in Health Benefits* on page 68.

When Coverage Begins

When coverage begins is described in *Participating in Health Benefits* on page 68.

How the Prescription Drug Plan Works

Prescription drug benefits are automatically provided when you are enrolled in a medical plan. Benefits are provided by CVS/Caremark, which offers three types of pharmacy services: retail (or pharmacy) for short-term prescriptions, mail order (or Maintenance Choice program) for long-term medications and/or specialty medications for chronic or genetic conditions.

Do Not Forget Your ID Card
Make sure you use an in-network pharmacy. Simply show your medical/prescription drug ID card to get the maximum benefits—and you will not need to file a claim.

Types of Prescription Drugs

You pay a copay or coinsurance for each prescription drug you purchase. In the HSA Plan, you must first meet the annual deductible before you pay a copay or coinsurance for prescription drugs. The amount of the copay or coinsurance depends on how you have the prescription filled and the type of drug: generic, preferred formulary or non-preferred formulary prescription drugs. There are certain drugs that are not covered under the plan. CVS/ Caremark's formulary retains comprehensive therapeutic coverage of drug classes with safeguards for participants requiring medical necessity exceptions. If you are prescribed an excluded drug, CVS/ Caremark will provide resources necessary to support your transition to a cost-effective formulary alternative. Please contact Quantum Health for the current list of exclusions.

Keep in mind that if you choose a brand-name prescription drug when a generic is available, you will pay the appropriate brand-name drug copay or coinsurance up to the maximum as well as the difference between the cost of the generic and the brand-name drug.

Generic. Drugs whose active ingredients, safety, quality and strength are the same as their brand-name counterparts.

Preferred formulary. Drugs that 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 equally effective for treating a particular condition.

A list of preferred brand-name drugs, which identifies drug classes that may have generic availability that could save you money, is available from CVS/Caremark Customer Care or **caremark.com**.

Non-preferred formulary. Drugs that have equally effective and less-costly generic equivalents and/or have one or more preferred brand options.

See the "Glossary" on page 177 for more information about these types of drugs.

CVS/Caremark Website

Remember that the CVS/Caremark website is available to you 24 hours a day, 7 days a week for pharmacy information. You can access the CVS/Caremark website by logging in to **myhondaconnect.com**.

Once you are on the CVS/Caremark website, you can find a variety of information, including:

- Prescription drug information;
- Prescription drug costs;
- Information on generic vs. preferred formulary and non-preferred formulary drugs; and
- Paid claims.

Retail Services

When your doctor prescribes medication for an acute (or short-term) condition, use a CVS/Caremark participating pharmacy. You will find that most pharmacies in your area accept CVS/Caremark. Then, simply show your medical/prescription drug ID card to the pharmacist and you will pay a copay or coinsurance based on the type of prescription drug you buy, as shown in "Your Share of the Cost" on page 175.

Mail Order or Maintenance Choice Program

You should use the CVS/Caremark mail order program or Maintenance Choice program for your long-term maintenance prescriptions—those needed for an ongoing or chronic condition. This program allows you to receive up to a three-month supply (90 days) either through the mail or at a CVS/Caremark retail pharmacy for most maintenance medications. To encourage use of the mail order or Maintenance Choice program, you will pay $25 in addition to your regular copay or coinsurance if you refill a 30-day prescription at a retail pharmacy beginning with the fourth fill. (See "Your Share of the Cost" on page 175 for the copays or coinsurance that applies.)

To use the mail order program, get a prescription from your doctor for up to a 90-day supply, plus any appropriate refills. Complete a mail order service form and send it with the original prescription to CVS/Caremark. Forms are available from the "Caremark" link at **myhondaconnect.com** or by calling Quantum Health at **1-866-778-5885**. Payment by check, money order or credit card should be included with your order.

You pay one copay when you obtain up to a 30-day supply of drugs; you pay two copays for a 90-day (three-month) supply.

Additional features available include automatic refills and automatic renewal. You can sign up for these by logging in to **caremark.com** or calling CVS/Caremark directly at **1-800-386-1575**.

Important Note!

*First-time mail-order users can get started by calling Quantum Health for assistance at **1-866-778-5885** to enroll in the Fast Start program. Or call **1-800-386-1575** to speak to a CVS/Caremark representative who will gather information and contact your physician on your behalf.*

Additional Options…

Maintenance Choice. *A program is available to you that provides added convenience in filling your maintenance drugs. You can obtain a 90-day prescription at a CVS/Caremark retail pharmacy. Keep in mind the prescription must be written to dispense in a 90-day supply, plus any appropriate refills.*

If you are a first-time mail order user, you can get started by using the Fast Start program. You can call Quantum Health at **1-866-778-5885** or call **1-800-386-1575** and speak to a CVS/Caremark representative who will gather important information and contact your physician to obtain a 90-day prescription on your behalf.

Your medication is conveniently and safely shipped to your home within 10 to 14 days. You can also order refills by phone by calling **1-800-386-1575**, 24 hours a day.

Under Maintenance Choice, you also may obtain a 90-day prescription at a CVS/Caremark retail pharmacy.

Exclusions or Limitations

Some medications are *not* available through the mail order program, including:

- Medications (e.g., antibiotics) used to treat short-term illnesses;
- Narcotics; and
- Drugs that cannot be refilled without a written prescription, etc.

Call Quantum Health at **1-866-778-5885** or go to **caremark.com** for more information about exclusions or limits that may apply to mail order drugs.

Pre-Certification for Certain Drugs

Certain drugs, due to safety, health and cost concerns, require pre-certification by CVS/Caremark prior to dispensing. For a list of these drugs, log in to **caremark.com** or obtain a list from CVS/ Caremark.

*Certain Preventive Medications Covered with No Cost Sharing**

Preventive drugs are designed to prevent the onset of a disease, as well as to prevent the recurrence of a disease from which someone has recovered. They manage disease states and include immunizations, contraceptives, mental health, smoking cessation and much more. Honda medical plans have two preventive drug lists:

- **The High Deductible Health Plan (HDHP)—Health Savings Account (HSA) Preventive Therapy Drug List** *(applies to the HSA Plan only)*: If you are enrolled in the HSA Plan and are prescribed a medication found on this list, you only pay the coinsurance for the drug, even if you have not yet met your annual deductible.
- **The Affordable Care Act (ACA) Preventive Drugs List** *(applies to all Honda medical plans)*: If you're enrolled in a Honda medical plan and your doctor prescribes a medication found on this list, Honda pays the full cost of the drug.

  Medications including those listed below are covered at no cost to you with a valid prescription.

  - Generic birth control medication and brand-name medications with no generic availability;
  - Certain birth control devices, including emergency contraception, injectable, transdermal and implantable contraception, vaginal rings and barrier methods (such as diaphragms and cervical caps);
  - Certain smoking cessation medications (limited to two cycles annually);
  - Aspirin;

- Fluoride (for children up to age 6);
- Iron supplementation (for children ages 6 to 12 months);
- Vaccines *(currently covered at 100% through medical plan)*;
- Generic tamoxifen and generic raloxifene will be covered as preventive, and therefore, if an associate or dependent qualifies, the drugs will be covered with no copay. To be considered preventive, the medication must be prescribed for primary prevention of breast cancer for women ages 35 and older, who have an increased risk of breast cancer.

*You can contact CVS/Caremark for more specifics on these items.

Specialty Pharmacy Services

The Specialty Pharmacy Services are available for chronic and genetic disorders. This service offers convenient delivery of your specialty medicines and free ancillary supplies. It also offers personalized services 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's disease, growth hormone deficiency, hemophilia, hepatitis C, immune disorders, multiple sclerosis, psoriasis, pulmonary hypertension, rheumatoid arthritis, respiratory syncytial virus (RSV) prevention and other conditions.

You pay one copay when you obtain up to a 30-day supply of drugs through the specialty pharmacy services; you pay two copays for a 90-day (three-month) supply.

To inquire about or begin services with CVS/Caremark Specialty Pharmacy Services, please call or have your healthcare provider call Quantum Health at **1-866-778-5885**. You can also begin the enrollment process online. Once you fill out the requested information, a CVS/Caremark specialist will contact you. Regardless of how you begin the process, CVS/Caremark's specialists will work with you and your provider to confirm coverage for your treatment—and will conduct a full benefits investigation for the medicines you may need.

How CVS/Caremark Works with You

One of the ways CVS/Caremark ensures your safety is through a review process that evaluates prescriptions that are filled through its mail order program or at a participating local retail pharmacy. In some instances, a CVS/Caremark pharmacist may consult with your doctor by telephone or fax to discuss a current prescription. Your doctor may agree to change the medicine, adjust the number of doses or alter the length of time you need to take the medicine.

Please remember that your doctor is the final decision maker regarding any changes in your course of therapy. CVS/Caremark will not change a prescription without full consent of your prescribing doctor, either directly or through an authorized agent. If the pharmacist and the doctor agree that an alternate medicine is not appropriate for you, the prescription will be filled as originally written.

Your Share of the Cost

Your prescription drug copay or coinsurance is determined by the type of prescription drug you receive (e.g., generic versus non-preferred formulary). In addition, your share of the cost also varies depending on how you have your prescription filled. The cost to associates is the full cost of the negotiated rate through contracting with CVS/Caremark (excluding company rebates). See the chart below for your share of the cost.

You will pay a $25 copay in addition to your regular copay or coinsurance if you refill a 30-day prescription at a retail pharmacy beginning with the fourth fill.

	Health Savings Account (HSA) Plan		Preferred Provider Organization (PPO) Plan		HMO Plan
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**
Retail Prescription Drugs	*30-day supply***		*30-day supply*		*30-day supply*
Generic	$5 copay*	No coverage *(Covered only at participating pharmacies)*	$5 copay	No coverage *(Covered only at participating pharmacies)*	$5 copay
Preferred formulary	$30 copay*		$35 copay		$35 copay
Non-preferred formulary	$60 copay*		$70 copay		$35 copay
Mail Order/Maintenance Choice Prescription Drugs	*90-day supply***		*90-day supply*		*90-day supply*
Generic	$10 copay*	No coverage *(Covered only at participating pharmacies)*	$10 copay	No coverage *(Covered only at participating pharmacies)*	$10 copay
Preferred formulary	$60 copay*		$70 copay		$70 copay
Non-preferred formulary	$120 copay*		$140 copay		$70 copay
Specialty Drugs	30-day supply at $125 copay;** 90-day supply at $250 copay**	No coverage *(Covered only at participating pharmacies)*	30-day supply at $125 copay; 90-day supply at $250 copay	No coverage *(Covered only at participating pharmacies)*	30-day supply at $125 copay; 90-day supply at $125
Prescription Drug Out-of-Pocket Maximum	Included with medical**	N/A	Included with medical	N/A	Included with medical

*After deductible.

**Note: You must pay the full cost of prescriptions until you meet your annual deductible. Prescription drug copay coupons and other drug manufacturer assistance will not count toward your deductible or out-of-pocket limit. Certain preventive prescriptions are not subject to deductible.

Out-of-Pocket Maximum for Prescriptions

There is no separate out-of-pocket maximum for prescription drugs. All Honda medical plans have a combined out-of-pocket maximum for medical and prescription drug expenses.

Note: There is a $10,000 lifetime maximum for fertility medications for the HSA and PPO Plans.

Covered Expenses

The following are covered under the prescription drug plan:

- Drugs and medicines that can be legally obtained only by the written prescription of a physician or other legal prescriber and are approved by the U.S. Food and Drug Administration for general human use;

- Diabetic supplies including:
  - Insulin prescribed in writing by a physician or other legal prescriber; and
  - Disposable blood/urine glucose/acetone testing agents and lancets.
- Contraceptives for birth control. Please note, certain contraceptives are only packaged in a 90-day supply; because of this, the mail order or Maintenance Choice program must be used to fill these prescriptions.

Blood Glucose Meter Program

There are two ways you can get your blood glucose checked—through the CVS/Caremark Pharmacy Resource Center (PRC) or Livongo.

Plan participants who are diagnosed with diabetes and test their blood sugar can receive a complimentary blood glucose meter kit by calling the CVS/Caremark PRC at **1-800-588-4456**. The PRC's hours of operation are 9 a.m. to 7 p.m. ET, Monday through Friday.

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

- You must be diagnosed with diabetes or be 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.

Honda also offers you access to Livongo, a company dedicated to helping its qualified participants manage their diabetes by providing a free smart glucometer, unlimited testing supplies (such as test strips) and smart monitoring analytics. On-call coaching is available 24 hours a day, 365 days a year.

Expenses Not Covered by the Plan

The plan does not cover:

- Drugs dispensed by a physician's office;
- Charges for administering any drug or insulin;
- Allergy serums;
- Immunization agents, biological serum and blood/blood plasma;
- Therapeutic devices or appliances, including support garments and other non-medicinal substances;

- Over-the-counter drugs (except for certain preventive care drugs when you have a prescription);
- Compound lotion form of minoxidil when prescribed for cosmetic purposes (that is, to alter appearance without restoring or improving impaired physical function);
- Experimental drugs and those labeled as limited by federal law to investigational use;
- Any prescription refilled beyond the number allowed by the physician or refills dispensed later than one year after the date your physician wrote the prescription. You will need to get the prescription filled for the first time generally within six months of the date the prescription was written. (**Note:** This may vary for controlled substances.);
- Medication taken or administered while in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar facility with an operating pharmacy;
- Prescription drugs that are available to you without charge under Workers' Compensation laws;
- Weight loss drugs;
- Certain sleep aids;
- Erectile dysfunction aids or medications; and
- Medication obtained at out-of-network pharmacies.

Claims

There are no claims to file if you:

- Use your medical/prescription drug ID card at a participating pharmacy; and
- Use the mail order program or Maintenance Choice program for long-term and specialty prescriptions.

When Coverage Ends

When coverage ends is described in *Participating in Health Benefits* on page 68.

In certain cases, you or your dependent may continue prescription drug coverage for a limited time by paying the full cost. See *COBRA* on page 204 for more information.

Glossary

The following definitions are provided to help you understand your prescription drug coverage.

Brand-Name Drug

A prescription drug that trademark registration protects.

Generic Drug

A drug whose active ingredients, safety, quality and strength are the same as its brand-name counterpart.

Non-Preferred Formulary

Drugs that have equally effective and less costly generic equivalents and/or have one or more preferred-brand options.

Preferred Drug List

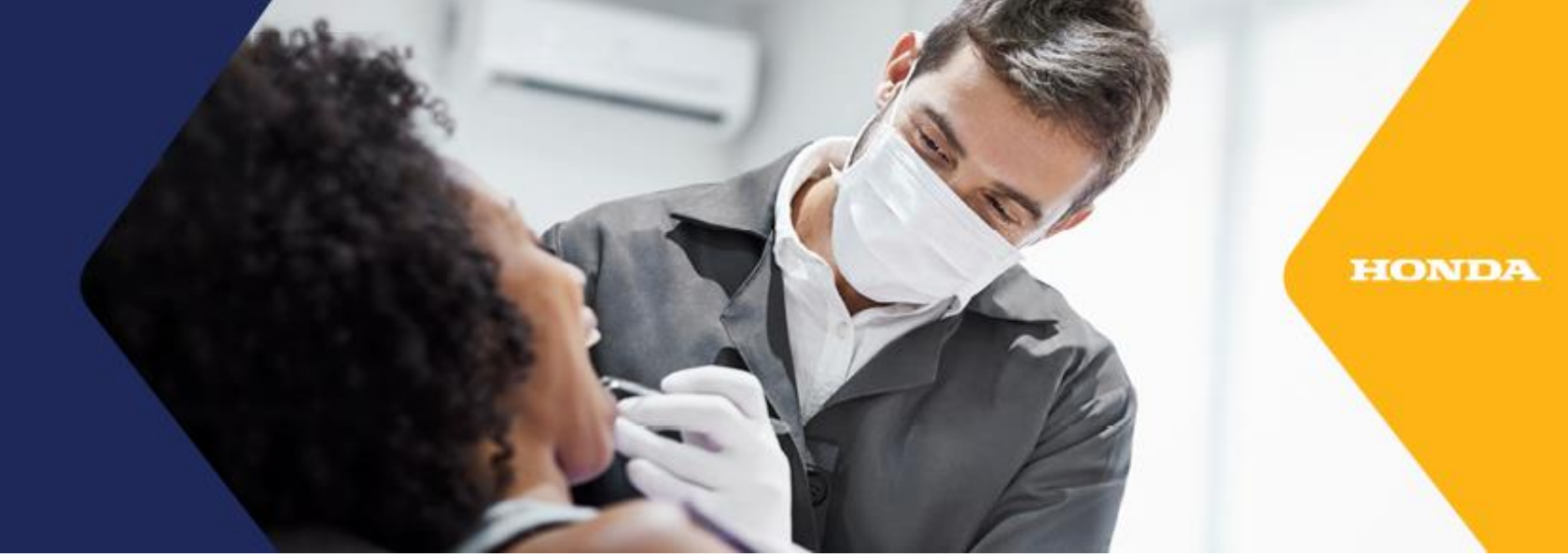
A preferred drug list is a list of recommended brand-name prescription drugs reviewed and updated every three months by a CVS/Caremark committee of independent physicians and pharmacists. A medication becomes a preferred-brand drug based on safety, effectiveness and then cost. The preferred list identifies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

Preferred Formulary

Drugs that 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 equally effective for treating a particular condition.

Specialty Drug

Drugs that are used to treat chronic or genetic conditions.



Dental Plan

The dental plan helps you pay for covered dental care expenses. You have two dental plan options from which to choose. Both options are offered through Delta Dental Plan of Ohio, Inc., referred to herein as Delta Dental, and cover most of the same services. And, no matter which plan you select, you have a choice of using any dentist.

For More Information

Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

Highlights

Options	• Dental Plan • Dental Plus Plan • Waive coverage
Cost Per Pay	Rates are available during the enrollment process and on your confirmation statement of benefit elections
Who Is Covered	Eligible associates and their eligible dependents
Coverage Begins	First day of the month following your date of hire, if you are eligible for coverage
About This Benefit	Both plans are administered by Delta Dental. You can seek services from a licensed dental provider of your choice, whether a participating dentist or non-participating dentist. However, if you use a participating dentist, your out-of-pocket expenses may be lower because benefits will be based on the negotiated rate instead of the maximum approved fee.
Plan Features	Preventive care covered at 100% (based on negotiated rates) with no deductible. In addition, both plans provide coverage for basic/restorative, major and orthodontic services. With the Dental Plan, a deductible applies for these types of services. There is no deductible under the Dental Plus Plan.
Coverage Ends	Last day of the month your Honda employment ends or your eligibility ends
Administered By	Delta Dental

Table of Contents

Who Is Eligible

Eligibility for you and your dependents is defined in *Participating in Health Benefits* on page 68.

Your Cost

Rates are available during the enrollment process and on your confirmation statement of benefit elections.

When Coverage Begins

When coverage begins is described in *Participating in Health Benefits* on page 68.

How the Dental Plan Works

Honda offers associates a choice of two dental plans:

- Dental Plan; and
- Dental Plus Plan.

Or, you can waive coverage.

Both plans are offered by Delta Dental. You can seek services from a licensed dental provider of your choice, whether a participating dentist or a non-participating dentist. Your choice will determine how much you'll pay out-of-pocket for your dental services.

In either plan, you can see a dentist who participates in one of Delta Dental's networks—Delta Dental PPO and Delta Dental Premier—or you can see a non-participating dentist. The Delta Dental PPO network has a smaller number of dentists who have agreed with Delta Dental to charge the lowest fees, so you most likely will pay the least out-of-pocket if you see a Delta Dental PPO dentist. There are also many Delta Dental Premier dentists to choose from, and while they have also negotiated contracts with Delta Dental, they will charge a slightly higher fee. For both networks, you will pay the same percentage of the negotiated fee (called coinsurance) for the care you receive.

If you choose to see a non-participating dentist, your out-of-pocket costs may be higher. Non-participating dentists can charge what they like; however, Delta Dental will only cover their portion of coinsurance on the maximum approved fee. You will be responsible for your portion of coinsurance, plus the difference between the maximum approved fee and the dentist's submitted fee.

Both plans cover preventive and diagnostic dental services at 100% with no deductible if provided by a participating provider, and at 100% of the maximum approved fee, if provided by a non-participating provider. When services are rendered by a non-participating provider you will be responsible for the difference between Delta Dental's payment and the non-participating provider's submitted fee. Preventive and diagnostic services do not apply towards your annual maximum benefit.

For other types of care, each covered person must meet a deductible for the calendar year, unless you enroll in the Dental Plus Plan, which does not have a deductible. Then, the plan pays benefits for covered dental services for the rest of the year, up to plan limits.

The deductible and amount the plan pays depends on the plan you choose, as shown in the table below.

Summary of Dental Plan Benefits

Feature	Dental Plan*	Dental Plus Plan*
Annual Deductible	$25 per person $75 per family	$0
Annual Maximum Benefit per Person*	$1,500	$2,000
Preventive and Diagnostic Services • Exam/teeth cleaning (2 per calendar year) • Sealants (once per tooth per 3-year period to age 16) • Fluoride (twice per calendar year to age 19) • X-rays	Covered at 100%; no deductible	Covered at 100%; no deductible
Basic Services • Fillings • Extractions	Covered at 80%, after deductible	Covered at 90%; no deductible
Major Services • Bridgework • Crowns • Dentures	Covered at 50%, after deductible	Covered at 60%; no deductible
Orthodontic Services*	Covered at 50%, after deductible, up to $1,500 lifetime maximum per person	Covered at 50%, up to $2,000 lifetime maximum per person

*The plan pays for non-network services based on a percentage of the non-participating dentist maximum approved fee. The nonparticipating dentist fee may be more than the maximum approved fee and you will be responsible for that difference.

**Preventive and diagnostic services and orthodontic services do not apply to the annual maximum benefit.

Negotiated Rates or Fees

If you seek care from a participating dentist, charges are based on negotiated network rates, which may be lower than what a non-participating dentist charges.

Non-participating Dentist Fee

The non-participating dentist fee is the maximum approved fee allowed per procedure for services rendered by a non-participating dentist as determined by Delta Dental.

Maximum Approved Fee

A maximum approved fee is a system used by Delta Dental to determine the approved fee for a given procedure for a participating dentist. A fee meets maximum approved fee requirements if it is the lowest of:

- The submitted amount;
- The lowest fee regularly charged, offered or received by an individual dentist for a dental service or supply, irrespective of the dentist's contractual agreement with another dental benefits organization; and

- The maximum fee that the local Delta Dental Plan approves for a given procedure in a given region and/or specialty, under normal circumstances, based upon applicable participating dentist schedules and internal procedures.

Delta Dental may also approve a fee under unusual circumstances. Participating dentists agree not to charge Delta Dental patients more than the maximum approved fee for a covered service. In all cases, Delta Dental will make the final determination regarding the maximum approved fee for a covered service.

How Benefits Are Paid

If you received care from a participating dentist, Delta Dental will base payment on the maximum approved fee for covered services. If your dentist is a non-participating dentist, payment is based on the non-participating dentist fee for covered services, as determined by Delta Dental.

Covered Dental Expenses

The plans cover dental expenses for services and supplies that are described in the plan's Summary of Dental Plan Benefits.

Special rules apply to orthodontia charges as described in "Orthodontic Services" on page 184.

Diagnostic and Preventive Services

- Oral exams and routine teeth cleaning (up to two per calendar year);
- Dental X-rays, including:
  - Bitewings (two per calendar year);
  - Full mouth or panoramic (once in any three-year period); and
  - Other diagnostic X-rays.
- Fluoride applications for children under age 19 (not more than two per calendar year);
- Space maintainers to replace missing or removed teeth;
- Emergency treatment to relieve pain, but not on the same day as any other service except X-rays; and
- Brush biopsy, oral brush biopsy procedure and laboratory analysis used to detect oral cancer.

Member Portal

*Log in to **deltadentaloh.com** and select the link for the Member Portal for dentist directories, information on covered dental services, claims and more.*

Basic Services

- Removal of teeth;
- Oral surgery—dental in nature (including pre-operative and post-operative care);
- Fillings for decayed or fractured teeth;
- General anesthetics when medically necessary for a covered dental service;

- Periodontal treatment or surgery to remove diseased gum tissue or bone, including periodontal maintenance following periodontal therapy;
- Endodontic treatment, including root canal therapy;
- Antibiotic injections given by a dentist;
- Repair and recementing of crowns, bridgework or dentures; and
- Relining or rebasing dentures (once in any two-year period).

Major Services

- Crowns or onlays to restore fractured or heavily decayed teeth only when the tooth cannot be restored with other fillings such as amalgam, plastic or composite resin, or if a tooth is an abutment to a covered partial denture or fixed bridge;
- Fixed bridgework or partial/full dentures to replace teeth other than third molars. No benefits will be paid for adjustments during the first six months after placement;
- Add teeth to an existing fixed bridge or partial/full denture to replace teeth; and
- Replacement of fixed bridge or partial/full denture with a new appliance of the same type, provided the replacement is needed to replace extracted teeth.

  In addition, the dentist must certify the existing appliance is at least five years old and cannot be repaired.

Orthodontic Services

Orthodontic treatment is covered under the Dental Plan and Dental Plus Plan if the initial active appliance is placed after coverage is in effect. Covered expenses include active appliances and adjustments.

Speech or myofunctional therapy and athletic mouth guards are not covered. In addition, before beginning orthodontic work, the dentist should submit a pre-treatment review to Delta Dental as described in the "Pre-Treatment Review" box in this section.

The plans will consider orthodontic charges incurred as follows:

Orthodontia Expenses

If you use the Healthcare Flexible Spending Account or Limited Purpose Flexible Spending Account to reimburse orthodontia expenses, reimbursement is based on when you are required to make the payment, even if that is before services are provided.

- Charges for the initial active appliance are incurred on the date of placement. At that time, the plan pays 30% of the initial covered charges—less the deductible (Dental Plan), payable at 50% up to the lifetime orthodontia maximum benefit level; and
- The rest of the cost of treatment is divided by the months needed to complete treatment. This amount is incurred on a monthly basis and paid by the plan at 50% until the lifetime orthodontia maximum benefit is reached, treatment is completed or eligibility ends.

Example: Assume orthodontic treatment will cost $4,000 and last 10 months and the associate is covered under the Dental Plan. The deductible has already been met.

- **First plan payment:** 30% × $4,000 = $1,200 × 50% benefit = $600

- **Remaining plan payments:** $2,800 ÷ 10 months = $280 × 50% benefit = $140/month for six months plus a final payment of $60, which meets the $1,500 lifetime orthodontia maximum

The plans will issue payments monthly after the first bill is received. Payments end when the maximum is reached or when treatment or eligibility ends. The provider does not need to submit monthly billing.

Pre-Treatment Review

If a course of treatment will cost more than $350, the treatment plan should be reviewed by Delta Dental before care begins. The purpose of this review is to give you information about how treatment will be covered under the plan and how much you will need to pay out of your pocket. To get a pre-treatment review, your dentist should submit a description of each planned service, charges and related materials, such as X-rays, to Delta Dental. Instructions and the address are on the dental claim form. See "Claims" on page 192.

Expenses Not Covered by the Plans

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in Delta Dental's Summary of Dental Plan Benefits. All charges for the same will be your responsibility (though your payment obligation may be satisfied by insurance or some other arrangement for which you are eligible):

- Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation or similar entity. **Note:** This provision does not apply to any programs provided under Title XIX of the Social Security Act (Medicaid);
- Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations;
- Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental;
- Services started or appliances started before a person became eligible under the plan—exclusion does not apply to orthodontic treatment in progress (if a covered service);
- Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions and relative analgesia
- General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry;
- Charges for hospitalization, laboratory tests and histopathological examinations;
- Charges for failure to keep a scheduled visit with the dentist;
- Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated;
- Services or supplies, as determined by Delta Dental, that are investigational in nature, including services or supplies required to treat complications from investigational procedures;
- Services or supplies, as determined by Delta Dental, that are specialized techniques;

- Services or supplies, as determined by Delta Dental, that are not provided in accordance with generally accepted standards of dental practice;
- Treatment by other than a dentist, except for services performed by a licensed dental hygienist or other dental professional, as determined by Delta Dental, under the scope of his or her license as permitted by applicable state law;
- Services or supplies excluded by the policies and procedures of Delta Dental, including the processing policies, such as:
  - Dentists cannot charge for a second filling on the same tooth surface as a previous filling within two years.
  - Dentists cannot charge separately for services that are required as a whole to complete a procedure, also called unbundling (e.g., charging for anesthetic, creating a post and core, providing a temporary crown and seating a crown cannot be billed separately when done by the same dentists or dental office. These procedures are all required for placing a crown and are charged as one service).
  - Dentists cannot charge for a follow-up office visit that is required as part of a procedure. (e.g., a follow-up visit after a patient receives dentures to ensure that the denture is sitting properly and not causing discomfort).
- Services or supplies for which no charge is made, for which the patient is not legally obligated to pay or for which no charge would be made in the absence of Delta Dental coverage;
- Services or supplies received due to an act of war, declared or undeclared;
- Services or supplies covered under a hospital, surgical/medical or prescription drug program;
- Services or supplies that are not within the categories of benefits covered under the terms of the plan's Summary of Dental Plan Benefits;
- Fluoride rinses, self-applied fluorides or desensitizing medicaments;
- Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.);
- Lost, missing or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers;
- Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position;
- Veneers;
- Prefabricated crowns used as final restorations on permanent teeth;
- Appliances, surgical procedures and restorations for increasing vertical dimension; for altering, restoring or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction or erosion; or for periodontal splinting. If orthodontic services are covered services, this exclusion will not apply to orthodontic services as limited by the terms and conditions of the plan's Summary of Dental Plan Benefits;
- Paste-type root canal fillings on permanent teeth;
- Replacement, repair, relines or adjustments of occlusal guards;

- Chemical curettage;
- Services associated with overdentures;
- Metal bases on removable prostheses;
- The replacement of teeth beyond the normal complement of teeth;
- Personalization or characterization of any service or appliance;
- Temporary crowns used for temporization during crown or bridge fabrication;
- Posterior bridges in conjunction with partial dentures in the same arch;
- Precision attachments and stress breakers;
- Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index;
- Appliances, restorations or services for the diagnosis or treatment of disturbances of the temporomandibular joint;
- Biopsy of hard tissue is a covered service;
- Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a covered service;
- Myofunctional therapy; and
- Mounted case analyses.

Delta Dental will make no payment for the following services or supplies. Participating dentists may not charge eligible persons for these services or supplies. All charges from non-participating dentists for the following are your responsibility:

- The completion of forms or submission of claims;
- Consultations, patient screening or patient assessment when performed in conjunction with examinations or evaluations;
- Local anesthesia;
- Acid etching, cement bases, cavity liners and bases or temporary fillings;
- Infection control;
- Temporary, interim or provisional crowns;
- Gingivectomy as an aid to the placement of a restoration;
- The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces;
- Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures;
- Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition;
- Post-operative X-rays, when done following any completed service or procedure;

- Periodontal charting;
- Pins and preformed posts, when done with core buildups for crowns, onlays or inlays;
- A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same dentist or dental office on the same day as completed root canal treatment;
- A pulpotomy on a permanent tooth, except on a tooth with an open apex;
- A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed;
- Retreatment of a root canal by the same dentist or dental office within two years of the original root canal treatment;
- A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling and root planing;
- An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard;
- Reline, rebase or any adjustment or repair within six months of the delivery of a partial denture; and
- Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

Limitations

The benefits for the following services or supplies are limited as follows, unless otherwise specified in the plan's Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in Delta Dental's records with any Delta Dental Plan or, at the request of your group, any dental plan:

- Bitewing X-rays are payable twice per calendar year. Panoramic or full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Any combination of teeth cleanings (prophylaxes, full mouth debridement and periodontal maintenance procedures) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease. Full mouth debridement is payable only once in a lifetime.
- Oral examinations and evaluations are only payable twice per calendar year, regardless of the dentist's specialty.
- Problem-focused oral examinations are covered without limitations.
- Comprehensive periodontal evaluations are payable once per calendar year.
- Patient screening is payable once per calendar year.
- Preventive fluoride treatments are payable twice per calendar year for people under age 19.
- Space maintainers are payable once per lifetime with no age limits.

- Sealants are payable once per tooth per three-year period for permanent molars up to age 16.
- Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth.
- Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture.
- Individual crowns over implants are payable at the prosthodontic benefit level.
- Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people under age 12.
- An occlusal guard is payable once in any five-year period.
- An interim partial denture is payable only for the replacement of permanent anterior teeth for people under age 17 or during the healing period for people age 17 and over.
- Antibiotic drug injections are covered services.
- Prosthodontic services limitations include:
  - One complete upper and one complete lower denture are payable once in any five-year period.
  - A removable partial denture, implant, or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
  - Fixed bridges and removable partial dentures are not payable for people under age 16.
  - A reline or the complete replacement of denture base material is payable once in any two-year period per appliance.
  - Implant removal is payable once per lifetime per tooth or area.
  - Implant maintenance is payable once per calendar year.
- Orthodontic services limitations include:
  - Orthodontic services are payable for eligible persons.
  - If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
  - Upon written notification to Delta Dental and to the patient, a dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
- Delta Dental's obligation for payment of benefits ends on the last day of coverage. However, Delta Dental will make payment for covered services provided on or before the last day of coverage, as long as Delta Dental receives a claim for those services within one year of the date of service.
- When services in progress are interrupted and completed later by another dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each dentist.
- Care terminated due to the death of an eligible person will be paid to the limit of Delta Dental's liability for the services completed or in progress.

- Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

  Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment:

  - Plastic, resin, porcelain fused to metal and porcelain crowns on posterior teeth—Delta Dental will pay only the amount that it would pay for a full metal crown.
  - Overdentures—Delta Dental will pay only the amount that it would pay for a conventional denture.
  - Plastic, resin or porcelain/ceramic onlays on posterior teeth—Delta Dental will pay only the amount that it would pay for a metallic onlay.
  - Inlays, regardless of the material used—Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
  - All-porcelain/ceramic bridges—Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
  - Implant/abutment supported complete or partial dentures—Delta Dental will pay only the amount that it would pay for a conventional denture.
  - Gold foil restorations—Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
  - Stainless steel crowns with esthetic facings, veneers or coatings—Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.
- Maximum payment:
  - The maximum benefits payable in any one benefit year will be limited to the maximum payment stated in the plan's Summary of Dental Plan Benefits
  - Delta Dental's payment for orthodontic services will be limited to the annual or lifetime maximum payment stated in the plan's Summary of Dental Plan Benefits
- If a deductible amount is stated in the plan's Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the deductible applies until the deductible amount is met.
- Processing policies may limit Delta Dental's payment for services or supplies. Delta Dental's proprietary processing policies are agreed upon by its participating providers and enforce best practices while providing patient cost savings. Some examples include the following:
  - Dentists cannot charge for a second filling on the same tooth surface as a previous filling within two years.

- Dentists cannot charge separately for services that are required as a whole to complete a procedure, also called unbundling (e.g., charging for anesthetic, creating a post and core, providing a temporary crown, and seating a crown cannot be billed separately when done by the same dentists or dental office. These procedures are all required for placing a crown and are charged as one service).
- Dentists cannot charge for a follow-up office visit that is required as part of a procedure. (e.g., a follow-up visit after a patient receives dentures to ensure that the denture is sitting properly and not causing discomfort).

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, participating dentists may not charge eligible persons for these services or supplies when performed by the same dentist or dental office. All time limitations are measured from the applicable prior dates of services in Delta Dental's records with any Delta Dental Plan or, at the request of your group, any dental plan:

- Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
- Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
- Recementation of a crown, onlay, inlay, space maintainer or bridge is payable within six months of the seating date.
- Retention pins are payable once in any two-year period. Only one substructure per tooth is a covered service.
- Root planing is payable once in any two-year period.
- Periodontal surgery is payable once in any three-year period.
- A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
- Tissue conditioning is payable twice per arch in any three-year period.
- The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
- Services or supplies are payable as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
- Processing policies may limit Delta Dental's payment for services or supplies.

Claims

Your Delta Dental provider will submit your claim for payment, along with proof of your claim, such as X-rays or other supporting documents. Without these materials, benefits may be reduced or not payable. Delta Dental will send payment directly to participating dentists and you will be responsible for any applicable copays or deductibles. If your provider is a non-participating dentist or out-of-country dentist, Delta Dental will usually send payment to you, and you will be responsible for making full payment to the dentist.

If You Have Dental Claims Questions

*The claims payor for the dental plans is Delta Dental. If you have questions about a claim, contact the Delta Dental claims office at **1-866-863-7522.***

Claims should be filed as soon as possible to avoid processing delays. **Expenses submitted more than 12 months after the date of service will not be covered.**

After your claim is processed, you will receive an Explanation of Benefits (EOB). This form explains what action was taken on your claim. If any part of your claim is denied, you have the right to appeal as described in "Claims and Appeals" in *Administrative Information* on page 316.

When Coverage Ends

When coverage ends is described in *Participating in Health Benefits* on page 68. In certain cases, you or your dependents may continue dental plan coverage for a limited time by paying the full cost. See *COBRA* on page 204.

Extended Benefits

If certain treatments are in progress when dental plan coverage ends, benefits may be extended. Benefits will be considered if the following apply to your treatment-in-progress:

- Dentures:
  - The impression was made and the denture ordered before coverage ended.
  - The denture is placed in the mouth within 60 days after coverage ends.
- Fixed bridgework, crowns, onlays and inlays:
  - Tooth (or teeth) was prepared, the impression was taken and the appliance was ordered before coverage ended.
  - The work is placed in the mouth within 60 days after coverage ends.
- Endodontic treatment, including root canals:
  - The tooth was opened before coverage ended.
  - The procedure is completed within 60 days after coverage ends.

Additional Information

- Delta Dental's website may contain additional information that may help you determine the cost of a service or supply. Log in to **deltadentaloh.com**, or contact Delta Dental's Customer Service Department at **1-866-863-7522** for assistance.

Glossary

The following definitions are provided to help you understand your dental coverage.

Amalgam
Silver filling used to restore posterior (back) teeth.

Anesthesia (General)
The condition, resulting from administration of anesthetics, in which the patient is rendered completely unconscious and completely without conscious pain.

Anesthetic
A drug that produces a loss of feeling or sensation, such as novocaine.

Appliance
An artificial device that provides healing effects or is used to assist in performing an intended function:

- Fixed: An appliance that is cemented to the teeth or attached by adhesive materials; and
- Removable: An appliance that is not cemented to the teeth and can be removed from the mouth and replaced at will.

Bitewing
Dental X-ray picture showing a part of either the right or left upper and lower jaw.

Bridgework
A replacement for one or more missing or extracted natural teeth:

- Fixed: Supported and held in place with crowns cemented to the natural teeth that are used as abutments and cannot be removed; and
- Removable: A partial denture retained by attachments that can be removed from the mouth and replaced at will.

Children
Your natural children, stepchildren, adopted children, children by virtue of legal guardianship or children who are residing with you during the waiting period for adoption or legal guardianship.

Clasp
The most common attachment for a removable partial denture. It is constructed of metal and used as a stabilizing and retaining device to keep the denture in place.

Completion Dates
Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the cementation dates; and
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment,

Copayment
As provided by your plan, the percentage of the charge, if any, that you will have to pay for covered services.

Crown
The portion of a tooth covered by enamel and visible above the gum. Some common types of artificial crowns include full cast crowns used for the teeth that chew the food, porcelain crowns (resembling the color of the natural tooth) generally used on front teeth, and stainless steel crowns generally used in restoring children's primary teeth.

Delta Dental
Delta Dental Plan of Ohio, Inc., a nonprofit dental care corporation providing dental service benefits. Delta Dental is not a commercial insurance company.

Delta Dental Plan
An individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Delta Dental PPO (Point-of-Service)
Delta Dental's national preferred provider organization program that can reduce your out-of-pocket expenses if you receive care from one of Delta Dental's PPO dentists. This program has back-up coverage through Delta Dental Premier when treatment is received from a non-PPO dentist.

Delta Dental PPO Dentist (PPO Dentist) or Participating Dentist
A dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in the Delta Dental PPO. Delta Dental PPO dentists agree to accept Delta Dental's fee determination as payment in full for covered services.

Delta Dental Premier
Delta Dental's national fee-for-service dental benefits program that covers you when you go to a non-PPO dentist.

Delta Dental Premier Dentist (Premier Dentist) or Participating Dentist
A dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental Premier. Delta Dental Premier dentists agree to accept Delta Dental's fee determination as payment in full for covered services.

Dental Hygienist
A person who has been trained to remove tartar and stains from the surface of the teeth and who may provide additional services and information on the prevention of oral disease.

Dental Services
Care and procedures employed by dentists for the diagnosis or treatment of dental disease, injury, or abnormal conditions based on valid dental need according to accepted standards of dental practice.

Dentist
A person licensed to practice dentistry in the state or country in which dental services are rendered.

Denture
A removable prosthetic appliance replacing missing natural teeth.

Fluoride
A chemical solution that is applied to the teeth for the purpose of preventing dental decay.

Gingivectomy
A surgical procedure involving cutting away diseased gums.

Malposed Teeth
The abnormal positioning and relation of the upper and lower teeth when they come together.

Maximum Approved Fee
A system used by Delta Dental to determine the approved fee for a given procedure for a given Delta Dental Premier dentist. A fee meets maximum approved fee requirements if it is the lowest of:

- The submitted amount;
- The lowest fee regularly charged, offered or received by an individual dentist for a dental service, irrespective of dentist's contractual agreement with another dental benefits organization; and
- The maximum fee that the local Delta Dental Plan approves for a given procedure in a given region and/or specialty, under normal circumstances.

Delta Dental may also approve a fee under unusual circumstances.

Participating dentists are not allowed to charge Delta Dental patients more than the maximum approved fee for the covered service. In all cases, Delta Dental will make the final determination about what is the maximum approved fee for the covered service.

Maximum Payment
The maximum dollar amount Delta Dental will pay in any benefit period or lifetime for covered dental services. (See your plan's Summary of Benefits.)

Non-participating Dentist
A dentist who has not signed an agreement with Delta Dental to participate in Delta Dental PPO or Delta Dental Premier.

Nonparticipating Dentist Fee
The maximum fee allowed per procedure for services rendered by a non-participating dentist.

Onlay
A preformed restoration that covers the entire chewing surface of a tooth and does not extend down to the gum.

Optional Treatment
A service or treatment other than that customarily provided or for which there is no dental need.

Orthodontics
That branch of dentistry concerned primarily with the detection, prevention and correction of abnormalities in the positioning of teeth in relationship to the jaws; commonly, straightening teeth.

Out-of-Country Dentist
A dentist whose office is located outside of the United States and its territories. Out-of-country dentists are not eligible to sign participating agreements with Delta Dental.

Out-of-Country Dentist Fee
The maximum fee allowed per procedure for services rendered by an out-of-country dentist.

Periapical
Pertaining to the area of the tooth around the apex (tip) of the root.

Periodontal Disease
Disease that weakens and destroys the gums, bones and membranes surrounding the teeth.

Plan Year
The time period in which the plan's payments for covered services accumulate toward the maximum payment.

Plaque
A sticky substance made up of bacteria, dead tissue cells and debris that accumulates on the teeth.

Post-Service Claims
Claims for benefits that are not conditioned on your seeking advance approval, certification or authorization to receive the full amount of any covered benefit. In other words, post-service claims arise when you receive the dental service or treatment before you file a claim for the benefit payment.

PPO Dentist Schedule
The maximum amount allowed per procedure for services rendered by a PPO dentist as determined by that dentist's local Delta Dental Plan.

Pre-Treatment Estimate
An estimate of the costs of covered services to be provided. A dentist may submit his or her treatment plan to Delta Dental before providing services. Delta Dental reviews the treatment plan and advises you and your dentist of what services are covered by your plan and what Delta Dental's payments may be. Delta Dental's payment for predetermined services depends on continued eligibility and the annual or lifetime maximum payments available under your plan. You are not required to seek a pre-treatment estimate. You will receive the same benefits under your plan whether or not a pre-treatment estimate is requested. A pre-treatment estimate is merely a convenience so that you will know before the dental service is provided how much, if any, of the cost of that service is not covered under your plan. Since you may be responsible for any cost not covered under your plan, this is likely to be useful information for you when deciding whether to incur those costs.

Processing Policies
Delta Dental's policies and guidelines used for pre-treatment estimate and payment of claims. The processing policies may be amended from time to time.

Prophylaxis
Removal of tartar and stains from the teeth.

Prosthesis
An artificial replacement of one or more natural teeth and/or associated structures.

Pulpectomy
The complete surgical removal of the pulp (nerve) of a tooth. A step-in root canal treatment.

Pulpotomy
The partial removal of the pulp (nerve) of a tooth, usually performed on children as a treatment after dental caries (cavities) or a fracture has penetrated to the pulp.

Restoration
A broad term applied to any amalgam filling, resin filling, jacket or crown that restores or replaces loss of tooth structure. The term applies to the end result of repairing, restoring or reforming the shape, form and function of part or all of one or more teeth.

Root Canal Treatment
The removal of the diseased pulp (nerve) tissue to the ends of the root. It is usually performed by completely removing the pulp, sterilizing the pulp chamber and the canals of the root, and filling the canals with a plastic sealing material.

Root Planing
The smoothing of roughened root surfaces with instruments that remove deposits and plane the root surfaces.

Space Maintainers
A fixed or removable appliance to prevent the movement of teeth, usually in children.

Submitted Amount or Submitted Fee
The fee a dentist bills to Delta Dental for a specific treatment.

Vision Plan

The vision plan is offered through Vision Service Plan (VSP) and provides coverage for many vision expenses. The vision plan helps you pay for vision exams, glasses and contact lenses.

For More Information

Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

Highlights

Options	• Elect coverage • Waive coverage
Cost Per Pay	Rates are available during the enrollment process and your confirmation statement of benefits elections.
Who Is Covered	Eligible associates and their eligible dependents
Coverage Begins	First day of the month following your date of hire, if you are eligible for coverage
About this Benefit	The vision plan offers a national network of vision care professionals such as eye doctors and opticians. These doctors have been selected to provide professional care at reasonable rates. Benefits are provided for eye exams, frames and lenses or contact lenses up to plan limits.
Plan Features	Use VSP participating providers for maximum benefits
Coverage Ends	Last day of the month your Honda employment ends or eligibility ends
Administered By	Vision Service Plan (VSP)

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Who Is Eligible

Eligibility for you and your dependents is defined in *Participating in Health Benefits* on page 68.

Your Cost

Rates are available during the enrollment process and your confirmation statement of benefit elections.

When Coverage Begins

When coverage begins is described in *Participating in Health Benefits* on page 68.

How the Vision Plan Works

The vision plan offers a national network of vision care professionals such as eye doctors and opticians. These doctors have been selected to provide professional care at reasonable rates.

- When you use a participating **VSP provider**, your vision exam is paid at 100%. The plan also provides an allowance for some services and pays up to 100% for others, up to plan limits.
- You pay toward the cost of eye exams when you use a **non-VSP provider**. In addition, the plan pays for covered services based on a schedule of fees and plan allowances that are generally less than when you use VSP providers.

In both situations, you may pay any additional amounts after the plan has provided its allowance.

You may use a VSP provider, non-VSP provider or both to receive care. For example, you may decide to use a non-VSP provider for your exam and have a VSP provider to fill your prescription.

Benefits

The vision plan pays benefits for:

- A vision exam, frames and lenses; or
- An exam and contact lenses.

Services are covered once per calendar year or once every other calendar year, depending on when you last received the applicable service.

Check **vsp.com** for additional discounts.

Schedule of Benefits

Service	If You Use VSP Providers	If You Use Non-VSP Providers
Annual Eye Exam (one per calendar year)	Plan pays 100%	Plan pays up to $50
Eyeglass Frames* (one pair every other calendar year)	Plan provides a $175 allowance toward frames ($95 allowance at Costco)* 20% off amount over your frame allowance	Plan pays up to $70*
Eyeglass Lenses* (every calendar year)	Plan pays 100% up to plan limits* Lens enhancements: • Standard progressive lenses: No copay • Premium progressive lenses: $80 – $90 copay • Custom progressive lenses: $120 – $160 copay	Plan pays up to:* • $50 for single vision • $75 for bifocal • $100 for trifocal • $125 for lenticular
Contact Lenses* (one pair every calendar year in place of eyeglass frames/lenses)	Plan pays up to: • $130 for lenses you use voluntarily for vision correction • Contact lens exam not to exceed $60 copay	Plan pays up to: • $120 for lenses you use voluntarily for vision correction • Maximum includes contact lens exam copay

*A $20 copay will be applied to the purchase of frames or lenses (annually if purchased).

**Plan benefits pay for basic lenses and frames; if you order non-basic items, you pay any additional cost (see "Non-Basic Items" under "Expenses Not Covered by the Plan" on page 202).

How to Use the Vision Plan

You choose whether to use a VSP or non-VSP provider. You can call VSP or access the VSP website for a list of participating doctors. The following describes how to file claims and receive benefits.

If You Use a VSP Provider

- The VSP provider will request your authorization. You are responsible for the material copay, as well as any costs above the plan limit.
- The doctor will file a claim to receive plan payment.
- You will receive plan discounts including:
  - 30% off additional glasses and sunglasses, including lens options, on the same day as your well- vision exam from the same VSP provider;
  - 20% off additional glasses and sunglasses, including lens options, from any VSP provider within 12 months of your last well-vision exam; and
  - A $60 copay for the contact lens exam (fitting and evaluation).

How to Contact VSP

*You can call VSP at **1-800-877-7195** or access the VSP website at **vsp.com**. Or, you can link to VSP's website through **myhondaconnect.com** or call **1-866-778-5885**.*

If You Use a Non-VSP Provider

- You pay the full amount for services received during your visit.
- Ask for an itemized receipt that includes:
  - Doctor's name or office name;
  - Name of patient;
  - Date of service;
  - Services and materials received and the amount paid; and
  - Type of lenses (for example, single vision, bifocal).
- You typically have 12 months from the date of service to submit for reimbursement.
- Go to **vsp.com** for information about submitting claims online or by mail.

If You Use a Non-VSP Provider and a VSP Provider

If you use a non-VSP provider for your eye exam and then have the eyeglass prescription filled by a VSP provider, here is what happens:

- After your exam with the non-VSP provider, you will pay the full exam fee and get an itemized receipt as described above. Send this with the exam receipt to VSP. You will be reimbursed for the exam based on the non-VSP level of benefits.

To have your prescription filled, call one of the VSP providers listed on the website and confirm whether the doctor is willing to fill another doctor's prescription. Take your prescription to a VSP provider who has agreed to fill another provider's prescription. The doctor will file a claim for plan payment and the VSP level of benefits will apply for your prescription.

Expenses Not Covered by the Plan

The plan will not pay benefits for services or materials related to:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± 0.50 diopter power); or two pair of glasses in lieu of bifocals. Replacement of lenses and frames furnished under this plan that are lost or broken, except at the normal intervals when services are otherwise available (unless you are eligible at that time as shown in "Benefits" on page 200);
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Costs for services and/or materials above plan benefit allowances;
- Services and/or materials not indicated in the plan's Schedule of Benefits as covered plan benefits;
- Services or materials provided under Workers' Compensation or a similar law;
- Eye exams required by an employer as a condition of employment; and
- Services or materials provided by any other plan with benefits for vision care.

Non-Basic Items

- You will pay any additional cost for these non-basic items:
- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Scratch coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2;
- Progressive multifocal lenses;
- UV (ultraviolet) protected lenses;
- Certain limitations on low vision care;
- A frame that costs more than the plan allowance;
- Contact lenses (except as noted elsewhere herein);
- Cost of frames or cosmetic contact lenses above plan allowance;
- Two pairs of eyeglasses in place of bifocals; and
- Any materials or services not needed for visual welfare.

When Coverage Ends

When coverage ends is described in *Participating in Health Benefits* on page 68. In certain cases, you may be able to continue your vision plan coverage for a limited time by paying the full cost. See *COBRA* on page 204.

COBRA

This section describes situations where you can continue healthcare coverage for yourself and your eligible dependents when eligibility for Honda benefits ends.

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Healthcare Continuation—COBRA

The federal law COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) allows you and your covered dependents to pay premiums to continue healthcare coverage after it ends due to certain events. COBRA applies to the medical, prescription drug, dental and vision plans, as well as the Healthcare Flexible Spending Account, the Limited Purpose Flexible Spending Account and the Associate Assistance Program (AAP). COBRA does not apply to any other benefit provided by Honda to you or your family.

Information about COBRA coverage is available through Alight Solutions, our COBRA administrator. For details, contact the My Benefits Connect Center at **myhondaconnect.com** or call **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET.

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Always compare costs yourself as each person's situation is different. Additionally, you may qualify for a 30-day special enrollment period for another group health plan (such as a spouse's plan) due to a qualifying event, even if that plan generally does not accept late enrollees.

COBRA Period

COBRA coverage can continue up to 18, 29 or 36 months depending on the situation. If more than one event applies, the maximum coverage period is 36 months total. For Healthcare Flexible Spending Accounts and Limited Purpose Flexible Spending Accounts, if any, COBRA coverage is only extended for the remainder of the calendar year in which the COBRA qualifying event occurs.

The following chart shows when you and your dependents may continue healthcare coverage under COBRA and for how long.

	Maximum Period Coverage Can Continue		
COBRA Qualified Life Event	**You**	**Spouse**	**Child**
You lose coverage because: • Your hours are reduced • Your employment ends for any reason (except gross misconduct)	18 months	18 months	18 months
You or your qualified dependent are disabled (as defined by Social Security) when you lose coverage	29 months	29 months	29 months
You die	N/A	36 months*	36 months*
You and your spouse divorce or become legally separated	N/A	36 months	36 months
You become entitled to Medicare	N/A	36 months**	36 months**
Your child no longer qualifies as an eligible dependent	N/A	N/A	36 months

*The 36-month COBRA limit is in addition to the first 12 months of coverage paid by Honda. A total of 48 months of healthcare continuation is possible for your dependents in the event of your death.

**If you become entitled to Medicare before the date you end employment (for reasons other than gross misconduct) or your hours are reduced, your spouse and any dependent children are entitled to elect COBRA coverage for up to the greater of 36 months from the date of Medicare entitlement, or 18 months from the date of the termination of employment or reduction of hours.

Continuation of Healthcare Coverage During Military Leave

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you can continue healthcare coverage, including any dependent coverage for up to 24 months. Active associates on military leave will be required to pay the associate contribution. Non-active associates on military leave will be required to pay 102% of the total premium (calculated the same way as the COBRA continuation coverage premium). Your USERRA continuation period will run concurrently with any COBRA continuation period for which you are eligible.

Your healthcare coverage may be reinstated with no waiting period when you return to work at the completion of your leave, even if your coverage was not continued during the entire period of the military leave because you did not pay the premium or the leave extended beyond active employment. Your healthcare coverage will end if you inform Honda that you will not be returning to work following the completion of your military leave.

Second COBRA Qualifying Event Extension

The 18-month COBRA period may be extended to 36 months for your spouse and dependent children who are qualified beneficiaries if a second qualifying event occurs during the 18-month COBRA continuation period. Second qualifying events include death, divorce, legal separation or your dependent child ceasing to be a dependent under the terms of the plan.

Note

Your Medicare entitlement (Part A, Part B or both) is not considered a second qualifying event for your spouse and dependent children under the Honda plan.

However, this extension will only be allowed if the second event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred. To be granted an extension, the qualified beneficiary must notify the My Benefits Connect Center by calling **1-866-778-5885** within 60 days of the second qualifying event. If you fail to provide notice within 60 days, the right to the extension will be lost.

Disability Extension

The 18-month COBRA continuation period may be extended to 29 months if a qualified beneficiary is determined to be disabled by Social Security at any time before the 60th day of the COBRA continuation period. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. To be granted this extension, you must notify the My Benefits Connect Center at **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET, within 60 days of the determination (of, if later, within the first 60 days of COBRA coverage) and within the 18-month COBRA continuation period. If you fail to provide notice within this period, the right to the extension will be lost. You must also provide a copy of the notice from the Social Security Administration showing their determination of disability.

The disabled individual must also notify the My Benefits Connect Center within 30 days of any final determination that he or she is no longer disabled.

Electing COBRA Coverage

Honda's COBRA coverage is administered by the My Benefits Connect Center. Honda will notify the My Benefits Connect Center of a COBRA event due to your reduced hours, terminated employment or death. For all other COBRA events, you or your dependent must notify the My Benefits Connect Center at **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET, within 60 days of the event. The My Benefits Connect Center will provide information to you about how to continue and pay for coverage under COBRA.

You have 60 days from the date coverage ends or the date of your COBRA election notice (whichever is later) to elect continued coverage. If you elect COBRA coverage, you may choose to continue any Health Benefits coverage you had at the time you lost coverage. If coverage is modified for active associates, COBRA coverage will also be modified. If you do not elect COBRA coverage within the 60 days, coverage will end and will not be reinstated.

You can also elect to continue deposits to your Healthcare Flexible Spending Account or Limited Purpose Flexible Spending Account for the remainder of the calendar year with after-tax dollars if the benefit available under the plan is equal to or greater than the contributions you would need to make to continue the coverage. While this gives you continued access to the account, you will lose all tax benefits on your contributions. The COBRA period for a Healthcare Flexible Spending Account or Limited Purpose Flexible Spending Account cannot be extended beyond the last day of the calendar year.

You, your spouse and dependent children who lose coverage as a result of the COBRA qualifying event are qualified beneficiaries entitled to elect COBRA. A child born to, adopted by or placed for adoption with you during the period of COBRA coverage would also be a qualified beneficiary with a right to COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children.

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

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. It is important that you consider your 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 you lose your Honda coverage.
- If you are eligible for group health coverage through a spouse or other family member, the special enrollment period for that coverage is generally within the 30 days after you lose your Honda coverage.

If you do not elect an option during the special enrollment period, you may not be able to enroll in that option until the next open enrollment period. You will also have a special enrollment period at the end of COBRA coverage if you elect and maintain COBRA coverage for the maximum time available to you.

Cost

You have 45 days from your COBRA election to make the first premium payment. Your first premium payment will cover all periods back to your loss of coverage. After your first premium payment, you must pay monthly premiums, due by the first day of each month. Each monthly premium has a 30-day grace period. However, if you pay a monthly premium after the first day of the month and before the end of the 30-day grace period, your COBRA coverage may be suspended and then retroactively reinstated (going back to the first day of the month) when the monthly premium is received. This means that any claim you submit while your COBRA coverage is suspended may be denied and have to be resubmitted once your COBRA coverage is reinstated. If you fail to pay a monthly premium before the end of the 30-day grace period for that month, you will lose all rights to COBRA coverage.

Premiums will be based on the coverage level and group of plans you elect plus 2% for administrative costs. If you are enrolled in the California HMO Plan and are only eligible for 18-month federal COBRA, you can continue coverage for another 18 months under Cal-COBRA. The cost of coverage for the 19th through 36th months of coverage under the California HMO Plan is an added 10% (110% total) and is administered through Kaiser CA.

COBRA premiums are set each year and may be adjusted to reflect changes in the plans or their cost.

Healthcare Flexible Spending Account and Limited Purpose Flexible Spending Account contributions, if any, can be continued with after-tax dollars plus 2% for administrative costs.

When COBRA Ends

If any of the following occurs, COBRA healthcare coverage will end before the maximum period described in the "Maximum Period Coverage Can Continue" chart under "COBRA Period" on page 205:

- Required premiums are not paid by the due date;
- You, your spouse or your dependent becomes covered under another group health plan after you have made your COBRA election;
- You, your spouse or your dependent becomes eligible for Medicare (this only affects the person with Medicare coverage);
- You, your spouse or your dependent recovers from disability during the 11-month extension period; or
- Honda no longer provides healthcare coverage to any of its associates.

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

If your COBRA coverage terminates for any reason, it cannot be reinstated. You may have the right to appeal for certain situations; please contact the My Benefits Connect Center at **1-866-778-5885** and file an appeal.

Notice and Election Procedure

To protect your family's rights, you should keep the appropriate parties informed of any changes in address, as follows:

- **Associate address.** If your address changes, you should notify the My Benefits Connect Center as shown below.
- **Dependent address.** If your spouse or dependent(s) changes his or her address (to an address other than your address), contact the My Benefits Connect Center as shown below.

COBRA Questions, Enrollment and Notices

To obtain information about COBRA coverage, (including a copy of the complete COBRA Notice), enroll for COBRA coverage or obtain a complete copy of the COBRA Notice distributed by Honda, contact the My Benefits Connect Center at:

Website: **myhondaconnect.com**
Phone: **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET
Fax: **1-847-554-5140**
Address: P.O. Box 661155, Dallas, TX 75266-1155

You should also keep a copy of any notices you send to the My Benefits Connect Center for your records.

Cancelling COBRA Coverage

To cancel coverage, please contact the My Benefits Connect Center and submit your cancellation request in writing.

VOLUNTARY/ SUPPLEMENTAL BENEFITS

Contents

Paying for Voluntary/ Supplemental Benefits

You pay for Voluntary/Supplemental Benefits through pre-tax or after-tax payroll deductions (depending on the benefits you choose).

Voluntary/Supplemental Benefits allow you to choose additional benefits you may want for yourself and your family.

Voluntary/Supplemental Benefits
You choose which benefits you want.
Pre-tax benefit options include:
• Healthcare Flexible Spending Account
• Limited Purpose Flexible Spending Account
• Dependent Care Flexible Spending Account
• Associate-Paid Long-Term Disability
After-tax benefit options include:
• Supplemental Life Insurance
• Voluntary Accidental Death and Dismemberment Insurance
• Survivor Medical Insurance Program
• Group Auto/Homeowners Insurance
• Group Legal Plan

Benefits for Honda

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Flexible Spending Accounts

Flexible spending accounts (FSAs) help you save taxes while paying for certain healthcare and dependent care expenses.

For More Information

Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

Highlights

Options	• Healthcare FSA • Limited Purpose FSA • Dependent Care FSA • No participation
Cost Per Pay	You can elect to make deposits on a pre-tax basis through automatic payroll deductions; costs vary depending on your elected contribution.
Who Can Participate	Regular associates working at least 16 hours per week
Participation Begins	January 1 or first day of the month following an eligible associate's date of hire
About the Healthcare FSA	• Contribute from $100 up to annual contribution limits announced each year during Benefits Enrollment ($2,750 for 2021) per calendar year on a pre-tax basis • Reimburses you for eligible out-of-pocket healthcare expenses for you and your family members
About the Limited Purpose FSA (must be enrolled in the HSA Plan to participate)	• Contribute from $100 up to annual contribution limits announced each year during Benefits Enrollment ($2,750 for 2021) per year on a pre-tax basis • Reimburses you for eligible out-of-pocket dental and vision expenses for you and your family members; also can be used for eligible out-of-pocket medical and prescription drug expenses after you have met the HSA Plan deductible
About the Dependent Care FSA	• Contribute from $100 up to $5,000 per year ($2,500 if married filing separately) on a pre-tax basis • Reimburses you for eligible dependent daycare expenses that enable you and your spouse to work (or attend school full time)

Special Features	• You make pre-tax deposits, which save you taxes. • For the Healthcare FSA, you can elect automatic reimbursement when you enroll and can opt out of automatic reimbursement mid-year if you wish. • The IRS requires you to forfeit any unused balances at year end that are not claimed by March 31 of the following year.*
Participation Ends	Each December 31 or when your employment ends, if sooner
Administered By	UMR

*Under the Consolidated Appropriations Act, 2021, Honda elected to allow funds in excess of $50 to be carried over. This carry over option will end December 31, 2022, and remaining funds not claimed by March 31, 2023, will be forfeited.

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Who Is Eligible

You can elect to participate in the Healthcare FSA or Limited Purpose FSA (if you are enrolled in the HSA Plan) and the Dependent Care FSA for a calendar year if you are a regular associate who routinely works at least 16 hours per week.

You are not eligible to participate if you:

- Are an active Honda associate who has a regular work schedule of less than 16 hours per week;
- Are a self-employed person who provides services to Honda through an agreement between Honda and you;
- Are employed by or obtain your employment through a company that provides temporary workers to Honda;
- Are a student, co-op, intern or temporary associate; or
- Are an associate of an international affiliate on assignment at Honda.

When Participation Begins

If you are eligible, you can elect to participate in the Healthcare FSA or Limited Purpose FSA, as well as the Dependent Care FSA, for any calendar year. IRS regulations mandate that associates cannot have a general purpose Healthcare Flexible Spending Account and contribute to a Health Savings Account at the same time. Instead, HSA Plan participants may contribute to the Limited Purpose FSA.

Participation normally begins on January 1 and continues until December 31. To participate, you need to enroll during the Benefits Enrollment period held in the fall for the following calendar year.

If you are a new associate, you must enroll within 31 days of your date of hire. Your participation will begin on the first day of the month after you enroll.

Making Changes during the Year

You may start, stop or change a Healthcare FSA or Limited Purpose FSA election during the calendar year only if you have a qualified life event change. The change to your election must be consistent with the qualified life event change (see *Life* on page 8).

If you need to stop, start or change your election due to one of these events, contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET, within 31 days (60 days for birth, adoption or placement for adoption) of the event (see *Life* on page 8).

Manage Your Account Online

You can check your account balances online using the UMR website. You can access the UMR website by visiting **myhondaconnect.com**, and clicking on the “Health & Insurance” tab.

How the Accounts Work

The three types of FSAs are:

- Healthcare FSA (for qualified healthcare expenses)
- Limited Purpose FSA (for qualified dental and vision expenses; also can be used for qualified medical and prescription drug expenses after you have met your HSA Plan deductible)
- Dependent Care FSA (for dependent care, preschool, etc.)

Important Note!
Please note that these accounts are not interchangeable, so estimate carefully when planning your contribution amount.

Here is how the accounts work:

- After estimating your expenses for the upcoming calendar year, you decide how much to deposit in an FSA. Your deposits are made with convenient pre-tax payroll deductions.
- When you have an eligible out-of-pocket healthcare or daycare expense, you file a claim and reimburse yourself with pre-tax dollars from your account(s). As a result, your healthcare and dependent care expenses will cost you less. If you contribute to the Healthcare FSA, you can elect streamlined automatic claims submission for your eligible healthcare claims when you enroll. See "Streamlined Automatic Claims Submission" under "Claims" on page 221.

Account Advantages

FSAs give you several advantages. They allow you to:

- Budget for predictable healthcare and daycare expenses by allowing you to set aside money for these expenses ahead of time;
- Make deposits with convenient payroll deductions; and
- Lower your taxable income by taking your deposits out of your pay *before* certain taxes.

Estimate Carefully

Use spending accounts for expenses you expect to have in the coming year. Unused funds will be forfeited if they are not claimed by March 31 of the following year.*

*Under the Consolidated Appropriations Act, 2021, Honda elected to allow funds in excess of $50 to be carried over. This carry over option will end December 31 2022, and remaining funds not claimed by March 31, 2023, will be forfeited.

Your Deposits

If you elect to participate, the following rules apply to your deposits:

- You can make deposits to a Healthcare FSA (or Limited Purpose FSA) and/or a Dependent Care FSA—**but you cannot move funds between them**.
- You can be enrolled in the Healthcare FSA or Limited Purpose FSA, but not both. According to federal guidelines, you cannot open a Healthcare FSA if you enroll in a high deductible health plan like the HSA Plan.
- You need to plan carefully because of the "use it or lose it" rule imposed by the IRS. Any eligible expenses must be incurred by December 31 of the calendar year and claims must be filed by March 31 of the following calendar year. Any remaining funds will be forfeited.*
- Your annual pre-tax contributions are deducted in equal installments during the calendar year.
- No interest is paid on your deposits.

Note

If you are a highly compensated associate, the amount you may contribute to the Dependent Care FSA may be limited due to IRS regulations. You will be notified by the My Benefits Connect Center after the start of the benefits plan year if you are affected.

*Under the Consolidated Appropriations Act, 2021, Honda elected to allow funds in excess of $50 to be carried over. This carry over option will end December 31, 2022, and remaining funds not claimed by March 31, 2023, will be forfeited.

Pre-Tax Benefits

Your deposits to FSAs are made before taxes are deducted. This reduces your taxable earnings, so you pay less in taxes.

Tax Savings

Your account deposits are not subject to:

- Federal income tax;
- Social Security (FICA) tax;
- Medicare tax; or
- Most state income tax.

Healthcare Flexible Spending Account

You can contribute from $100 up to annual contribution limits announced each year during Benefits Enrollment ($2,750 for 2021) per calendar year. To be eligible for reimbursement, healthcare expenses must be recognized by the IRS as deductible expenses and not be reimbursable by another plan. See "Eligible Healthcare Expenses" on page 217 and "Healthcare Expenses Not Eligible" on page 218 for common eligible and ineligible expenses.

If you have questions about an expense, contact Quantum Health at **1-866-778-5885** (or, if enrolled in the HMO Plan, contact UMR at **1-800-826-9781**). You may also obtain a copy of IRS Publication 502 from your local library, by calling the IRS, or by logging in to **irs.gov/publications/p502**.

Who Is Eligible

You can use the healthcare account for eligible expenses incurred by:

- You;
- Your legally married spouse;
- Your children (by birth, adoption or placement for adoption) and stepchildren through the end of the year in which they attain age 26 regardless of their tax dependent status; and
- Those who qualify as dependents on your federal income tax return.

This applies even if your spouse or dependents do not have Honda healthcare coverage.

Eligible Healthcare Expenses

Eligible expenses must be incurred for the diagnosis, cure, relief, treatment or prevention of a sickness or injury. These include:

- Non-covered physician's fees;
- Orthodontia expenses (if you use the Healthcare FSA to reimburse orthodontia expenses, claims must be submitted manually);
- Amounts not paid by your (or your spouse's) medical, prescription drug, dental and vision coverage, including:
  - Deductibles;
  - Copays or your share of expenses paid as a percentage; and
  - Amounts above plan limits.
- Non-covered dental care, vision care (exams, frames, lenses and contact lenses) and hearing care (exams, aids);
- Lasik eye surgery;
- Hospital services including anesthesiology;
- Diagnostic services, including laboratory and X-ray fees;
- Prescription and over-the-counter medications including insulin and birth control pills;
- Menstrual products;
- Nursing services for care of a specific medical condition;
- Hospice care;
- Chiropractor and osteopath services;
- Psychotherapist, psychiatrist and psychologist services;
- Treatment for alcoholism or drug dependency;
- Physical therapy;
- Acupuncture;

In addition to insulin, the CARES Act has made over-the-counter medicines eligible even without a doctor's written prescription.

- Sterilization and legal abortion;
- Organ donation expenses;
- Cost of a guide or seeing-eye dog for the blind;
- Wheelchair or Autoette; costs for equipping an auto for a disabled person;
- Crutches and artificial teeth or limbs;
- Oxygen and oxygen equipment;
- Wigs if prescribed due to hair loss caused by disease;
- Weight reduction programs, if prescribed by a doctor for a specific health condition;
- Smoking cessation programs; and
- Certain purchases and home modifications made for a specific health condition and prescribed in writing by a doctor.

Healthcare Expenses Not Eligible

Expenses that are beneficial to your general health and not related to specific medical care are not reimbursable. These include:

- Premium payments for healthcare coverage for you, your spouse or dependents;
- Household and domestic help, even if recommended by a doctor;
- Cosmetic surgery (unless related to a congenital defect, accidental injury or disfiguring disease);
- Marriage and family counseling; divorce costs;
- Health club dues, unless recommended by a doctor to treat a medical condition;
- Dance lessons and travel for general health, even if recommended by a doctor;
- Cosmetics, toiletries or bottled water;
- Physical treatments (e.g., massage) that are not related to a specific health condition;
- Custodial care in an institution;
- Illegal operations and treatments;
- Transportation expenses to and from work, even if disabled;
- Weight loss programs for general health (unless prescribed by a doctor for a specific health condition);
- Premiums for auto, medical, disability, accident or life insurance;
- Over-the-counter products such as sleeping aids (unless prescribed at the direction of a doctor) and sunblock or tanning products;
- Personal use items (toothpaste, toothbrush and tooth whitening aids, etc.);
- Premiums for other insurance coverages;

- Vacation or travel, when taken for general health purposes, improvement of morale or relief of physical or mental discomfort;
- Vitamins and food supplements, when taken for general health purposes; and
- Expenses incurred before you began contributing to the account, or after participation ends.

Limited Purpose Flexible Spending Account

You can contribute from $100 up to annual contribution limits announced each year during Benefits Enrollment ($2,750 for 2021) per calendar year. To be eligible for reimbursement, expenses must be recognized by the IRS as deductible expenses.

If you have not met your medical and prescription drug deductible, you may use the Limited Purpose FSA to pay for only eligible out-of-pocket dental and vision expenses. After you have met the deductible, you can use your account to pay for eligible out-of-pocket medical and prescription drug expenses, as well as dental and vision expenses.

See “Eligible Healthcare Expenses” on page 217 and “Healthcare Expenses Not Eligible” on page 218 for common eligible and ineligible expenses.

If you have questions about an expense, contact Quantum Health at **1-866-778-5885** (or, if enrolled in the HMO Plan, contact UMR at **1-800-826-9781**).

Who Is Eligible

Eligible individuals include:

- You;
- Your legally married spouse;
- Your children (by birth, adoption or placement for adoption) and stepchildren through the end of the year in which they attain age 26 regardless of their tax dependent status; and
- Those who qualify as dependents on your federal income tax return.

This applies even if your spouse or dependents do not have Honda healthcare coverage.

Eligible Limited Purpose FSA Expenses

Once you have met your medical and prescription drug deductible under the HSA Plan, eligible healthcare expenses for the Limited Purpose FSA are the same as for the Healthcare FSA. See “Eligible Healthcare Expenses” on page 217. If you have not met your medical and prescription drug deductible, the account can be used only for qualified dental and vision expenses.

Limited Purpose FSA Expenses Not Eligible

See “Healthcare Expenses Not Eligible” on page 218 for common ineligible healthcare expenses.

Dependent Care Flexible Spending Account

The minimum amount you can contribute in a calendar year to the Dependent Care FSA is $100. The maximum deposit you can make is based on your tax filing status as follows:

- Single or married and filing jointly—$5,000
- Married filing separately—$2,500

If you are married, your annual deposits cannot exceed the earned income of the lower-paid spouse. If your spouse is a student or incapacitated, your spouse is considered to "earn" $250/month if you have one child or $500/month if you have two or more children.

If your spouse is employed elsewhere and contributes to a similar account, your family can contribute a total up to $5,000/calendar year ($2,500 each if you and your spouse file separately).

Provider Identification

If you use this account, you need to give the name, address and Social Security number (or tax identification number) of the care provider when you file your claim for reimbursement and federal income tax return.

To be eligible, your dependent care expenses must be for care of a qualifying dependent that allows you (and your spouse, if married) to work.

If you are married and use this account, your spouse must work, be a full-time student or be incapacitated.

Who Is Eligible

You can use the Dependent Care Flexible Spending Account for eligible expenses incurred for the following qualifying dependents:

- A child under age 13 whom you claim as a deduction on your federal income tax return; and
- Your spouse or dependent of any age who is incapable of self-care, depends on you for support and lives in your home at least eight hours a day.

If you go on a leave of absence, you are not eligible to be reimbursed for expenses. Upon your return you must re-enroll in the plan by contacting the My Benefits Connect Center within 31 days.

For more information, contact Quantum Health at **1-866-778-5885** (or, if enrolled in the HMO Plan, contact UMR at **1-800-826-9781**). You may also refer to IRS Publication 503, which is available from your local library, by contacting the IRS or by logging in to **irs.gov/publications/p503**.

Eligible Dependent Care Expenses

These include expenses for:

- Dependent daycare provided in your home by a babysitter, housekeeper or relative who is not a dependent;
- Dependent daycare provided outside your home, including qualified daycare centers, day camp, preschool and before- and after-school programs; and
- Elder care for dependents who live with you.

Generally, eligible child care costs include only those for the actual care of your child—not costs for education, supplies or meals, unless those costs cannot be separated from the cost of care.

Dependent Care Expenses Not Eligible

These expenses cannot be reimbursed through the Dependent Care FSA:

- Care provided by your child under age 19 or any other dependent you claim on your tax return;

- Care obtained for reasons other than work, such as social and volunteer activities;
- Care that could be provided by your employed spouse while not at work;
- Overnight camp expenses;
- Expenses for food, clothing, education (kindergarten or higher), entertainment and transportation to and from the daycare location;
- Agency referral charges and finder's fees;
- Expenses paid by another organization or provided at no cost to you;
- Expenses claimed as a federal income tax credit; and
- Expenses incurred before you begin contributing to the account.

Claims

Claims for FSA reimbursement should be filed with UMR. Reimbursement request forms are available from Quantum Health at **1-866-778-5885** (or, if enrolled in the HMO Plan, contact UMR at **1-800-826-9781**) or online at **myhondaconnect.com**. You may also need to submit documentation of your expenses. Complete instructions are on the claim form.

Expenses are incurred on the date service is rendered, not billed (except durable goods, such as eyeglasses). In addition, expenses must be incurred in the same calendar year you make deposits. **You have until March 31 of the following year to submit claims for expenses incurred during the prior calendar year.***

*Under the Consolidated Appropriations Act, 2021, Honda elected to allow funds in excess of $50 to be carried over. This carry over option will end December 31, 2022, and remaining funds not claimed by March 31, 2023, will be forfeited.

For More Information
Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

If you participate in the Healthcare FSA, you can have your eligible medical, prescription, vision and dental expenses automatically submitted for reimbursement, as described in the "Streamlined Automatic Claims Submission" below. (**Note:** This does not apply if you are enrolled in the HMO Plan.)

You can log in to UMR by visiting **myhondaconnect.com** to review your account at any time.

The following applies when you need to file claims for reimbursement.

	Healthcare FSA and Limited Purpose FSA	Dependent Care FSA
Documentation Needed	• Itemized statement from provider • Explanation of Benefits (EOB) from Honda plan and any other plans paying benefits • Proof of payment for dental or vision services	Itemized bills including information on services, dates of service, dependent and provider (must give provider's Social Security/tax ID number)
When You Are Reimbursed	Weekly if claims total at least $10 (smaller amounts paid at year-end)	Weekly if claims total at least $10 (smaller amounts paid at year end)
Amount Reimbursed	Up to total deposit elected for calendar year	Up to current account balance

Streamlined Automatic Claims Submission

If you contribute to the Healthcare FSA and have elected Honda's HSA Plan or PPO Plan, you can enroll in streamlined automatic claims submission. This service allows you to receive reimbursement for eligible medical, prescription drug, vision and dental expenses from this account without filing a claim each time you incur eligible expenses.

Electing Automatic Claims Submission

You have the option of electing streamlined claims submission when you enroll in a Healthcare FSA (not available if you are enrolled in the International Plan).

When you or your healthcare provider submits a healthcare claim to UMR, BCBS-AL, CVS/Caremark, Delta Dental or VSP, the eligible healthcare expenses, including medical, prescription drug, vision and dental expenses, are automatically processed through your Healthcare FSA and reimbursement is paid to you based on your preferred option (check or direct deposit).

Please note the following exceptions:

- Automatic reimbursement is only available if you are enrolled in a Honda medical/prescription drug, dental or vision plan (but not if you are enrolled in the International Plan); if you or your dependents are covered by more than one plan, you will need to submit claims manually.
- Eligible over-the-counter drug expenses must be submitted manually (whether or not you are using the streamline feature), including:
  - The type of drug;
  - The date of service;
  - The amount of purchase; and
  - A completed reimbursement claim form.

If you wish to change your automatic reimbursement election, contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET.

Special Situations—When Participation Ends

Your participation ends when you do not elect to contribute to an FSA for the next year. In addition, participation ends in the following special situations:

- If you are on an approved leave of absence, the following rules apply:
  - **Healthcare FSA and Limited Purpose FSA.** Your payroll deductions for your account may stop until you return to work. However, you can continue to file claims against your account and be reimbursed as described in "Claims" on page 221. If your return to work is within the same calendar year that your leave of absence began, your payroll deduction will be adjusted to get you caught up on your missed deductions. If your leave of absence crosses over calendar years you will have to re-enroll.
  - **Dependent Care FSA.** Your election will be suspended. Your payroll deductions for your account will stop, and you will not be eligible to get reimbursed for expenses incurred while on your leave.

If your return to work is within the same calendar year that your leave of absence began, your payroll deduction will be adjusted to get you caught up on your missed deductions. If your leave of absence crosses over calendar years you will have to re-enroll.

- If your Honda employment ends for any reason, your termination date is the last date you can incur expenses. You can still file claims up until March 31 of the following calendar year.
  - **Healthcare FSA or Limited Purpose FSA.** You may continue Healthcare FSA or Limited Purpose FSA contributions on an after-tax basis under COBRA by contacting the My Benefits Connect Center at **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET. You may submit claims for expenses incurred before and after your termination, up to the amount elected that year, if you continue to participate in the plan.
  - **Dependent Care FSA.** Contributions end. You may continue to submit claims for dependent care expenses incurred during the year in which you leave your job, both before and after you left. You are permitted to do this provided you are working somewhere else or are actively looking for work. Reimbursement is limited to the balance in your account on the day you left.

  Note: In either case, when you enroll in an FSA, keep in mind that expenses *must* be incurred by December 31 of the calendar year. You then have until March 31 of the following calendar year to request reimbursement from your account(s) for amounts incurred in the previous year. Any amount remaining in your account(s) after that date will be forfeited.*
- If you die while participating, the executor or administrator of your estate can sign claim forms and submit claims for reimbursement for services incurred prior to your death, as long as UMR receives a copy of the executor form or administrator of the estate court document.
- **Certain highly paid associates may have additional limits put on their Dependent Care FSA contributions to meet IRS requirements. You will be notified by the My Benefits Connect Center if these limits affect you.**

*Under the Consolidated Appropriations Act, 2021, Honda elected to allow funds in excess of $50 to be carried over. This carry over option will end December 31, 2022, and remaining funds not claimed by March 31, 2023, will be forfeited.

Effect on Other Benefits

- **Social Security.** Social Security taxes are not deducted from your account deposits. So, over a long period of time, you may have a reduction in your Social Security benefits. For most people, however, the decrease in the Social Security benefits (if any) is small and offset by current tax savings.
- **Honda benefits.** Your deposits do not affect other Honda benefits based on your pay (for example, life insurance, pension and savings plans). These benefits will continue to be based on your total base earnings before any deductions.

Other Tax Treatments

Instead of using FSAs, you may be able to get a tax break on eligible healthcare and dependent care expenses on your federal income tax return. You cannot use both methods for the same expense. The one that will work best for you depends on your financial and family situation.

The following guidelines may help you make a decision. For specific advice, you should consult a tax advisor or other professional.

- **Healthcare deduction.** If you itemize deductions on your federal income tax return, you may be able to deduct eligible healthcare expenses. You can deduct expenses that exceed 10% of your adjusted gross income (7.5% in 2021). For most people, unreimbursed expenses rarely reach this level.
- **Dependent care tax credits.** If you qualify, you can take a dependent care tax credit on your income tax return—whether or not you itemize. In 2021, IRS rules allow you to reduce the amount of tax you owe by a percentage of amounts up to $3,000 for one child and $6,000 for two or more children. The credit ranges from 20% to 35% of your eligible dependent care expenses, depending on your adjusted gross income. These limits may be subject to change for future years. The expenses you apply toward the tax credit will be reduced for every dollar reimbursed from your Dependent Care FSA. So, you need to decide which method makes the most sense for your situation. For more information, contact the IRS or your tax advisor.

Supplemental Insurance Plans

Honda offers a number of supplemental insurance programs to meet the varying needs of our associates.

For More Information

Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

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Associate-Paid Long-Term Disability

You can elect associate-paid long-term disability (LTD) coverage for yourself to get a higher monthly income benefit when your disability continues beyond 26 weeks.

Associate-paid LTD provides an additional 10% of base monthly earnings when you are on a disability for more than 26 weeks. Combined with Company-paid LTD, you can receive 60% of base monthly earnings while out on long-term disability.

See *Company-Paid Long-Term Disability* on page 46 for coverage details on eligibility, claims, coverage beginning and end and what is and is not covered.

Company-Paid LTD Reminder
Your Company-paid LTD provides 50% of your base monthly earnings while you are on long-term disability leave. *See* Company-Paid Long-Term Disability *on page 46.*

Highlights

Cost Per Pay	Paid by you through pre-tax payroll deduction
Who Is Covered	If elected, eligible associates regularly working at least 16 hours per week
Coverage Begins	First day of the month following date of hire
Benefits	Provides benefits for disability (occupational or non-occupational) that continues for more than 180 days (210 days in California). Benefit amounts are an additional 10% of your base monthly earnings on top of your Company-paid LTD, up to the plan maximum.
Plan Features	Pays a survivor benefit if you die while receiving benefits
Coverage Ends	When your Honda employment or plan eligibility ends
Administered By	New York Life Group Benefit Solutions (formerly Cigna Group Insurance)

Who Is Eligible

See “Who Is Eligible” in *Company-Paid Long-Term Disability* on page 46.

When Coverage Begins

See “When Coverage Begins” in *Company-Paid Long-Term Disability* on page 47.

Cost

You authorize Honda to deduct premiums for coverage from your paycheck before taxes are deducted. This reduces your taxable earnings, so you pay less in taxes.

Coverage

Associate-paid LTD benefits provide 10% of additional coverage, for a total LTD monthly benefit at 60% of your base pay (combined with 50% Company-paid LTD), with a maximum benefit of $18,000 per month.

Special Situations

If you are on an approved leave of absence, you will be billed directly for any missed premiums and you must make payments to continue coverage. You will receive a monthly invoice from the My Benefits Connect Center.

If you have an approved leave of absence for your own medical condition, payments for your associate paid long-term disability are due during the elimination period but are waived once LTD benefits begin.

Once you return to work, your paycheck deductions will begin the first of the month following the return date.

How to Enroll

For information about associate-paid LTD or to enroll in that coverage, contact the My Benefits Connect Center at ***myhondaconnect.com*** *or by calling* ***1-866-778-5885****, Monday through Friday, from 8:30 a.m. to 10 p.m. ET.*

When Coverage Ends

See “When Coverage Ends” in *Company-Paid Long-Term Disability* on page 50.

Supplemental Life Insurance

You can elect Supplemental Life Insurance for yourself, as well as for your spouse and eligible children.

Supplemental Life Insurance is underwritten by MetLife Insurance Company (MetLife). You, your spouse and your children may not covered under two plans (e.g., covered as an associate and as a spouse).

The Supplemental Life Insurance benefits described in this section are subject to the terms and conditions of the group insurance policy issued by MetLife. If you are approved for Supplemental Life Insurance coverage, you can receive a certificate of insurance describing your coverage in greater detail. To request a Supplemental Life Insurance or a voluntary accidental death and dismemberment certificate, call MetLife at ***1-800-638-6420.***

Highlights

Cost Per Pay	Paid by you through payroll deduction
Who Is Covered	If elected, eligible associates and/or their eligible dependents
Coverage Begins	First day of the month following approval from MetLife
Pays Benefits	In the event of covered person's death from any cause*
Special Features	You can continue Supplemental Life Insurance coverage after you leave Honda or are no longer eligible.
Coverage Ends	The day your Honda employment or eligibility ends unless you opt to continue your coverage by direct bill via MetLife
Administered By	Supplemental Life Insurance is insured by MetLife and administered by the My Benefits Connect Center.

*Benefit limitations apply for suicide. See your plan certificate of coverage for details.

Who Is Eligible

You are eligible for Supplemental Life Insurance if you are a regular associate who routinely works at least 16 hours per week.

The new hire eligibility period begins the first of the month following your date of hire (provided you are actively at work).

You can also elect to cover your:

- Legally married spouse and not legally separated; and
- Dependent children from birth up to the end of the month they reach age 26.

You are not eligible if you:

- Are an active Honda associate who has a regular work schedule of less than 16 hours per week;
- Are a self-employed person who provides services to Honda through an agreement between Honda and you;

- Are employed by or obtain your employment through a company that provides temporary workers to Honda;
- Are a student, co-op, intern or temporary associate; or
- Are an associate of an international affiliate on assignment at Honda.

When Coverage Begins

Coverage is effective on the first day of the month after coverage is approved by MetLife. Coverage under these plans is described in "Life Insurance Coverage" on page 232.

New Hire

You are eligible for Supplemental Life Insurance the first day of the month after the month in which you were hired. You must enroll within 31 days of your hire date to qualify for the special enrollment period.

This opportunity allows you to apply for coverage for the lesser of the following amounts:

- Up to 6 × your base annual earnings; or
- A maximum of $2,000,000.

Basic Life Insurance Refresher

Honda provides basic life insurance to you at no cost. That includes coverage of 2 × your base annual earnings up to $1.2 million. See "Basic Life and Accident Insurance" on page 56.

Your spouse, if applicable, may elect coverage in increments of $10,000 up to $200,000, not to exceed 100% of your coverage amount.

Please note that the amounts noted here reflect non-medical issue limits. If you enroll when first eligible, coverage amounts of 2 × base annual earnings up to $450,000 do not require evidence of insurability (EOI). If you enroll your spouse when first eligible, coverage amounts up to $50,000 do not require EOI. Any amounts in excess of these limits are subject to EOI review and approval.

You may enroll after your initial special enrollment period but will be subject to EOI review and approval.

Life Events

If you experience a qualified life event such as a marriage, birth or adoption, you are eligible to apply for additional coverage with limited underwriting for an additional 1 × your base annual earnings (not to exceed 6 × base annual earnings or $2,000,000). A newly eligible spouse may be eligible for coverage up to $50,000 with limited underwriting. Any amounts beyond this for you or your newly eligible spouse are subject to EOI review and approval.

You must request the coverage change within 31 days (60 days for birth, adoption or placement for adoption) of experiencing the life event (see *Life* on page 8).

Benefits Enrollment

Each year during Benefits Enrollment, you will have the opportunity to request additional coverage. You may request an additional 1 × base annual earnings (maximum of 6 × base annual earnings or $2,000,000 coverage) during this time with no EOI review for amounts. These limits reflect non-medical issue amounts. Evidence of insurability review and approval are required if you increase coverage by more than 1 × base annual earnings at one time and/or the election exceeds the non-medical issue amounts.

Your spouse will be subject to EOI if you elect spousal coverage at any time, including during Benefits Enrollment.

How to Enroll

For information about Supplemental Life Insurance or to enroll in that coverage, contact the My Benefits Connect Center at ***myhondaconnect.com*** *or by calling* ***1-866-778-5885****, Monday through Friday, from 8:30 a.m. to 10 p.m. ET.*

Changes in Dependent Eligibility

Contact the My Benefits Connect Center at **myhondaconnect.com** or **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET, to:

- Add coverage for a new spouse; or
- Report eligibility changes, such as a child reaching an age limit or divorce or legal separation.

These changes should be reported within 31 or 60 days of the event (see *Life* on page 8).

If your dependent's coverage ends, he or she may qualify for continued coverage.

Important Note!

You are responsible for ensuring that only eligible dependents are covered under the plans offered by Honda—and for providing accurate and up-to-date dependent information. If a dependent's status changes, you *must* immediately report the status change to the My Benefits Connect Center. Failure to do so—or providing false information about your dependents—could result in loss of elected benefits or in corrective action. Please note that removing a dependent child from medical coverage will not cancel his or her Supplemental Life Insurance coverage.

Cost

You authorize Honda to deduct premiums for coverage from your paycheck after taxes.

Your Supplemental Life Insurance premium is based on the age of the insured person(s) and desired amount of coverage.

Life Insurance Coverage

You can choose from the following coverage amounts for you, your spouse and/or eligible children under this plan.

The following table shows the key features available under the Supplemental Life Insurance plan.

For You	For Your Spouse	For Your Children
• 1 × base annual earnings* • 2 × base annual earnings* • 3 × base annual earnings* • 4 × base annual earnings* • 5 × base annual earnings* • 6 × base annual earnings* • Minimum: $5,000 • Maximum: $2 million	Any multiple of $10,000 from: • $10,000 (minimum) to • $200,000 (maximum)	Coverage applies to all eligible children: • $10,000 for each eligible child from birth to age 26 if eligible for healthcare coverage

*Base annual earnings means your regular base wage rate, excluding overtime, shift premium, bonus, expense allowances or other special compensation. If these amounts are not a multiple of $1,000, they are rounded up to the next $1,000.

You must enroll in Supplemental Life Insurance for yourself before you can enroll your spouse and/or children. The amount of your spouse's life insurance cannot exceed the amount of your Supplemental Life Insurance.

If you leave Honda, MetLife will send you information providing your options to continue coverage.

How Much Life Insurance Do You Need?

Once you decide that you need life insurance, how much is enough? A general rule of thumb suggests an amount equal to at least five to eight times your salary, depending on a number of factors:

- Your age and stage of life;
- How many children you have and their ages;
- How much your spouse earns (if your spouse is employed full- or part-time);
- How much you have in savings and investments;
- Your ongoing living expenses; and
- Future goals in your financial plan, such as college educations or retirement.

For assistance in deciding how much life insurance you need, see the Life Insurance Calculator on the MetLife website at **lifeonlinecalculator.com**.

Other Things to Consider

If you are…

- **Single and in your 20s.** You may not need much insurance, if any. Keep in mind that you should have sufficient cash available to meet any outstanding debt, in addition to your final expenses.
- **Married with young children.** You may need additional insurance since most young families have little savings and big responsibilities. If you die prematurely, life insurance provides your spouse and children with the support they require plus critical resources for future needs.
- **A single parent and sole breadwinner.** You need enough life insurance to cover daycare and other living expenses, as well as to help provide for your child's college education.
- **Married with no children.** If you own a home and significant assets, life insurance can help your spouse hold onto what you both worked so hard to achieve.
- **Married with children in college and/or elderly parents.** The unexpected death of one spouse could force the surviving spouse to deplete retirement savings in order to pay for college expenses or to care for older parents.
- **Older, married and have grown children.** You may need a minimal amount of life insurance if your savings and other assets provide an adequate financial cushion for your spouse.

When Coverage Amounts Change

Contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET, to request changes to your Supplemental Life Insurance. Satisfactory evidence of good health must be provided if you request any increase in coverage for you or your spouse. Requested changes are not effective until approved by MetLife.

With the automatic increase option, your coverage amounts (described in "Life Insurance Coverage" on page 232) change automatically as follows provided you are actively at work. Your coverage changes effective each January 1 (provided you are actively at work) based on your annual base pay as of the prior September 15.

Benefits

In the event of your death, the amount of your current Supplemental Life Insurance coverage is paid to the beneficiary you name. If no beneficiary is designated (or the beneficiary is not then living), amounts are paid as described in the certificate of insurance.

Supplemental Life Insurance benefits for your covered spouse and/or children are paid to you.

All death benefits are paid income tax-free.

Naming a Beneficiary

You may name or change your beneficiary by contacting the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**.

Claims

If you should die, a family member or beneficiary should notify the My Benefits Connect Center at **1-866-778-5885** (Monday through Friday, from 8:30 a.m. to 10 p.m. ET) as soon as possible. The beneficiary will receive information from MetLife about filing the claim and what documents will need to be provided as proof of loss.

Special Situations

If you are on an approved leave of absence and unable to have payroll deductions, you will be billed directly for any missed premiums and you must make payments to continue coverage. You will receive a monthly invoice from the My Benefits Connect Center.

If you have an approved leave of absence for your own medical condition, premiums for your policy may be waived if you become permanently and totally disabled. You can request Waiver of Premium paperwork after approximately five months of leave by contacting the My Benefits Connect Center at **1-866-778-5885**. If your claim is approved, you will continue to pay for your spouse's policy, if any.

Important Note!
It is important not to allow your coverage to lapse as you will be subject to evidence of insurability (EOI) review and approval to be reinstated.

It is important not to allow your coverage to lapse as you may be subject to an evidence of insurability (EOI) review and approval to be reinstated. Once you return to work, your paycheck deductions will restart.

When Coverage Ends

Unless you elect to continue coverage, your Supplemental Life Insurance coverage will end for you and your dependents on the earliest of:

- The day your Honda employment ends;
- The day your (or your dependents') plan eligibility ends;
- The date as of which you fail to pay the required premiums; or
- The date the plan ends.

Converting or Porting Coverage

You will be sent conversion/portability information directly from MetLife approximately three (3) weeks after your termination/retirement. Contact MetLife at **1-888-252-3607** if you do not receive your conversion/portability information timely. Rates and guarantees may change for continued coverage.

Voluntary Accidental Death and Dismemberment Insurance

You can elect additional voluntary accidental death and dismemberment (AD&D) insurance for you and your family. This insurance helps protect you and your family in case of accidental death or serious injury.

Honda automatically provides basic AD&D insurance at no cost to you to help protect your family in case of your death or serious injury. In addition to this basic AD&D insurance, you can also choose voluntary AD&D insurance, which would be paid for by you through payroll deduction. If you elect voluntary AD&D insurance for yourself, you can also elect voluntary AD&D insurance for your dependents.

Basic AD&D Insurance Refresher

Honda provides basic AD&D insurance to you at no cost. That includes coverage of 2 × your base annual earnings up to $1.2 million. *See "Basic Life and Accident Insurance" on page 55.*

Highlights

Cost Per Pay	Paid by you through payroll deduction
Who Is Covered	If elected, eligible associates and/or their eligible dependents
Coverage Begins	First day of the month following your date of hire
Pays Benefits	In the event of covered person's serious injury or death*
Coverage Ends	The day your Honda employment or eligibility ends
Administered By	Voluntary AD&D insurance is insured by MetLife and administered by the My Benefits Connect Center

*Benefit limitations apply. See your plan certificate of coverage for details.

Who Is Eligible

You are eligible for voluntary AD&D insurance if you are a regular associate who routinely works at least 16 hours per week.

The new hire eligibility period begins the first of the month following your date of hire.

You can also elect to cover your:

- Legally married spouse and not legally separated; and
- Dependent children from birth up to the end of the month they reach age 26.

You are not eligible if you:

- Are an active Honda associate who has a regular work schedule of less than 16 hours per week;
- Are a self-employed person who provides services to Honda through an agreement between Honda and you;

- Are employed by or obtain your employment through a company that provides temporary workers to Honda; or
- Are a student, co-op, intern or temporary associate.

When Coverage Begins

Coverage is effective on the first day of the month coincident with or following directly after three full months of consecutive employment.

New Hire

You are eligible for voluntary AD&D insurance the first of the month following your date of hire. You must enroll within 31 days of your hire date to qualify for the special enrollment period.

Life Events

If you experience a qualified life event such as a marriage, birth or adoption, you are eligible to apply for coverage amounts of $25,000 or $50,000, plus additional coverage in increments of $50,000 up to $500,000 not to exceed 10 times your base annual earnings. You must request the coverage change within 31 days of experiencing the life event.

Benefits Enrollment

Each year during Benefits Enrollment you will have the opportunity to enroll for coverage or request additional coverage. You may apply for coverage amounts of $25,000 or $50,000, plus additional coverage in increments of $50,000 up to $500,000 not to exceed 10 × your base annual earnings.

Cost

Rates are available during the enrollment process and on your confirmation statement of benefits elections.

Coverage

Here is an overview of the coverage provided under the plan:

	Coverage
• Associate Only	Choose a coverage amount as follows: • $25,000 • $50,000 • Plus additional increments of $50,000 up to $500,000 (as long as it does not exceed 10 times your base annual earnings)
• Associate + Spouse (No children)	Choose an associate coverage amount as follows: • $25,000 • $50,000 • Plus additional increments of $50,000 up to $500,000 (as long as it does not exceed 10 times your base annual earnings) • Spouse—60% of associate coverage amount
• Associate + Children (No spouse)	Choose an associate coverage amount as follows: • $25,000

	Coverage
	• $50,000 • Plus additional increments of $50,000 up to $500,000 (as long as it does not exceed 10 times your base annual earnings) • Each child—20% of associate coverage amount
• Family Coverage (Associate + Spouse + Children)	Choose an associate coverage amount as follows: • $25,000 • $50,000 • Plus additional increments of $50,000 up to $500,000 (as long as it does not exceed 10 times your base annual earnings) • Spouse—50% of associate coverage amount • Each child—15% of associate coverage amount

Note: If you choose to elect voluntary AD&D insurance, it will be a separate election from your Supplemental Life Insurance coverage.

Benefits

In the event of your death, the amount of your current voluntary AD&D insurance coverage is paid to the beneficiary you name. If no beneficiary is designated (or the beneficiary is not then living), amounts are paid as described in the certificate of insurance. In the event of your serious injury, the benefit will be paid to you.

Voluntary AD&D insurance benefits for your covered spouse and/or children are paid to you.

All death benefits are paid income tax-free.

Naming a Beneficiary

You may name or change your beneficiary by contacting the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**.

Claims

In case of death or serious injury of you or your covered spouse and/or children, the My Benefits Connect Center should be contacted at **1-866-778-5885** (Monday through Friday, from 8:30 a.m. to 10 p.m. ET) as soon as possible. The beneficiary will receive information from MetLife about filing the claim and what documents will need to be provided as proof of loss.

Special Situations

If you are on an approved leave of absence, you will be billed directly and/or have catch-up payroll contributions for any missed premiums and you must make payments to continue coverage.

Once you return to work, your paycheck deductions will begin the first pay period following the return date.

When Coverage Ends

Your voluntary AD&D insurance coverage will end for you and your dependents on the earliest of:

- The day your Honda employment ends;
- The day your (or your dependents') plan eligibility ends;
- The date you fail to pay the required premiums; or
- The date the plan ends.

Survivor Medical Insurance Program

The Survivor Medical Insurance Program lets you buy extended medical and prescription drug coverage for your eligible dependents if you die while you are working at Honda.

Highlights	
Cost Per Pay	Amount you pay is based on your age
Coverage Begins	January 1 or first day of the month following an eligible associate's date of hire
Pays Benefits For	Extended medical/prescription drug coverage for an associate's eligible dependents in the event of his or her death
Special Features	Eligible dependents receive medical/prescription drug coverage at no cost for five years
Coverage Ends	When you become eligible for retirement or leave Honda
Administered By	The Survivor Medical Insurance Program is administered by the My Benefits Connect Center. Your medical claims administrator is the claims payor.

Who Is Eligible

All regular associates working at least 16 hours per week and are covering at least one dependent in a Honda medical plan are eligible to participate. When you enroll, all of your eligible dependents are covered under the plan. Eligible dependents include your:

- Legally married spouse not legally separated; and
- Child(ren) up to age 26.

You are not eligible if you:

- Are eligible for retirement (e.g., age 55 with 10 or more years of service), due to extended coverage available under the Retirement Medical Program;
- Are a self-employed person who provides services to Honda through an agreement between Honda and you;
- Are employed by or obtain your employment through a company that provides temporary workers to Honda;
- Are a student, co-op, intern or temporary associate; or
- Are an associate of an international affiliate on assignment at Honda.

When Coverage Begins

You can enroll in the Survivor Medical Insurance Program:

- During the Benefits Enrollment period; or
- Within 31 days (or 60 days for birth/adoption/placement for adoption) of a qualified life event change (see *Life* on page 8).

If you are a new associate who is eligible, you must enroll within 31 days of your hire date. If you do not enroll during the 31-day period, your next opportunity will be the next Benefits Enrollment period, unless you have a qualified life event change.

Coverage begins on the earliest of the following:

- January 1 of the next plan year if you enroll during the Benefits Enrollment period;
- The first day of the month following your date of hire if you are a new associate; and
- As soon as possible if you enroll due to a qualified life event change.

Cost

Your cost for coverage is similar to Supplemental Life Insurance in that the amount you pay is based on your age. Contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET, for rate information.

Note

Your contributions for Survivor Medical Insurance are made with after-tax dollars.

Coverage

Honda automatically provides all eligible associates with medical/prescription drug, dental, and vision coverage for their spouse and eligible dependents for 12 months following their death.

By enrolling in the Survivor Medical Insurance Program, you can extend medical/prescription drug coverage for an additional five years for your eligible dependents, for a total of six years of coverage. After six years, your eligible dependents can purchase coverage at 50% of the applicable COBRA rates.

Here is an overview of the coverage provided under the plan:

Coverage Type

	Automatic 12-Month Coverage	***5-Year Survivor Medical Insurance Extension***	***Survivor Medical Insurance 50% COBRA Rates (until eligibility ends)***
Includes All Eligible Dependents	√	√	√
Medical/Prescription Drug Coverage	√	√	√
Dental	√	*	N/A
Vision	√	*	N/A

*Available by paying normal COBRA rates for up to 36 months (three years).

An Example

The following example shows how the plan would work for the dependents of a covered associate if that associate were to die in June 2021.

Survivor Medical Insurance Program—Enrolled in Plan for 2021

June 2021 – June 2022	***July 2022 – June 2027***	***Beginning July 2027***
Automatically covered under Honda's healthcare programs: • Medical/Prescription drug • Dental • Vision	Coverage provided through Survivor Medical Insurance Program for five additional years: • Medical/Prescription drug	Eligible dependents can continue medical/prescription drug coverage at discounted COBRA rates.

Special Situations

If you miss payroll deductions, you will be billed directly for premiums and you must make payments to continue coverage.

When Coverage Ends

Participation in the plan ends when you become retirement eligible or leave Honda.

Survivor Medical Insurance Program coverage ends for your dependents when one of the following occurs:

- Your spouse remarries;
- Your spouse/dependent becomes eligible for Medicare;
- Your child(ren) no longer qualify as an eligible dependent(s) under Honda's medical plan;
- Your spouse/dependent does not make the required contributions after he or she has received five years of Survivor Medical Insurance Program coverage at no cost; or
- A dependent submits a false or fraudulent claim.

Group Auto Insurance

Group Auto Insurance gives you the option of purchasing comprehensive auto insurance coverage.

Highlights

Cost Per Pay	Depends on type of coverage you choose; paid by you through payroll deductions
Coverage Begins	Can enroll at any time during year; coverage begins as soon as administratively possible after you enroll
Pays Benefits For	Auto liability, medical, collision/comprehensive, uninsured/under-insured drivers
Special Features	Helps pay benefits to survivors if an accident results in death
Coverage Ends	Can cancel at any time; can convert coverage to individual policy if you leave Honda
Administered By	Mercer Voluntary Benefits; insured by Travelers Indemnity Company or MetLife

Important Note

The Group Auto Insurance benefits described in this section are subject to the terms and conditions of the Group Auto Insurance policy issued by the carrier. If you are approved for insurance coverage, you will receive a certificate of insurance describing your coverage in greater detail.

Who Is Eligible

You are eligible for Group Auto Insurance if you are a regular associate who routinely works at least 16 hours per week.

You are not eligible if you:

- Are an active Honda associate who has a regular work schedule of less than 16 hours per week;
- Are a self-employed person who provides services to Honda through an agreement between Honda and you;
- Are employed by or obtain your employment through a company that provides temporary workers to Honda;
- Are a student, co-op, intern or temporary associate; or
- Are an associate of an international affiliate on assignment at Honda.

When Coverage Begins

You can enroll in Group Auto Insurance coverage at any time during the year. Coverage begins as soon as administratively possible after you enroll.

Cost

Your cost for coverage is based on the type of coverage you choose. For a quote, contact Mercer Voluntary Benefits at **1-800-441-5572** or log in to **hondavoluntaryplans.com**.

Please have the following information available when calling or visiting the website:

- Your current auto policy;
- Vehicle identification number(s);
- Year, make and model of your vehicle(s);
- Your driver's license number; and
- Driver's license numbers for any other eligible drivers in your household.

Coverage

When you enroll in Group Auto Insurance, you may receive the following coverage:

- **Liability.** Applies to property damage or injuries that you cause to other people while driving;
- **Medical.** Applies to medical treatment for you and your passengers if you are in an accident;
- **Collision/Comprehensive.** Collision applies to the damage to your car up to the book value of your car in an accident that you cause. Comprehensive applies to other kinds of damage or loss from theft, vandalism, natural disasters, etc.
- **Uninsured/Under-insured drivers.** Applies to your costs if a driver cannot pay for injuries to you and/or your passengers; and
- **Other options.** Towing and car rental are available.

This coverage can also help to offset the cost of:

- Bodily injuries to yourself or others;
- Lost wages due to injury;
- Benefits to survivors if an accident results in death;
- Lawsuits brought against you as the result of an accident; and
- Repairs made to your car due to damage caused in an accident.

Other Types of Coverage

You can also purchase coverage for:

- Motorcycles;
- Recreational vehicles;
- Campers;
- Travel trailers;
- All-terrain vehicles;
- Personal excess liability (umbrella); and
- Personal articles.

Claims

To file a claim, contact Mercer Voluntary Benefits at **1-800-441-5572** or log in to **hondavoluntaryplans.com**.

Special Situations

If you are on a leave of absence, coverage continues as long as premium payments are made. For the first six weeks of your leave, any missed premiums due are divided evenly among the remaining pay periods for the rest of the policy period.

After six weeks of missed premiums, you will be billed directly by Mercer Voluntary Benefits. You can resume payroll deductions once you have returned and your policy renews. Please contact Mercer Voluntary Benefits at **1-800-441-5572** for additional information or assistance with the direct bill process. Coverage will end if you fail to pay premiums.

When Coverage Ends

Your coverage is generally renewable every six months. You can cancel your coverage at any time. If you leave Honda, you can continue your coverage through an individual policy and make direct payments to the carrier.

Group Homeowners Insurance

You have the option of purchasing Group Homeowners Insurance to protect your property and belongings. If you rent, you can purchase insurance to cover the loss of your belongings.

The Group Homeowners Insurance benefits described in this section are subject to the terms and conditions of the group insurance policy issued by the carrier. If you are approved for insurance coverage, you will receive a certificate of insurance describing your coverage in greater detail.

Highlights

Cost Per Pay	Depends on individual coverage; paid through payroll deductions
Coverage Begins	Can enroll at any time during year; coverage begins as soon as administratively possible after you enroll
Pays Benefits For	Loss of your belongings and cost of repairs or replacement to property
Coverage Ends	Can cancel at any time; can convert coverage to individual policy if you leave Honda
Administered By	Administered by Mercer Voluntary Benefits; insured by Travelers Indemnity Company or MetLife

Who Is Eligible

You are eligible for Group Homeowners Insurance if you are a regular associate who routinely works at least 16 hours per week.

You are not eligible if you:

- Are an active Honda associate who has a regular work schedule of less than 16 hours per week;
- Are a self-employed person who provides services to Honda through an agreement between Honda and you;
- Are employed by or obtain your employment through a company that provides temporary workers to Honda;
- Are a student, co-op, intern or temporary associate; or
- Are an associate of an international affiliate on assignment at Honda.

When Coverage Begins

You can enroll in Group Homeowners Insurance coverage at any time during the year. Coverage begins as soon as administratively possible after you enroll.

Cost

Your cost for coverage is based on the coverage you choose and your individual circumstances, such as size of home and location. For a quote, contact Mercer Voluntary Benefits at **1-800-441-5572** or log in to **hondavoluntaryplans.com**.

You should have the following information available when calling or visiting the website:

- Current policy information;
- Year the home was built; and
- Square footage and special features.

Coverage

Homeowners insurance covers the loss of your belongings. If you must repair or replace property that is damaged, destroyed or stolen, your insurance will generally pay for all or part of the cost. This policy also protects you against liability lawsuits if you are sued by someone who is injured or whose property is damaged.

Coverage typically included in a homeowners insurance package includes:

- **Dwelling.** Covering your residence and an attached garage;
- **Other structures.** Covering a detached garage, shed, barn or fence;
- **Personal property.** Covering the contents of your home;
- **Medical payments coverage.** Paying medical expenses if someone is injured on your property; and
- **Additional living expenses.** Paying for your living expenses if you need to move out of your home during repairs.

If available, you may add these features to your homeowners insurance policy:

- Debris removal (for example, after a tornado);
- Reasonable repairs to prevent further loss, such as repairing a storm-damaged patio to prevent soil erosion;
- Lightning damage to trees, plants, shrubs and lawns;
- Fire department service charges;
- Jewelry; and
- Earthquake.

Coverage is available for most homes, including mobile homes. If you rent a house, condominium, townhouse or apartment, your coverage protects the contents of your home.

Claims

To file a claim through the carrier, contact Mercer Voluntary Benefits at **1-800-441-5572** or log in to **hondavoluntaryplans.com**.

Special Situations

If you are on a leave of absence, coverage continues as long as premium payments are made. For the first six weeks of your leave, any missed premiums due are divided evenly among the remaining pay periods for the rest of the policy period.

After six weeks of missed premiums, you will be billed directly by Mercer Voluntary Benefits. You can resume payroll deductions once you have returned and your policy renews. Please contact Mercer Voluntary Benefits at **1-800-441-5572** for additional information or assistance with the direct bill process. Coverage will end if you fail to pay premiums.

When Coverage Ends

Your coverage is generally renewable every year. You can cancel your coverage at any time. If you leave Honda, you can continue your coverage through an individual policy and make direct payments to the carrier.

Group Legal Plan

The Group Legal Plan offers you access to legal advice and a variety of legal services.

The Group Legal Plan benefits described in this section are subject to the terms and conditions of the insurance policy issued by the carrier. You will receive a certificate of insurance describing your coverage in detail.

Highlights	
Cost Per Pay	Paid by you through payroll deductions
Coverage Begins	• January 1 if you enroll during Benefits Enrollment • First day of the month following the date your enrollment is received and processed after a life event or as a new hire
Pays Benefits For	Legal advice and services
Coverage Ends	December 31, if you cancel during Benefits Enrollment, or the last day of the month if you end employment
Administered By	Administered by Mercer Voluntary Benefits; insured by ARAG

Who Is Eligible

You are eligible for the Group Legal Plan if you are a regular associate who routinely works at least 16 hours per week.

You are not eligible if you:

- Are an active Honda associate who has a regular work schedule of less than 16 hours per week;
- Are a self-employed person who provides services to Honda through an agreement between Honda and you;
- Are employed by or obtain your employment through a company that provides temporary workers to Honda;
- Are a student, co-op, intern or temporary associate; or
- Are an associate of an international affiliate on assignment at Honda.

When Coverage Begins

You can enroll in the Group Legal Plan as a new hire within 31 days, during the Benefits Enrollment period or within 31 days of a qualifying life event change (60 days for birth, adoption or placement for adoption). Coverage begins on the earlier of:

- January 1 of the next plan year; or
- The first day of the month following the date your enrollment is received and processed.

Cost

Rates are available during the enrollment process and on your confirmation statement of benefits elections.

Coverage

This plan provides legal services for a variety of reasons, including buying a home, negotiating landlord or tenant issues, creating a will or adopting a child.

When you enroll in the Group Legal Plan, you receive the following coverage:

- Access to a wide network of attorneys across the nation;
- Unlimited, toll-free phone access to attorneys for advice on common legal matters, to review documents, and provide simple preparation of items such as wills and a power of attorney;
- Help with family and juvenile issues, criminal misdemeanors and more; and
- Online service including access to the Law Guide, which helps you learn more about common legal matters and provides access to do-it-yourself legal documents.

Refer to **myhondaconnect.com** for a carrier link to the plan and more detailed description of what is covered.

Special Situations

If you are on a leave of absence, coverage continues as long as premium payments are made. For the first six weeks of your leave, any missed premiums due are divided evenly among the remaining pay periods for the rest of the policy period. If you miss premium payments for fewer than six consecutive weeks, your payments will be recalculated.

If you miss required premium payments for more than six consecutive weeks, coverage will be cancelled. You will need to contact ARAG directly at **1-800-247-4184** if you wish to continue coverage.

When Coverage Ends

Your coverage will automatically renew each year unless you cancel it during Benefits Enrollment.

Your coverage ends on the earlier of the following:

- December 31, if you cancel coverage during Benefits Enrollment; or
- If you stop paying the required premiums while on leave or when terminating.

If you leave Honda, you can continue your coverage through an individual policy and make payments to ARAG (**1-800-247-4184**).

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OTHER BENEFITS

Contents

Honda offers a variety of other benefits, including Honda stock ownership opportunities and assistance with health, safety and financial needs.

For More Information
Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

Stock Ownership

Honda provides you with the opportunity to take ownership in the Company and acquire Honda Motor Company Ltd. stock American Depository Receipts (ADRs) through the Stock Purchase Plan.

ADRs

You will receive ADR book entry shares through the Stock Purchase Plan. American Depository Receipts are receipts for shares of a foreign company, which are deposited in the foreign branch of an American bank. Honda Motor Company Ltd. ADRs are traded on the New York Stock Exchange under the ticker symbol HMC. Computershare is the recordkeeper for the Stock Purchase Plan. Unless you request an ADR certificate (as described below), you will not receive actual ADR certificates for your Stock Purchase Plan purchases.

Stock Purchase Plan

This plan allows you to purchase ADRs for Honda Motor Company Ltd. stock through payroll deduction and without broker's fees. This helps you to cost-effectively invest in the Company.

Who Is Eligible

You are eligible to join the Stock Purchase Plan on the first day of the month following your date of hire if you are:

- A regular Honda associate working at least 16 hours per week; and
- At least age 18.

You are not eligible to join the Stock Purchase Plan if you are classified by Honda as:

- An active Honda associate who has a regular work schedule of less than 16 hours per week;
- A self-employed person who provides services to Honda through an agreement between Honda and you;
- Employed by or obtain your employment through a company that provides temporary workers to Honda;
- A student, co-op, intern or temporary associate; or
- An associate of an international affiliate on assignment at Honda.

Consult an Expert

Taxes may apply to your ADR purchases, sales and dividends. Because tax laws are complex and subject to change, you should seek the advice of a financial or tax advisor. Honda cannot advise you on investment decisions.

How to Enroll or Make Changes

To enroll or change your Stock Purchase Plan elections, contact Computershare through:

- Their website at **www-us.Computershare.com/Employee** (available 24 hours a day, 7 days a week);
- Their interactive voice response (IVR): **1-800-331-9597** (available 24 hours a day, 7 days a week); and
- A customer service representative: **1-800-331-9597** (available 8 a.m. to 7 p.m. ET, on regular business days).

Use company code "HMC" or company name "Honda" when you log in or call.

You can change or cancel your Stock Purchase Plan election at any time. Please allow one to two weeks for your change to be implemented.

Purchasing ADRs

Honda will transfer your payroll deductions to Computershare. This transfer takes place once per month after the last pay date of the month. Computershare will purchase Honda Motor Company Ltd. ADRs on the open market at the current market value on your behalf and hold them for you in your Stock Purchase Plan account.

For the ADRs you purchase through payroll deduction:

- Broker's fees and service charges are paid by Honda.
- Any dividends are automatically reinvested in Honda ADRs, with no fees for reinvestment.

You can also make lump-sum purchases of Honda ADRs. These lump-sum purchases are subject to broker's fees and service charges. The form to make a lump-sum purchase is available on the Computershare website under "Downloadable Forms" or by calling Computershare and requesting the form.

You can obtain information about your account by calling Computershare at **1-800-331-9597** or by going to the website (**www-us.Computershare.com/Employee**). In addition, Computershare will send you a statement of your account in January following the end of the calendar year. The annual statement will include the number of shares purchased, the purchase price and the value of your account at the end of the year. **You should keep these statements. They provide information you will need if you sell your ADRs.**

If you move, notify Honda Payroll of your address change. Honda will provide this information to Computershare.

Selling ADRs

You can sell your ADRs by accessing your account on the Computershare website. Just click on the "Sell Shares" link and follow the simple steps to complete your sales request. You can also sell your ADRs by calling Computershare (**1-800-331-9597**) and entering your sell request through the IVR or by speaking with a customer service representative.

Your order to sell your ADRs will be processed at the next available sale price as soon as market conditions allow.

Tracking Stock Performance

For financial information about Honda Motor Company Ltd., you can contact Computershare or refer to a number of resources online or in the business section of newspapers such as The Wall Street Journal.

You have the ability to place two types of Limit Orders:

- **Day Limit Order.** This order allows you to specify a price at which you would like your sale to be processed.
- **Good Until Canceled Order (GTC).** This order allows you to indicate a price at which you would like your sale transaction to be placed. Your order instructions will be effective for a maximum of 30 days.

The check for your sale proceeds will be mailed on the settlement date, which is three business days after your ADRs are traded. Checks to be delivered within the U.S. are typically received within 10 to 14 days from the day you place the order.

For current ADR prices, contact Computershare at **1-800-331-9597**, Monday through Friday, from 8 a.m. to 7 p.m. ET. Price quotes are also available virtually on the Computershare IVR 24 hours a day.

Certificate Withdrawals/Transfers

You can contact Computershare to receive any of the full share ADRs in your account as an ADR certificate. Certificate fees will be charged. For certificates you withdraw and hold on your own, dividends will be paid directly to you instead of being automatically reinvested. Once a certificate is issued, your account will be transferred to Honda Motor Company Ltd.'s ADR transfer agent (JP Morgan).

You can contact Computershare to request a transfer of full-share ADRs in your account to another broker. Broker's transfer fees will be charged.

Transaction Fees

For each transaction executed on your account, a fee will be deducted from the proceeds of the sale. Current fees are shown below:

Fee Schedule—Subject to Change

Sales Transaction Fee Schedule	*Representative Assisted Trades*	*IVR or Web Trades*
	• $0.07 per share for trades up to 1,000 shares • $0.05 per share for trades from 1,001 to 5,000 shares • $0.03 per share for trades of over 5,000 trades • Minimum fee of $39.95 applies	• $0.03 per share (minimum fee of $19.95 applies)
Postage and Handling	$5.35 per transaction	
SEC Fee	Subject to change	
Foreign Currency Check	$10 (if applicable)	
Foreign Currency and U.S. $ Wires	$25 (if applicable)	
Overnight Check Request	$20 (if applicable)	
Certificate Withdrawal	$30 (if applicable)	
Broker Transfer	$30 (if applicable)	
Duplicate Statements (beyond the two previous quarters)	$10 (if applicable)	

If You Leave Honda

If your Honda employment ends, you will have the following options for your Stock Purchase Plan account:

- Close your account and receive full ADR shares in certificate form. Whole and fractional ADR shares will be sold to cover transaction and handling fees. The remaining proceeds, if any, will be sent directly to you;
- Close your account by authorizing the sale of your ADRs. The cost of applicable transaction and handling fees will be deducted from the proceeds. The remaining proceeds, if any, will be sent directly to you;
- Transfer your account to another broker. Only whole ADR shares will be transferred. Whole and partial ADR shares will be sold to cover transaction and handling fees. The remaining proceeds, if any, will be sent directly to you;
- If you retire from Honda, you may leave your ADRs at Computershare. If your employment ends before you are eligible for retirement, you must select one of the other alternatives; and
- If you leave Honda and your account balance is less than $25.00, the account will be closed after 90 days and the funds used to cover the transaction and handling fees. Because the transaction and handling fees exceed $25.00, you will not receive a payment.

Important!

Honda has policies to prevent insider trading. Under these policies, your ability to sell Honda ADRs, or to change your elected payroll deduction level under the Stock Purchase Plan, may be restricted when you know material non-public information about Honda or about the companies doing business with Honda.

Associate Assistance Program

The Associate Assistance Program (AAP), called "GuidanceResources" and provided by ComPsych, offers resources and services to improve your life at work and home. You, your dependents and household members are eligible to utilize the AAP. Your AAP services include:

Confidential Counseling

Life can be stressful. Personal issues, planning for life events or simply managing daily life can affect your work, health and family. ComPsych provides support, resources and information for personal and work-life issues. ComPsych is designed to provide short-term counseling services for you and your dependents/household to help you handle concerns constructively, before they become major issues. Call anytime about concerns such as:

- Marital, relationship or family issues;
- Relationship/Marital conflicts;
- Child care or parenting issues;
- Grief and loss;
- Substance abuse;

- Elder care; and
- Maintaining work-life balance.

ComPsych counselors are at the master's degree level or are Ph.D. credentialed. Telephonic and face-to-face counseling is available for you and your dependents/household. Face-to-face counseling will be available in your local community by a credentialed counselor. If your problem cannot be resolved in a short-term setting (six visits), your counselor will refer you to another qualified professional. You and your dependents/household are eligible for six visits per incident per year. All calls are voluntary and strictly confidential. Honda pays this benefit entirely.

GuidanceResources

Go online to access timely, expert information on thousands of topics, including relationships, work, school, children, wellness, legal, financial and free time. You can search for qualified child and elder care, attorneys and financial planners as well as ask questions, take self-assessments and more.

GuidanceResources is available to you 24 hours a day, 7 days a week.

There are two ways to access your GuidanceResources benefits:

- Call **1-866-778-5885** or **1-800-232-6357**. You can speak with a counseling professional who will listen to your concerns and can guide you to the appropriate services you require; or
- Visit GuidanceResources Online at **guidanceresources.com** and enter company ID: HONDA.

Remember, your GuidanceResources benefits are strictly confidential. To view the ComPsych HIPAA privacy notice, please go to **guidanceresources.com/privacy**.

Adoption Assistance Program

The Adoption Assistance Program is designed to provide financial support in the event of an adoption. Through the program, you are eligible for qualified adoption expenses* up to a maximum reimbursement of $5,000 per adopted child** with a lifetime maximum of $10,000 per associate. You become eligible for this program as of the first day of the month following your date of hire. Adopted children must be unrelated, under age 18 or physically or mentally incapable of caring for themselves. Reimbursement covers qualified adoption expenses as defined by the IRS. Please contact your HR Department for additional information and exclusions.

*Qualified adoption expenses do not include the adoption of a spouse's child.

**If both adopting parents are Honda associates, Honda will only reimburse up to the $5,000 maximum per child.

RETIREMENT BENEFITS

Contents

The retirement plans offered by Honda provide you with basic levels of financial security along with healthcare coverage and other helpful benefits after you retire—and also provide the opportunity to save and invest for your future through pre-tax or Roth after-tax 401(k) contributions, as well as Company contributions from Honda.

For More Information
Administrative details and procedures for appealing a claim can be found in Administrative Information *on page 316.*

Benefits for Honda

Retirement Benefits

As an eligible associate, you are automatically enrolled in the Honda 401(k) Savings Plan (unless you elect not to participate). You decide how much you want to contribute using either pre-tax or Roth after-tax 401(k) contributions. In addition, as an eligible associate, you have the opportunity to participate in the Retirement Medical Program.

The Honda Retirement Plan (referred to as the "Pension Plan") was closed to new entrants on September 4, 2013. Associates who were hired or rehired prior to September 4, 2013, were given a choice between continuing to earn pension benefits at a reduced rate (Option 1) or receiving a Company Service-Based contribution to the Honda 401(k) Savings Plan (Option 2). These choices became effective January 1, 2014.

Here is a high-level overview of retirement benefits:

Associates hired on or after Sept. 4, 2013	Associates hired before Sept. 4, 2013, who chose Option 1	Associates hired before Sept. 4, 2013, who chose Option 2

• **Honda 401(k) Savings Plan**
  ◦ Associate contribution
  ◦ Company Service-Based contribution
  ◦ Company matching contribution
• **Retirement Medical Program**
	• **Honda 401(k) Savings Plan**
	  ◦ Associate contribution
	  ◦ Company matching contribution
	  ◦ Company Savings contribution
	• **Honda Pension Plan**
	• **Retirement Medical Program**
		• **Honda 401(k) Savings Plan**
		  ◦ Associate contribution
		  ◦ Company Service-Based contribution
		  ◦ Company matching contribution
		  ◦ Company Savings contribution
		• **Honda Pension Plan (benefits accrued through December 31, 2013)**
		• **Retirement Medical Program**

If you qualify for retirement from Honda, you may also be eligible to continue:

- Supplemental Life Insurance
- Group Legal Plan
- Group auto and homeowners insurance
- Associate Assistance Program

401(k) Savings Plan

The Honda 401(k) Savings Plan ("401(k) Savings Plan" or "the plan") allows you to save and invest for retirement with tax advantages and a savings match and other contributions from Honda.

Highlights

Associate Contributions	You elect how much to contribute as pre-tax and/or Roth after-tax 401(k) contributions, up to 75% of eligible compensation; Honda then matches a portion of your contributions
Who Is Eligible	Active associates
Participation Begins	The first day of the month coinciding with or following three full months of Honda employment, unless you elect not to participate
Benefits	Allows you to: • Save and invest money for retirement; and • Increase your savings with Honda contributions; and • Defer taxes on contributions and earnings, which helps your account grow
Special Features	• Automatic increase of your contributions • Automatic rebalancing of your investments • You can roll over money from another eligible retirement plan into the plan
Payments Can Begin	At age 59½, when you terminate employment with Honda, retire, qualify for Social Security disability benefits, or qualified military leave, or die
Administered By	Honda 401(k) Savings Plan Committee

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Who Is Eligible

You are eligible to participate in the 401(k) Savings Plan if you are an active associate who has worked for Honda for at least three full months.

You are not eligible for the 401(k) Savings Plan if you:

- Provide services to Honda pursuant to an agreement that specifies you are not an associate of Honda; or
- Are a leased contingent worker; or
- Are an independent contractor; or
- Are covered by another defined contribution plan sponsored by Honda or an affiliate; or
- Are a student, including co-op or student intern; or
- Are a member of a unit of employees covered by a collective bargaining agreement, unless participation in this plan was the subject of good faith bargaining; or
- Are an associate of an affiliate that is not participating in the plan (entities that participate in the plan are called "adopting employers"). You can request a list of adopting employers by contacting the AHM Benefits Department at **regional_retirement@ahm.honda.com**; or
- Are an associate of an international affiliate on assignment at Honda.

If you are not eligible for the 401(k) Savings Plan due to one of the classifications outlined above and later become eligible for the plan, the time spent in one of the above classifications may count toward the three-month eligibility requirement and for vesting service. For example, if you are a leased/contingent worker for two months prior to joining Honda as an associate, then you only have to work one month as an active associate to become eligible for the plan.

When You Will Join the Plan

As a new hire, you will join the plan no later than the first day of the month on or following the month you meet the eligibility requirements. For example, if you are hired on January 15, you will have three full months of service on April 15 and will participate in the 401(k) Savings Plan beginning on May 1.

Once you become eligible to participate, a 401(k) Savings Plan account (also referred to as "account") will be established in your name to hold your contributions and contributions made by Honda. Honda will deposit a Company Service-Based contribution and Company Savings contribution (if eligible) into your account each pay period—even if you do not contribute to the plan yourself. See "Honda Retirement Contributions" on page 266 for more information.

If You Are Rehired

If you were a participant in the 401(k) Savings Plan prior to your rehire, you will be automatically re-enrolled (this will include the Company Service-Based contribution) unless you are rehired in a classification that is excluded from the plan.

How to Enroll

After meeting the eligibility requirements, you will be automatically enrolled in the plan, on a pre-tax basis, unless you contact Fidelity to change the percentage, enroll in Roth 401(k) contributions or elect not to participate within 30 days after meeting your eligibility. Once you are automatically enrolled:

- A contribution of 6% of your eligible compensation will be deducted from your pay on a pre-tax basis during your first calendar year of participation. You will also be enrolled in the Auto-Increase Service, which, unless cancelled, will automatically increase your contributions by 1% each year beginning January 1 of the following year until you reach 15% (see "Auto-Increase Service" on page 274 for more details); and
- Contributions will be invested in the plan's default fund, the Vanguard Target Retirement Trust Select, based on an assumed retirement age of 65, unless you elect to invest your account in other investment options.

In addition, if you were contributing less than 6% of your eligible compensation on January 1, 2019, and you had not previously made an election to contribute to the plan, your contribution election was automatically increased to 6% as of January 1, 2019. Your contribution election will be subject to the Auto-Increase Service as described above unless you opted not to participate in the auto-increase.

Automatic Enrollment

As a newly eligible participant, you will be automatically enrolled in a pre-tax contribution at 6% of your eligible compensation, unless you call or go online to change your contribution percentage, enroll in Roth 401(k) contributions or elect not to participate. Within 90 days after automatic enrollment contributions first commence, you may request a distribution of such contributions and will be deemed to have elected not to participate.

Once you are eligible to participate in the 401(k) Savings Plan, your payroll deductions will begin as soon as administratively possible. If your deduction does not begin, please contact Fidelity at **1-800-835-5095** immediately.

When enrolling in the plan, you should also designate your beneficiary. This important information will ensure your vested plan account goes to your chosen beneficiary upon your death. To designate a beneficiary, log in to NetBenefits® at **401k.com** (see the "Naming a Beneficiary" box under "If You Die" on page 280).

How the 401(k) Savings Plan Works

The 401(k) Savings Plan allows you to save money through pre-tax and Roth 401(k) contributions. Honda will also contribute to your account. See "Your Contributions" on page 264 for more information.

You can choose from a range of investment funds offered by the 401(k) Savings Plan to invest the money in your account. To help you keep track of your plan account, you can view your account statements at **401k.com** or by calling Fidelity at **1-800-835-5095** and requesting the information be mailed to you.

Your account is payable to you when your Honda employment ends for any reason. While you are actively employed, withdrawals are limited to special situations.

Honda has elected to meet the safe-harbor requirements set forth in the Internal Revenue Code Section 401(k)(12). As a participant, you will receive an annual notice regarding this election.

The rest of this section provides more detail about how the 401(k) Savings Plan works.

Your Contributions

You decide how much to contribute, as either pre-tax and/or Roth 401(k) contributions, in whole percentages up to 75% of your eligible compensation, up to limits set by the IRS. (See the 401(k) Savings Plan annual limits by going to **irs.gov/pub/irs-tege/cola_table.pdf**.)

You can change or stop your contributions at any time by logging in to NetBenefits at **401k.com** or calling **1-800-835-5095**. Your new contribution rate will take effect as soon as administratively possible after you make the change.

Annual Eligible Compensation

Eligible compensation means your current base wages (or salary) while an active participant or during paid leaves (such as paid vacations, sick days, holidays, jury duty, funerals or military leaves).

It includes compensation paid within 75 days of your termination if that compensation would be considered eligible compensation during your employment. It also includes military differential wage payments, back pay or similar awards.

Eligible compensation also includes amounts that were deducted pre-tax from your wages due to pre-tax contributions to the plan or for health and welfare benefits under a cafeteria plan.

If you (i) are scheduled to work 12-hour days, (ii) are credited with at least 36 hours of pay that would otherwise be eligible compensation and (iii) are paid for additional hours that are not considered to be eligible compensation, those additional hours will be treated as eligible compensation, but only up to 40 hours per week will be recognized as eligible compensation.

Eligible compensation does not include gifts and awards; bonuses; expense allowances; commissions; severance pay; pay for unused sick days, unused vacation or other paid time off; overtime pay; shift premiums; attendance pay; temporary assignment allowances; tax-free Code Section 132(f) transportation benefits or cash in lieu of such benefits; short-term or long-term disability pay; disability allowance pay; exempt holiday pay; legal settlements or other similar special supplemental pay; amounts deferred under a nonqualified deferred compensation program; and other non-cash compensation.

Pre-Tax Contributions

Pre-tax contributions are deducted from each paycheck before federal and most state taxes. However, your contributions are deducted after Social Security taxes and, in most cases, local income taxes.

Example: Pre-Tax Contributions

When you contribute pre-tax dollars to the 401(k) Savings Plan, the amounts you contribute are not taxed until such amounts are withdrawn from the plan. Here is an example:

Assume you are single, earn $50,000 a year and save 6% of pay ($3,000). Here is a comparison of what happens if you save pre-tax in the 401(k) Savings Plan versus after-tax elsewhere. This shows your savings assuming a 22% federal tax rate. Your actual savings could be greater if you are in a higher tax

bracket or consider state taxes. This is just a general example—you should consult with your tax or financial advisor to learn more about how your contributions may impact your taxes.

	Roth After-Tax 401(k) Contributions	Pre-Tax Savings
Your annual eligible compensation	$50,000	$50,000
Pre-tax contribution	N/A	$3,000
Taxable income	$50,000	$47,000
Federal tax (22%)	$11,113	$10,340
Roth after-tax contributions	$3,000	N/A
Net pay	$35,887	$36,660
Difference in take-home pay		+773/year

By contributing pre-tax dollars, you can save the same amount and take home an additional $773 a year.

Roth 401(k) Contributions

Unlike pre-tax contributions, Roth 401(k) contributions are deducted from your pay after federal income taxes are withheld. However, Roth 401(k) contributions are distributed tax-free. Earnings on Roth 401(k) contributions can be withdrawn tax-free as long as the distribution of such amounts occurs after five calendar years since the start of the year in which you made your first Roth 401(k) contribution and you are least age 59½ or are disabled.

In the event of your death, your beneficiary may be able to receive earnings on your Roth 401(k) contributions tax-free if you started making your Roth 401(k) contributions five or more calendar years before the calendar year in which such amounts are distributed to your beneficiary.

Contribution Limits

You can elect Roth 401(k) contributions in conjunction with your pre-tax contributions. The total of both your Roth 401(k) and pre-tax deferral election percentages can be between 1% and 75% of your eligible compensation.

You will receive matching contributions on both your pre-tax contributions and Roth 401(k) contributions. However, your total match will not exceed the amount of your pre-tax contributions and Roth 401(k) contributions to the plan (capped at 6% of your eligible compensation).

Because Roth 401(k) contributions are under the same IRS limits as pre-tax contributions, each dollar of Roth 401(k) contributions that you make reduces the amount that you can contribute on a pre-tax basis (and vice versa).

401(k) Savings Plan Catch-Up Contributions

Beginning with the year you turn age 50, you are eligible to make catch-up contributions. Catch-up contributions are either pre-tax or Roth 401(k) contributions to your account that exceed the normal IRS associate contribution limits. See the annual limits by going to **irs.gov/pub/irs-tege/cola_table.pdf**. This extra money helps accelerate your savings potential as you near retirement.

If you will be age 50 or older and you reach the normal IRS savings limit at any time during the calendar year, all contributions after that date are catch-up contributions for that year. You do not need to make a separate catch-up contribution election.

To calculate the percentage of your eligible compensation you need to save to meet the IRS savings limit and maximize your catch-up contributions, divide the maximum amount by your eligible compensation. Catch-up contributions will be invested according to your current elected 401(k) Savings Plan investment options.

IRS Limits

Keep in mind that the total of both your Roth 401(k) and your pre-tax contributions cannot exceed the IRS limits.

Honda Retirement Contributions

Even if you do not contribute to the plan, Honda will make contributions on your behalf. Here is an overview of how Honda helps you save for a secure financial future.

Company Matching Contribution

For all active participants, Honda will match the first 6% that you contribute (including catch-up contributions) to your 401(k) Savings Plan account. This means Honda will contribute $1 for every $1 of the first 6% you contribute to the plan.

Whether you make Roth 401(k) or pre-tax contributions, or a combination of the two, you will be eligible for matching contributions.

Rollovers from Other Plans

You also can roll over amounts from a prior employer's eligible retirement plan or your IRA (excluding certain types of contributions) into the 401(k) Savings Plan. To process a rollover, request a rollover form from Fidelity at ***401k.com*** *or* ***1-800-835-5095****.*

Vesting of Company Matching Contributions

You will be 100% vested in—or the owner of—the Company matching contribution when it is deposited into your account. That means it is included in the value of your account and belongs to you if your employment ends for any reason.

Company Service-Based Contribution

Certain active participants receive a contribution from Honda based on eligible pay and years of service. Here is the percentage Honda contributes to your account:

Years of Benefit Service	Company Service-Based Contribution
0 – 4	2% of eligible compensation
5 – 9	3% of eligible compensation
10 – 14	4.5% of eligible compensation
15 – 19	6.5% of eligible compensation
20+	8% of eligible compensation

You will receive a year of benefit service for the purpose of receiving a Company Service-Based contribution for each full 365-day period beginning on your date of hire and on the anniversaries of your date of hire in which you work for Honda.

Your Company Service-Based contribution percentage increases the longer you work at Honda.

Honda generally contributes your Company Service-Based contribution to your account each pay period. However, if you are eligible to participate in the Honda Savings Equalization Plan, you will only receive a Company Service-Based contribution if you are employed by Honda on the last day of the year. For those associates, Honda will contribute the Company Service-Based contribution by the last business day of the first calendar quarter following the last day of the year.

Eligibility for Company Service-Based Contributions

You are eligible to receive the Company Service-Based contribution if you are eligible to participate in the 401(k) Savings Plan (see "Who Is Eligible" on page 262) and you also meet one of the following: (i) you were hired or rehired on or after September 4, 2013, or (ii) you previously participated in the Honda Pension Plan and you elected to discontinue participation in the Pension Plan effective January 1, 2014 (Option 2). The Company Service-Based contributions will be credited to your account once you have met the eligibility requirements under the 401(k) Savings Plan.

Vesting of Company Service-Based Contributions

You become vested in—or the owner of—your Company Service-Based contributions based on your years of service, as shown in the chart below, with 100% vesting after five years of service, or upon your death, disability or attainment of age 65 while employed by Honda. If your employment ends for any reason, the vested portion of your Company Service-Based contributions and earnings is included in the value of your account and belongs to you.

Vesting Schedule	
Less than 2 years of service	Not vested
2 years of service	25% vested
3 years of service	50% vested
4 years of service	75% vested
5 or more years of service	100% vested

You will receive a year of service for vesting for each full 365-day period beginning on your date of hire and on the anniversaries of your date of hire in which you work for Honda. Your years of service will be forfeited if you terminate employment at a time when you are not vested, and you are not re-employed by Honda for five or more years.

Company Savings Contribution

If you are an active participant who was hired or rehired on or before September 3, 2013, you may be eligible to receive a Company Savings contribution to your 401(k) Savings Plan account. The amount of the contribution is equal to 3% of your eligible compensation each pay period. It will be contributed to your account each pay period. (See the "Eligible Compensation" box in the "Your Contributions" section on page 264 for a definition of eligible compensation.)

Eligibility for Company Savings Contributions

If you are an active participant who was hired or rehired on or before September 3, 2013, and you were given the opportunity to elect to continue active participation in the Pension Plan effective January 1, 2014, you will receive the Company Savings contribution each pay period. You do not have to be making your own contributions to the plan to receive the Company Savings contribution.

You are not eligible to receive the Company Savings contribution if you are hired or rehired after September 3, 2013.

Vesting of Company Savings Contributions

You will be 100% vested in—or the owner of—the Company Savings contribution when it is deposited into your account. That means it is included in the value of your account and belongs to you if your employment ends for any reason.

Military Leave

If you are on a military leave of absence, you will continue to have your pre-tax or Roth 401(k) contributions taken out of the pay you receive from Honda and to receive all applicable Company contributions on such amounts. If your re-employment rights are protected by law, after your return to work, at the end of your military leave, you will be given the opportunity to make up pre-tax and Roth 401(k) contributions for the period of time you were not receiving pay from Honda, and you will receive matching contributions on such amounts. In addition, after your return to work at the end of your military leave, you will be eligible to receive Company Service-Based contributions and Company Savings contributions for the period in which you were in the military. Also, after your return to work, your years of service for vesting will include your service while in the military.

Investing in Your Retirement Account

You choose how to invest the money in your 401(k) Savings Plan account, including any contributions Honda makes to your account on your behalf. If you do not make an investment election, all contributions will be invested in a Vanguard Target Retirement Income Trust Select fund based on an assumed retirement age of 65. See "Investing Your Account" on page 269 for more information, or visit NetBenefits at **401k.com**.

How Your Savings Grow

Your contributions, combined with Honda's contributions, provide you with a significant opportunity to save for your future financial security. The example below shows how the 401(k) Savings Plan account could grow for an associate with 10 years of Honda service and a monthly eligible compensation of $4,298.

If You Save Monthly*	Company Service-Based Contribution**	Company Matching Contribution	Company Savings Contribution***	Total Monthly Savings	Total Annual Savings
$42.98 (1%)	$193.41	$42.98	$128.94	$408.31	$4,899.72
$214.90 (5%)	$193.41	$214.90	$128.94	$752.15	$9,025.80
$429.80 (10%)	$193.41	$257.88	$128.94	$1,010.03	$12,120.36
$644.70 (15%)	$193.41	$257.88	$128.94	$1,224.93	$14,699.16
$859.60 (20%)	$193.41	$257.88	$128.94	$1,439.83	$17,277.96
$1,074.50 (25%)	$193.41	$257.88	$128.94	$1,654.73	$19,856.76
$1,289.40 (30%)	$193.41	$257.88	$128.94	$1,869.63	$22,435.56
$1,504.30 (35%)	$193.41	$257.88	$128.94	$2,084.53	$25,014.36
$1,719.20 (40%)	$193.41	$257.88	$128.94	$2,299.43	$27,593.16
$1,934.10 (45%)	$193.41	$257.88	$128.94	$2,514.33	$30,171.96
$2,149.00 (50%)	$193.41	$257.88	$128.94	$2,729.23	$32,750.76

*Remember, under the plan, you may save any percentage of your eligible compensation in whole percentages, up to 75%. This chart shows contribution percentages in 5% increments for illustrative purposes only.

**For eligible associates who were hired or rehired on or after September 4, 2013 or chose Option 2 during the 2013 Pension Plan Choice Period. For information on how the Company Service-Based contribution is calculated, see "Company Service-Based Contribution" on page 266.

***For eligible associates who were hired or rehired on or before September 3, 2013 and were given the opportunity to continue active participation in the Pension Plan effective on and after January 1, 2014. For information on how the Company Savings contribution is calculated, see "Company Savings Contribution" on page 267.

Federal tax laws impose certain limits on contributions that can be made to the plan. (See the annual limits by going to **irs.gov/pub/irs-tege/cola_table.pdf**.) The above illustrations do not reflect these limitations.

Investing Your Account

It is important to remember that you can decide how you want your contributions invested. Honda understands that participants have different levels of experience and comfort with investing. Honda offers four tiers of investment options for you to choose from:

- **Tier 1: Target date investments.** Target date investments are the closest thing to a maintenance-free retirement fund. The distinguishing feature of the target date investment is that its overall asset allocation automatically adjusts to become more conservative, reducing the proportion invested in stocks, as your expected retirement date approaches.
- **Tier 2: Passively managed investments (or index funds).** Designed to match the returns of the market or a benchmark, passively managed funds typically have lower fees than actively managed funds.
- **Tier 3: Actively managed investments.** These funds attempt to outperform a particular index. The objective is to earn greater returns than those of the applicable index.
- **Tier 4: Self-directed brokerage account.** This option provides you with a limited brokerage window to invest in more than 5,000 Fidelity and non-Fidelity mutual funds beyond those offered directly through the plan.

Short-Term Trading Rules

To prevent "market timing," mutual fund companies can set a minimum holding period and impose a "redemption fee" for selling shares before meeting the holding period, a trading block that prevents the repurchase of a fund for a period after fund shares have been sold, and/or a trading block that prevents the purchase and sale of a fund within a specific amount of time. For details, log in to NetBenefits at **401k.com** or call **1-800-835-5095**.

More about Your Investment Options…

You can invest your account balance and your future contributions in any of the funds that are part of the investment lineup. For detailed information on the investment options available under the 401(k) Savings Plan, including investment performance and research, please log in to NetBenefits at **401k.com**.

Automatically Invested

When you become eligible for the 401(k) Savings Plan, your contributions will be automatically invested into a Vanguard Target Retirement Trust Select Fund based on an assumed retirement age of 65, unless you elect to make a change.

The lineup is divided into four tiers:

Tier 1: Target Date Investments

Choosing the right Vanguard Target Retirement Trust Select is easy. Just consider the trust option with a target year nearest your expected retirement date (2065, 2060, 2055, 2050, 2045, 2040, 2035, 2030, 2025, 2020 or 2015). If you were born before 1948, the Vanguard Target Retirement Income Trust Select maintains a conservative investment mix.

If you are not sure when you will retire, use the "Vanguard Target Retirement Trust Select Age-Based Chart" to choose a fund based on your current age. For example, if you are currently 42 years old, consider the Vanguard Target Retirement 2045 Trust:

- Retirement Age 65 − Current Age 42 = 23 Years
- 23 Years + 2021 (Current Year) = 2044

This guideline is based on an assumed retirement age of 65. If you think you may retire around age 60, consider the Vanguard Retirement 2040 Trust.

If you do not choose an investment election, contributions to your account (including your own savings) will default to the Vanguard Target Retirement Trust Select Series fund that has a target retirement year closest to the year you might retire (assumed to be age 65), based on your current age, until you provide further investment instruction. You may change your investment election at any time.

Each Vanguard Target Retirement Trust Select is a broadly diversified multi-fund portfolio that *gradually* and *automatically* shifts over time to more conservative investments. Each Vanguard Target Retirement Trust Select is a complete investment package, so any one can serve as your entire plan portfolio. If you think you will retire significantly earlier or later, you may want to consider a trust with an asset allocation more appropriate to your situation.

Keep in mind that although Vanguard Target Retirement Trusts can simplify investment selection, all investing is subject to risk. Target Retirement Trusts invest in up to five broadly diversified Vanguard funds and are subject to risks associated with their underlying funds. Diversification does not ensure a profit or protect against a loss in a declining market.

Vanguard Target Retirement Trust Select Age-Based Chart

Date of Birth	Fund Name	Target Retirement Date
Before 1948	Vanguard Target Retirement Income Trust Select	Before 2013
1/1/1948 – 12/31/1952	Vanguard Target Retirement 2015 Trust Select	2013 – 2017
1/1/1953 – 12/31/1957	Vanguard Target Retirement 2020 Trust Select	2018 – 2022
1/1/1958 – 12/31/1962	Vanguard Target Retirement 2025 Trust Select	2023 – 2027
1/1/1963 – 12/31/1967	Vanguard Target Retirement 2030 Trust Select	2028 – 2032
1/1/1968 – 12/31/1972	Vanguard Target Retirement 2035 Trust Select	2033 – 2037
1/1/1973 – 12/31/1977	Vanguard Target Retirement 2040 Trust Select	2038 – 2042

Date of Birth	Fund Name	Target Retirement Date
1/1/1978 – 12/31/1982	Vanguard Target Retirement 2045 Trust Select	2043 – 2047
1/1/1983 – 12/31/1987	Vanguard Target Retirement 2050 Trust Select	2048 – 2052
1/1/1988 – 12/31/1992	Vanguard Target Retirement 2055 Trust Select	2053 – 2057
1/1/1993 – 12/31/1997	Vanguard Target Retirement 2060 Trust Select	2058 – 2062
1/1/1998 and later	Vanguard Target Retirement 2065 Trust Select	2063 and later

This investment is not a mutual fund. It is a collective trust available only to tax-qualified plans and their eligible participants.

Investment objectives, risks, charges, expenses and other important information should be considered carefully before investing. The average weighted expense ratio of the above trusts as of December 31, 2020, is 0.05%.

The collective trust mandates are managed by Vanguard Fiduciary Trust Company, a subsidiary of The Vanguard Group, Inc.

Tier 2: Passively Managed Funds

Passively managed investments allow you to construct a diversified portfolio at a low cost.

Tier 3: Actively Managed Funds

Actively managed investments allow you to construct a diversified portfolio using broad investment styles.

Tier 4: Self-Directed Brokerage Account

This option provides you with a limited brokerage window (mutual funds only) to invest in more than 5,000 Fidelity and non-Fidelity mutual funds beyond those offered directly through the plan. This additional flexibility and choice may help you build a retirement portfolio that is all your own.

You may open a Brokerage Window account by logging in to NetBenefits at **401k.com** or calling Fidelity at **1-800-835-5095**. Once you establish a Fidelity BrokerageLink® account, you will receive a Welcome Kit that contains your account number.

Making Choices

As you consider your investment choices, keep in mind that:

- *The value of any fund can increase or decrease; and*
- *Past fund performance does not guarantee you will get similar results in the future; and*
- *You need to decide on a mix of investments that is right for you; and*
- *Honda cannot advise you on how to invest your savings*.

When you open a BrokerageLink account, you are making the decision to more actively manage a portion of your retirement savings. You will have access to tools, mobile applications and third-party research to help put you in control of your investments. BrokerageLink is designed for hands-on investors and may not be appropriate for everyone.

You may transfer not more than 50% of the market value of your account into your self-directed brokerage account.

There is no annual account fee for opening a BrokerageLink account. However, transaction fees and short-term trading fees may apply to the purchase and sales of investments.

For a complete listing of all applicable brokerage fees, please refer to the Fidelity BrokerageLink Commission Schedule. This can be found on NetBenefits at **401k.com**, as well as in your Welcome Kit once you establish an account.

For more information, log in to NetBenefits at **401k.com** or call Fidelity at **1-800-835-5095**.

Other Considerations

The plan currently offers investment funds with a range of *risk and return* opportunities.

- **Risk** is the chance that the value of your investment could decline. Risk is based on factors such as interest rate changes, inflation and fluctuations in the stock market.
- **Return** is an investment's profit or loss. These may include an increase or decrease in a fund's value, interest, dividends or other income.

Generally, investors expect a higher return as the level of risk increases; however, the level of potential loss also increases.

Fund prospectuses and objectives and characteristics of each fund are available at **401k.com** or by calling **1-800-835-5095** and requesting the information be mailed to you.

The plan is intended to qualify as a participant-directed plan under Section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. This means that you are responsible for your investment decisions under the plan. Under this provision, the Company provides detailed information about the plan's investment options to assist you in making informed decisions about investing your account balances under the plan. As a result, the plan's fiduciaries, including the Honda 401(k) Savings Plan Committee, Honda and the Trustee, are relieved of liability for any losses that are the result of your investment instructions.

Special Note about Fees

Keep in mind that there are two types of fees associated with the 401(k) Savings Plan that you pay as a plan participant:

- **Investment Management Fees.** These fees are deducted from the fund's assets and cover professional management and research, investment prospectuses, annual reports and other shareholder services.
- **Administrative Fees.** These fees generally cover the cost of operating the plan and pay for expenses such as recordkeeping (plan service provider), accounting and legal services.

Professional Investment Services

There are two advisory programs available through Fidelity® Personalized Planning & Advice at Work ("managed accounts"):

- **Online Advice.** For those who actively manage their accounts, this service offers objective, professional advice to help you refine your investment strategy. You can log in for a personalized forecast and a step-by-step action plan with specific fund recommendations. Online Advice is available at no additional cost to you.
- **Professional Management.** This program is designed for those who do not have the time, expertise or desire to make investment decisions on their own. Fidelity Personalized Planning & Advice at Work researches and analyzes the options available in the plan to create a customized investment strategy for you. They monitor your portfolio on an ongoing basis, making adjustments as needed to keep your portfolio properly diversified and on track.*

Portion of Account	Annual Rate
For the first $100,000,	0.35%
Between $100,000 and $250,000	0.30%
For additional assets over $250,000	0.25%

*Investing involves risk, including risk of loss. Fidelity Personalized Planning & Advice at Work is a service of Fidelity Personal and Workplace Advisors LLC and Strategic Advisers, Inc. Both are registered investment advisors and Fidelity Investments companies, and may be referred to as "Fidelity," "we" or "our" within.

**Professional Management fees are charged in the frequency and manner detailed in the Terms and Conditions. The net fee does not include underlying fees and expenses of each investment in your plan account, or any separate recordkeeping or administrative fees that may be charged to your account. For a description of underlying expenses for a mutual fund, see the prospectus for that fund.

Changing Your Investment Elections

Because your needs and goals may change over time, the plan allows you to change your investment elections (see "Short-Term Trading Rules" on page 269); a change made before the close of the stock market on a business day will generally be effective the following business day. You can:

- Transfer money between investment funds daily; and
- Change how your future contributions will be invested; and
- Change or transfer your current investment funds; and
- Set up a Brokerage Window account.

To make these changes, log in to NetBenefits at **401k.com** or call Fidelity at **1-800-835-5095**. You will receive a confirmation statement of your changes. Be sure to check the statement for accuracy, as you are responsible for notifying Fidelity of any corrections.

Account Access and Information 24/7

To see your account or make changes anytime:

- Visit NetBenefits at **401k.com**. First-time visitors can click "Register Now" and follow the instructions to set up their accounts; or
- Call **1-800-835-5095** to speak with a representative or use the automated voice response system, 24 hours a day, 7 days a week.

The following services are also available to you any time through the *automated* system by calling **1-800-835-5095**. Enter your Social Security number and password. Then, select the menu option for the service you want. These services are also accessible through NetBenefits at **401k.com**.

Account Information

- View account balances (total and by fund) and vested balance
- View outstanding loan balances
- View contribution, disbursement and loan repayment history
- Download forms (online)

Investment Information

- Access investment fund descriptions, prices and performance

- Order or access fund prospectuses (online)
- Open or access a Brokerage Window account
- Access Fidelity Personalized Planning & Advice at Work

Transactions

- Change your password
- Change your contribution rate
- Change investment elections
- Transfers between funds
- Set up the automatic increase feature
- Set up the automatic rebalancing feature
- Select/update your beneficiaries

Statements

- Request duplicate or detailed summary statements
- Request trade confirmations

Additional Plan Features

Auto-Increase Service

Your 401(k) Savings Plan account grows through a combination of your contributions, Honda's contributions and potential investment gains. You can help boost your account's growth by increasing the percentage of your eligible compensation that you contribute over the course of your career. The plan offers you an easy way to accomplish this via the Auto-Increase Service. The service automatically increases your payroll deduction each year. You choose the amount of the increase and the month you want to start. Simply log in to NetBenefits at **401k.com** or call Fidelity to initiate the service.

Important Note!
New hires are set up with increases of 1% each year if their savings rate is below 15%.

If you participate in the Auto-Increase Service and make both pre-tax and Roth 401(k) contributions to the 401(k) Savings Plan, your annual increase will be applied to your pre-tax contribution rate. If you are making Roth 401(k) contributions only, then the annual increase will be applied to your Roth 401(k) contribution rate.

Advantages of Automatic Increases and Compounding

As an example, let's look at the potential advantages of automatically increasing your contribution and the effects of compounding:

- Assume you are a newly eligible associate and start with a salary of $50,000 and an initial contribution rate of 6%.

- Your potential account balance after 30 years *if* you automatically increase your contribution 1% annually up to a maximum of 15% of your salary is **$668,911**.
- Your potential account balance if you keep your contribution at 6% is only **$324,974**.
- By automatically increasing your contribution, your potential gain is **$343,937**.

Assumptions

This example assumes you receive an annual return of 7% on your investments and your salary increases 1% each year. Of course, this is a hypothetical example for illustrative purposes only and is not meant to represent the investment return of any of your plan's options. Your situation will vary.

Auto-Rebalancing

Rebalancing your account regularly is a good investment practice. When you sign up for auto-rebalancing, your account is rebalanced for you quarterly, semi-annually or annually, restoring your chosen allocation of stocks, bonds and stable value investments.

To enroll, visit NetBenefits at **401k.com** or call Fidelity at **1-800-835-5095**. To initiate this service, select "Auto-Rebalance" within the "Services Information" section. You can cancel this service at any time.

Statement

To help you track your 401(k) Savings Plan account and investments, you will receive a statement in the month following the end of each calendar quarter (March 31, June 30, September 30 and December 31). The statement will include:

- Your total account balance at the beginning of the quarter; and
- Your contributions (matched and unmatched) for the quarter; and
- Contributions Honda made to your account for the quarter; and
- Your total account balance as of the end of the quarter; and
- The amount of any withdrawals; and
- Administration fees; and
- Any loan balance.

Loans

The purpose of the 401(k) Savings Plan is to help you with long-term savings for retirement. You may borrow from your vested account by requesting a loan (excluding your Company Savings contribution account, Company Service-Based contribution account or, if applicable, grandfathered Employer Retirement Contribution Account*). The minimum loan amount that can be requested is $1,000. The maximum is one-half of your vested balance, up to $50,000. You may have only one outstanding loan at a time, and there is a 12-month waiting period between paying off one loan and applying for another. If you default on a loan, you will not be permitted to take another loan until 12 months have passed since you paid off the defaulted loan (***not* 12 months from the default date**).

To apply for a loan, log in to NetBenefits at **401k.com** or call Fidelity at **1-800-835-5095** and speak to a representative to request a loan. A $50 nonrefundable loan fee will be assessed against your account.

You repay the loan, with interest, by making after-tax payments to your account through payroll deduction. The repayment period can be from 12 to 60 months. You are not permitted to pre-pay loan payments unless you pay off the entire balance. The specific rules and limitations concerning loans from the plan are set forth in more detail in the plan's loan policy. You may request a copy of the plan's loan policy by contacting Fidelity at **1-800-835-5095**.

The interest rate is the prime rate plus 2%. If you are on a leave of absence and not receiving a paycheck from Honda, you will be required to make repayments directly to Fidelity in order to avoid default. Contact Fidelity at **1-800-835-5095** to request additional information.

Important

Be sure to research all options before making a decision to take a loan. Taking a loan can change potential growth in your account.

Company Contributions Not Available for Loans…

Please note that you cannot borrow from the Employer Retirement Contribution Account, your Company Savings contribution account or your Company Service-Based contribution account. See "Honda Retirement Contributions" on page 266 for more information.

A Taxable Distribution…

If you do not repay the loan after you leave Honda—or you default on the loan while you are employed—the amount of your remaining loan balance will be treated as a taxable distribution and may be subject to an early withdrawal penalty.

If you terminate your employment with Honda, the entire amount of the outstanding loan will become payable upon distribution of your account. If you do not repay the loan after your termination of employment or you default on the loan while you are currently employed, the amount of your remaining loan balance (plus accrued interest to the date of default) will be treated as a taxable distribution and may be subject to an early withdrawal penalty. If you retire or terminate employment and have not taken a distribution of your account, you may have the option of continuing your loan payment via direct payment. Please contact Fidelity for further details.

Special rules apply if you have an outstanding loan when you begin a military leave of absence. For more information, contact Fidelity at **1-800-835-5095**.

*The grandfathered Employer Retirement Contribution Account is frozen and is no longer receiving contributions. The Employer Retirement Contribution has been replaced with the Company Savings contribution.

When Your Account Can Be Paid to You

Your vested 401(k) Savings Plan account is payable to you when your employment with Honda ends for any reason, including retirement or death.

Withdrawals While Employed

The purpose of the 401(k) Savings Plan is to help you with long-term savings for retirement. However, you may make withdrawals from your plan account while you are actively employed by Honda if you:

- Reach age 59½ (excluding your Company Savings contributions, Company Service-Based contributions or grandfathered Employer Retirement contributions). You may withdraw all or a portion of your eligible contributions upon attainment of age 59½;
- Hardship Withdrawals" on page 278 (which allows you to withdraw your pre-tax and Roth 401(k) contributions only);
- Rolled over money from a prior plan or IRA (you may withdraw all or a portion of your rollover contributions plus earnings at any time); or
- Are entitled to receive Social Security Disability income as a result of an illness, injury or other event that occurred while you were employed by Honda (you may withdraw your entire account).

Company Contributions Not Available for Withdrawal

Please note that you cannot withdraw from your Company Savings contribution account or Company Service-Based contribution account until you leave Honda. See "Honda Retirement Contributions" on page 266 for more information.

Have an approved financial hardship, as described in "Important Note!

Before taking a hardship withdrawal, you **must** *attempt to satisfy the hardship by applying for a loan from the plan.*

In addition, if you are on military leave for more than 30 days, or are a member of the reserves who is ordered or called to active duty for more than 179 days (or an indefinite period), you are entitled to withdraw your pre-tax and Roth 401(k) contributions (plus earnings). However, if you take a withdrawal from your pre-tax or Roth 401(k) contributions on account of being on military leave for more than 30 days, you cannot make pre-tax or Roth 401(k) contributions to the plan for a period of six months.

Coronavirus-Related Distributions

From January 1, 2020, through December 31, 2020, some associates were eligible to withdraw all or a portion of their vested account balance as a Coronavirus-Related Distribution. If you took a Coronavirus-Related Distribution, you have the ability to repay that distribution back to the plan. You may repay up to 100% of your Coronavirus-Related Distribution, as long as you make your repayment within three years of the date you took your Coronavirus-Related Distribution. To find out more about how to repay your Coronavirus-Related Distribution, please contact Fidelity at **1-800-835-5095**.

Hardship Withdrawals

Important Note!
Before taking a hardship withdrawal, you **must** *attempt to satisfy the hardship by applying for a loan from the plan.*

If you have a financial hardship and exhaust other savings available to you, you can make a limited hardship withdrawal from your account consisting of your pre-tax or Roth 401(k) contributions (including earnings on such amounts). You must take a loan (if eligible) from your account prior to being approved for a hardship withdrawal, unless you can present satisfactory evidence to the plan administrator that a loan repayment will constitute a financial hardship or you provide a recent loan denial from a commercial lender in the amount of the proposed hardship withdrawal.

A hardship is defined as an immediate and heavy financial need required to or for:

- Purchase your primary residence (excluding mortgage payments); or
- Pay unreimbursed medical expenses for you, your spouse, your primary beneficiary or your dependents incurred in the last 12 months or to be incurred in the future; or
- Pay college tuition and related fees, including room and board charges for the next 12 months for you, your spouse, your primary beneficiary or your dependents; or
- Prevent eviction from or foreclosure on your primary residence; or
- Catastrophic damage to your primary residence that would qualify for the casualty loss deduction under the Internal Revenue Code; or
- Funeral or burial expenses for your parent, spouse, children, primary beneficiary or dependents.

Note: Your "primary beneficiary" means the person that you name as the beneficiary of your 401(k) Savings Plan account.

From these funds, you may withdraw an amount that does not exceed the amount needed to pay the hardship expense, including amounts to pay income taxes or penalties on the expense. Your hardship withdrawal is subject to applicable income taxes and may not be rolled over. A 10% additional tax may also be imposed on any distribution received by you before age 59½. See "About Taxes" on page 281.

Hardship Withdrawal

You may request a hardship withdrawal by calling Fidelity at **1-800-835-5095** or by logging in to your account at **401k.com**. Allow up to 10 days for processing a hardship withdrawal.

Disability

If you are still employed but are entitled to receive Social Security disability benefits as a result of an illness, injury or other event that occurred while you were employed by Honda, you may take a distribution of your account.

Forms of Payment

When your Honda employment ends for any reason or if you become disabled while actively employed, as determined by the Social Security Administration, and are entitled to receive Social Security disability benefits, you can receive:

- Your contributions with investment earnings; and
- Your vested Honda contributions with investment earnings.

You can elect to receive the total vested value of your account as one of the following:

- **Lump Sum.** The account value is paid to you in one single cash payment.
- **Installments.** If your account is more than $5,000, adjusted for gains and losses, it may be paid in monthly, quarterly, semi-annual or annual installments for a period of years selected by you, but not continuing past your normal life expectancy.
- **Partial Withdrawal.** You may request a partial withdrawal.

Deferring Taxes

Distributions that you receive from the plan may be subject to federal and state income tax. For more information, see "About Taxes" on page 281.

If you want to continue deferring taxes on your account, you have two additional options. You can elect to:

- Roll over your account to an Individual Retirement Account (IRA) or another eligible retirement plan (see "Rollovers upon Leaving Honda" on page 279); or
- If, at the time your employment with Honda ends, **your account is over $5,000**, you may leave your account in the plan until a later date. However, a minimum distribution is required to begin by April 1 of the year following the year in which you reach age 72 (or age 70½ if you turned that age before January 1, 2020). You can continue to make fund transfers as needed by calling **1-800-835-5095**:
  - If the value of your **account is not more than $1,000**, you will receive a lump-sum payment of your benefit within a reasonable time after your termination of employment; or
  - If the value of your **account is more than $1,000 and not more than $5,000**, you will be given the option to take a distribution or roll over your account within a specified amount of time. If you fail to make an election, your account will be automatically rolled over to a Fidelity IRA and invested in the Fidelity Cash Reserves Fund.

Requesting Payment of Your Account

For information about how to receive payment of your account, contact Fidelity. In the event of your death, your beneficiary should notify Fidelity.

Rollovers upon Leaving Honda

If you receive a distribution in the form of a lump sum or in the form of installments over less than 10 years, you may be able to roll over your 401(k) Savings Plan account to another employer's eligible retirement plan (a 403(b) tax-sheltered annuity, a plan qualified under section 401(a) of the Internal Revenue Code, a 457(b) governmental plan or an IRA or Roth IRA).

Rollovers can be made as follows:

- With a direct rollover, your account is transferred in one payment from the 401(k) Savings Plan to the eligible retirement plan you specify. In this case, unless you make a rollover to a Roth IRA, no federal income tax is withheld, and you will continue deferring taxes on your account funds until you receive a distribution from the eligible retirement plan.
- With an indirect rollover, you receive a lump-sum distribution of your account and then transfer the money on your own to the eligible retirement plan. In this case, the following apply:
  - 20% of the taxable portion of the amount distributed to you will automatically be withheld for federal income tax purposes (you will need to make up this amount to roll over the full distribution).
  - You must roll over the full amount (including the 20% withheld) within 60 days of receiving the payout to an eligible retirement plan other than a Roth IRA to avoid additional taxes. If you roll over part of the amount, you will pay taxes only on the amount you do not roll over.
  - Any amount not rolled over within 60 days will be subject to federal income taxes and possibly additional taxes (see “About Taxes” on page 281 for more details).

If You Die

If you die prior to the date your retirement benefits begin, the total vested value of your account is payable to your beneficiary. You are automatically 100% vested in your account if you die while employed by Honda or while in qualified military service. See “Naming a Beneficiary” below. Your beneficiary can request one of the payment options listed in “

Forms of Payment" on page 279.

If you are married, your legal spouse will be the sole primary beneficiary and the vested value of your account will be paid to your spouse. To name a person other than your spouse as beneficiary, you must have your spouse's written consent with his or her signature notarized. If you die without naming a beneficiary or your beneficiary is not alive on the date of your death, your vested account will be paid in the following order: first to your spouse, or if none, to the executors or administrators of your estate.

Naming a Beneficiary

When you enroll in the 401(k) Savings Plan, you name a beneficiary to receive your account in the event of your death.

- If you are married, your spouse is your sole primary beneficiary and any death benefit will be paid to your spouse. To name a person other than your spouse as beneficiary, you must have your spouse's written consent with his or her signature notarized.
- If your spouse is designated as your beneficiary and the marriage is later dissolved, the designation will be cancelled automatically as of the effective date of the dissolution, except if required under a qualified domestic relations order (QDRO).
- If you are legally separated but not yet divorced, you do not need to name your spouse as your beneficiary, provided the court order granting legal separation does not include an order requiring your spouse to be listed as a beneficiary. You need to submit a copy of the court order granting legal separation status to Fidelity.
- You may name more than one beneficiary and indicate the order and percentages for payment of your account (with your spouse's consent as described above if you are married). Without these instructions, the surviving beneficiaries will receive equal shares.
- You may name a trust as your beneficiary (with your spouse's consent as described above if you are married).
- You may change your beneficiary at any time by logging in to **401k.com**. If you are married, changes are subject to spousal consent as described above.

About Taxes

Your pre-tax contributions (including catch-up contributions), Honda contributions, pre-tax rollover contributions and all investment earnings on these contributions are not taxed while they are in the plan. As a result, these amounts from your account *are* taxable when withdrawn.

There are two types of taxes that may apply to your account: ordinary income tax and a 10% additional tax. This section outlines these taxes based on current tax law. This section is only providing a summary and does not consider particular situations or specific rules governing state, local or foreign taxes. Because taxes are complex and subject to change, you may want to consult a tax advisor about your situation. You will receive a special tax notice before you receive a distribution from the plan or when your Honda employment ends.

Ordinary Income Tax

Your pre-tax contributions (including catch-up contributions), Honda contributions, pre-tax rollover contributions, and investment earnings on these contributions are subject to federal income tax in the year you receive payment of such amounts. If you receive a distribution in the form of a lump sum or in installments over fewer than 10 years, 20% of your distribution will automatically be withheld from your

payment to cover federal income tax. If your actual federal income tax liability is less, you will receive a refund after you file your federal income tax return. The 20% withholding does *not* apply to amounts you directly roll over to another eligible retirement plan or to hardship withdrawals (which may not be rolled over). See “Rollovers upon Leaving Honda” under “

Forms of Payment" on page 279 and "When Your Account Can Be Paid to You" on page 277.

10% Additional Tax

The 401(k) Savings Plan is designed for long-term savings. As a result, the IRS may impose a 10% additional tax on withdrawals and distributions you receive before age 59½.

This tax is not applied in special situations, regardless of your age. There are a number of exceptions to the 10% penalty tax, not all listed below. However, in particular, the 10% tax does not apply to payments:

- Made due to your death or disability; or
- Rolled over directly to an IRA or other eligible retirement plan; or
- Made to your spouse or dependent under a qualified domestic relations order (see "Administrative Information" on page 316 for information); or
- Used for unreimbursed medical expenses (as defined by the IRS) which exceed 10% (7.5% if you or your spouse is over age 65) of your income; or
- Made to you if you terminated employment with Honda after or during the year in which you turn age 55; or
- Considered qualified reservist distributions.

Roth 401(k) Contributions

Earnings on your Roth 401(k) contributions can be withdrawn tax-free as long as it has been at least five calendar years since the start of the calendar year you made your first Roth 401(k) contribution and you are at least 59½ years old or are disabled. In the event of your death, your beneficiaries may be able to receive earnings on your Roth 401(k) contributions tax-free if you started making Roth contributions five or more calendar years prior to the calendar year of your death.

If you take a distribution of earnings on your Roth 401(k) contributions, including a hardship withdrawal, before the end of the five-year period or reaching age 59½, it will be deemed a nonqualified distribution and will be subject to federal income tax.

You can roll your Roth 401(k) account into a Roth IRA in order to continue earning tax-free income after you leave Honda.

For More Information

Certain limits apply to your 401(k) Savings Plan participation and benefits. For information about these limits, see the IRS website at **irs.gov/pub/irs-tege/cola_table.pdf**.

Additional information about the plan can also be found in *Administrative Information* on page 316.

Pension Plan

The Honda Retirement Plan ("Pension Plan") works together with Social Security and your personal savings to provide the building blocks you need for your future financial security.

Important Note about the Honda Pension Plan

The Honda Retirement Plan ("Pension Plan") was closed to new entrants effective September 4, 2013. Associates who were hired or rehired before September 4, 2013 were given a choice between continuing to earn pension benefits at a reduced rate (Option 1) or receiving a Company Service-Based contribution to the Honda 401(k) Savings Plan (Option 2). The choice was effective January 1, 2014.

Pension benefits earned before January 1, 2014 were not impacted by this choice. See "Benefits" on page 289 for a high-level overview. Associates who chose Option 2 retain any previously earned pension benefit but earn no additional benefits after December 31, 2013.

The appendices that follow this Pension section describe additional Pension Plan provisions that may affect you under the Affiliate Plans.

This guide only applies to associates actively employed on or after January 1, 2014. Associates who left employment prior to January 1, 2014, should refer to the document in place at the time of separation.

Highlights

Cost	Paid for by Honda
Who Participates	Active associates hired or rehired before September 4, 2013
Participation Began	First day of the month on or following one full year of Honda service
Pays Benefits	• If you are vested (you have at least five years of Honda eligible service or at age 65) • Based on a percentage of your base earnings for each year you work at Honda
Special Features	Can choose payment options, including some that provide income to your survivors
Payments Can Begin	After your Honda employment ends (as long as you are vested)
Administered By	Honda Retirement Plan Committee
Third-Party Administrator	Alight Solutions

Table of Contents

Who Participates

The Honda Retirement Plan ("Pension Plan") was closed to new entrants on September 4, 2013. Associates who were active before September 4, 2013 were given a choice between continuing to earn Pension Plan benefits at a reduced rate (Option 1) or receiving a Company Service-Based contribution to the Honda 401(k) Savings Plan (Option 2). (See "401(k) Savings Plan" on page 260 for details.) This choice was effective January 1, 2014.

You are eligible for the Pension Plan if you were an active associate on September 3, 2013, who had federal income tax withheld by Honda.

You are not eligible if you:

- Were hired or rehired after September 3, 2013; or
- Are a person who works for an entity that provides goods or services (including temporary/contingent worker services) to Honda; or
- Are a student associate or a student intern; or
- Have agreed in writing to not be eligible for the Pension Plan; or
- Are an associate of an international affiliate on temporary assignment at Honda; or
- Are regarded as an independent contractor or are otherwise not regarded as an associate by Honda.

If you were not eligible for the Pension Plan due to one of the classifications outlined above and later became an active associate, the time spent in one of the above classifications may be counted toward the eligibility requirement and vesting. For example, if you were a temporary worker for two months prior to joining Honda as an active associate, then you only had to work 10 months as an active associate to become eligible for the plan. Remember that no associates hired or rehired after September 3, 2013, are eligible to participate in the Pension Plan, even if they worked in an eligible classification before that date.

Only associates or former associates of adopting employers may be eligible to participate in the Pension Plan. Additionally, participants who transfer to a non-adopting employer are also eligible to continue participating in the Pension Plan. Not all Honda entities are adopting employers. You can request a list of adopting employers and non-adopting employers that employ transferred associated by contacting the AHM Benefits Department at **regional_retirement@ahm.honda.com**.

When Participation Began

Your participation in the Pension Plan began on the first day of the month on or after you completed one full year of Honda service. Service is measured in days, and an associate will be credited with one year of service for each 365 days in their period or periods of service. Service measurements are slightly different for participants associated with Affiliate Plan 4—the Honda of America Mfg., Inc. (HAM) Pension Plan. See "Affiliate Plan 4 Appendix—Honda of America Mfg., Inc., (HAM) Pension Plan" on page 301 for details.

For example, if you were hired on March 10, 2011, you completed one year of service on March 10, 2012, and Pension Plan participation began on April 1, 2012.

Note: Pension Plan participants who chose Option 2 during the Choice Period in 2013 retain any previously earned pension benefit and continue to be participants but earn no additional benefits after December 31, 2013.

Service

Service determines when your participation began, whether you have a vested right to a Pension Plan benefit and whether you qualify for early retirement. Service began on your date of hire (or rehire).

Service includes approved leaves of absence, including qualified disability, temporary layoff and military leave (provided you return to active employment within the time required by law after your honorable discharge). Qualified disability is included in service only if you were disabled before January 1, 2014. See "If You Become Disabled" in the appendices starting on page 296 for a definition of qualified disability. **Note:** If you are associated with the Affiliate Plan 3—Honda Transmission Mfg. of America, Inc. (HTM) Pension Plan, the qualified disability provision does not apply to you. See "Affiliate Plan 3 Appendix—Honda Transmission Mfg. of America, Inc. (HTM) Pension Plan" on page 299 for details.

If you were credited with service while you were a leased employee, that service was recognized for when your participation in the Pension Plan began. It is not recognized when determining your vested right to a Pension Plan benefit, or in determining whether you qualify for early retirement, including any applicable reduction factors that are used in calculating your early retirement benefit.

Service ends when you have a break in service, as described under "If You Leave Honda before Retirement" on page 296.

How the Pension Plan Works

To be eligible for Pension Plan benefits as described in this "Pension Plan" section, you must be vested. You are vested when:

- You have completed five years of service with Honda; or
- You reach age 65 while employed by Honda, regardless of your length of service.

When you begin receiving payments, you can choose from several payment options under the Pension Plan. The amount of your monthly benefit or lump sum paid to you will be based on:

- The total benefit amount you have earned at the time your Honda employment ends; and
- When you elect to begin payments; and
- The form of payment you choose.

The rest of this "Pension Plan" section provides more detail about how the Pension Plan works.

When Payments Can Begin

After your Honda employment ends, you can begin receiving your vested pension benefits at any time. See the appendices starting on page 296 for additional details on when payments begin.

Normal Retirement

Your normal retirement age is the date you reach age 65.

You qualify for normal retirement benefits to begin on the first day of the month falling on or immediately following the date on which you reach age 65 ("normal retirement date").

In this case, you qualify for a full and unreduced normal retirement benefit. If you choose to retire before you qualify for normal retirement, your benefit may be reduced. See "Early Retirement Benefits" on page 291 for more information.

Note

When you reach age 65, you are eligible for a full, unreduced normal retirement benefit. When you reach age 62 and complete 10 years of service you are eligible for a full, unreduced early retirement benefit. See "Early Retirement Benefits" on page 291 for more information.

Early Retirement

You may qualify for early retirement beginning on the first day of any month on or after the date you reach age 55 and have at least 10 years of service (but before age 65). If your early retirement benefit begins before you reach age 62, you will receive a *reduced* early retirement benefit. If your early retirement benefit begins after you reach 62, you will receive an *unreduced* early retirement benefit.

Late Retirement

You may elect a late retirement date to begin on the first day of any month falling on or immediately following your termination of employment after your normal retirement date. However, you must begin your late retirement benefit no later than your mandatory benefit starting date as explained in "Mandatory Benefit Starting Date" below.

Mandatory Benefit Starting Date

You are required by law to receive your benefit no later than April 1 of the calendar year following the later of the calendar year in which you attain age 72 (or age 70½ if you reached that age before 2020) or the calendar year in which you terminate your employment with Honda.

Benefits

Your Pension Plan benefit is based on how long you work for Honda and your accumulated eligible compensation credited under the pension benefit formulas.

Associates who chose to continue in the Pension Plan (those who chose Option 1) earn 1% of their accumulated eligible compensation credited on and after January 1, 2014. The amount you earned before 2014 under an Affiliate Plan may be calculated differently. See the appendices starting on page 296 for more information.

Annual Eligible Compensation

Effective on and after January 1, 2014, annual eligible compensation means your basic straight-time wages (or salary) while an active participant or during paid leaves (such as paid vacations, sick days, holidays, jury duty, funerals or military leaves).

It includes compensation paid within 75 days of your termination if that compensation would be considered compensation during your employment, as well as military differential wage payments, back pay or similar awards.

If you (i) are scheduled to work 12-hour days, (ii) are credited with at least 36 hours of pay that would otherwise be eligible compensation and (iii) are paid for additional hours that are not considered to be eligible compensation, those additional hours will be treated as eligible compensation, but only up to 40 hours per week will be recognized.

It does not include gifts and awards; bonuses; expense allowances; commissions; severance pay; pay for unused sick, unused vacation or other paid time off; overtime; shift premiums; attendance pay; temporary assignment allowances; disability pay (STD, LTD or Honda Disability Allowance); exempt holiday pay; or other special compensation.

It also does not include deferrals to a nonqualified deferred compensation plan.

The IRS limits the amount of annual eligible compensation that can be used to determine your Pension Plan benefit.

The Affiliate Plans may have exceptions and/or additions to the above list. See the appendices starting on page 296 for more information.

Calculating the Pension Plan Benefit

When you retire, your Pension Plan benefit is calculated using your accumulated eligible compensation and the pension formulas applicable to you. Beginning January 1, 2014, the Pension Plan formula is the same for all participants who chose Option 1 during the Choice Period in 2013.

The current pension formula is the accumulation of your eligible compensation credited on and after January 1, 2014 multiplied by 1%. This amount is added to your benefit earned under the pension formula in your Affiliate Plan as of December 31, 2013. This is your total pension benefit under the plan. Your monthly pension benefit is your total pension benefit divided by 12. See the appendix describing your Affiliate Plan for the pension formula that applies to you as of December 31, 2013.

If you chose Option 2 during the Choice Period in 2013, your total pension benefit is your benefit earned under the pension formula in your Affiliate Plan as of December 31, 2013.

To get an estimate of your actual pension benefit combining the calculation under the pension formula beginning January 1, 2014 (if you chose Option 1) with your Affiliate Plan calculation as of December 31, 2013, log in to **myhondaconnect.com** and select the "Pension" tile from the home page. You can use the available automated pension tools to help you estimate your benefit.

Normal Retirement Benefits

Your normal retirement benefit is your total pension benefit under the plan determined as of your normal retirement date.

Keep in mind that you receive a full and unreduced normal retirement benefit if you elect to receive the pension benefit after qualifying for normal retirement.

If you wish to retire before qualifying for normal retirement, you will receive a full and unreduced early retirement benefit if you qualify for early retirement and you begin your pension benefit on or after age 62 but before age 65. If you begin your early retirement benefit before age 62, then your pension benefit will be reduced. See "Early Retirement Benefit" on page 288 for information.

Federal laws impose certain limits on pension benefits (described under "Pension and 401(k) Savings Plan Limits" in *Administrative Information* on page 316).

Early Retirement Benefits

Your early retirement benefit is your total pension benefit determined as of your early retirement date. Your age and years of service at your early retirement date directly affect the amount of your early retirement benefit. If you choose to retire early after reaching age 62, you will receive an unreduced early retirement benefit. If you choose to retire early before reaching age 62, your early retirement benefit will be reduced by a retirement reduction factor for each month that you receive your early retirement benefit before your normal retirement date.

See the appendices starting on page 296 for the early retirement age and service requirements and the retirement reduction factor for each Affiliate Plan.

Social Security Supplemental Benefit (If You Terminate Employment on or after January 1, 2014)

This Social Security Supplemental Benefit is in addition to your early retirement benefit. If you were hired before September 4, 2013, and chose to continue earning benefits in the Honda Pension Plan (Option 1), have at least 20 years of Honda service at retirement and work to age 55, you are eligible for a $600 monthly supplement payable to age 62, when you are eligible to begin receiving Social Security benefits, or if earlier your date of death.*

**(Cannot be more than unreduced Social Security old age benefit.)*

Early Retirement Example

Let's look at an example to see how an associate's total monthly pension benefit is calculated using her 0.1667% monthly reduction factor for associates terminating their employment after December 31, 2020:

- Martha chooses to retire from Honda with 24 years of service and elects to commence her pension benefit on April 1, 2021 in the form of a life annuity.
- She is age 59.
- The total monthly pension benefit she has earned is $2,500.
- The retirement reduction factor for Martha's Affiliate Plan is 0.1667% for each month preceding her normal retirement date.
- Because Martha elected to commence her benefit at age 59, she will receive an actuarially reduced benefit of $2,350 per month (which is 94% of her earned benefit).

The retirement reduction factor applicable to you is described in the appendix for your Affiliate Plan.

Late Retirement Benefits

If you elected the Option 1 during the Choice Period in 2013 and you continue to work for Honda after you qualify for normal retirement, you will continue to earn the Pension Plan benefit for your service until your termination of employment at your late retirement. If you elected Option 2 during the Choice Period in 2013 and you continue to work for Honda after you qualify for normal retirement, your late retirement benefit is determined as of December 31, 2013.

Requesting a Pension Estimate

You can request a Honda pension estimate online at any time by following these steps:

- Log in to **myhondaconnect.com** and select the "Pension" tile from the home page. You can use the available automated pension tools to help you estimate your benefit.
- If it is your first time signing in, select "New User" on the login page and follow the prompts.

- If you can't remember your User ID, password or phone PIN, click "Forgot User ID or Password" and follow the prompts to reset them. After answering your security questions, a one-time code will be sent to your mobile device or a temporary password will be sent by postal mail. Once you have confirmed your one-time code or received a temporary password in the mail, you can easily create a new password or phone PIN.

- When you are ready to retire, you can request your actual pension package online, or you can speak to a retirement specialist who is trained on Honda's retirement benefits. The specialist can help you request an actual pension package and walk you through the retirement process. Retirement specialists are available at the My Benefits Connect Center at **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET.

If you have questions regarding Pension Plan information, including your estimate or actual package, contact the My Benefits Connect Center at **1-866-778-5885**.

There may be special circumstances, such as a qualified domestic relations order, that will prohibit you from running your estimate online. A manual calculation will need to be completed. Please contact the My Benefits Connect Center to request a pension estimate.

If You Leave Honda before You Are Retirement-Eligible

If you leave Honda for any reason before meeting the age and service requirements for normal or early retirement, you are not considered a "retiree from Honda." However, you are still eligible to receive your vested benefit after your termination of employment. If Pension Plan benefit payments begin before you reach normal retirement age, different reduction factors will be applied because payments are made over a longer period of time. See the appendices starting on page 296 for details.

How Your Benefit Is Paid

The *way* your benefits are paid can be as important as the *amount* that is paid. Because everyone has different needs at retirement, you may choose how your benefits will be paid, subject to certain restrictions. Once your benefits begin, you cannot change the form of benefit payment you have chosen. If you are married, you must have your spouse's consent for certain elections (see "If You Are Married" on page 293).

The Pension Plan provides the following forms of payment.

Understanding Your Benefit…

Your age and the payment form you choose affect your benefit payment amount. That is because your benefit will be reduced if:

- *Payments begin before normal retirement; and/or*
- *You choose a payment form that continues income to your survivors.*

Single Life Annuity

A single life annuity provides a monthly payment to you for your lifetime only. Benefits stop at your death with no survivor benefits payable. This payment form gives you the highest monthly payment amount.

Joint and Survivor Annuity (50%, 75% or 100%)

This payment option provides a reduced monthly benefit for your lifetime. After your death, a percentage of your benefit—50%, 75% or 100%, based on your election—is paid to your surviving spouse or designated beneficiary for his or her life. Joint and survivor annuity benefits are based on your spouse/designated beneficiary at the time of retirement.

Your benefit is reduced to pay for the cost of continuing benefits to your spouse or other designated beneficiary. The reduction amount is based on the ages of you and your spouse or other designated beneficiary on the date benefits begin. In addition, if you elect to continue 75% or 100% of your benefit (instead of 50%) to your spouse or other designated beneficiary, your benefit reduction will be greater.

Certain Period Option (Five or 10 Years)

This payment option provides reduced monthly benefits for your lifetime and guarantees to make payments for a certain period—five or 10 years, based on your election. This means that if you die before the end of the five- or 10-year period, payments will continue to your beneficiary for the remainder of the period (or your beneficiary may elect a lump-sum equivalent of the remaining payments). If you die after the five- or 10-year period, no further benefits are paid. If you and your beneficiary die before all of the guaranteed number of payments have been paid, then the lump-sum equivalent of the remaining payments will be paid to the estate of the last person to survive.

The reduction in your monthly benefit pays for the guarantee to make payments for the certain period. The longer the certain period, the greater your benefit reduction.

Social Security Level Income*

This payment option provides a larger monthly payment before Social Security benefits start (always assumed to be age 62) and a smaller benefit the month you turn 62, so you receive approximately the same monthly income both before and after Social Security benefits begin.

*This option is only available if you terminate employment after qualifying for early retirement

Lump-Sum Payment

Under this option, the value of your retirement benefit is paid to you in one single cash payment. You may elect to receive a lump-sum form of payment even though you have not reached your early or normal retirement age. If you do qualify for the lump sum, you will also be given the choice of any other form of payment.

You may also elect to roll over the lump-sum payment to an IRA or other eligible retirement plan. See the "Income Taxation and Rollover of Benefits" box below for information regarding taxes.

If You Are Married

Your spouse must agree in writing to your elected payment form if you:

- Elect a payment form other than a joint and survivor annuity; and/or
- Name a person other than your spouse as beneficiary.

The agreement must include your spouse's notarized signature and be filed within 180 days of the start of benefit payments. Your spouse is the person to whom you are legally married and not legally separated.

If You Do Not Choose a Payment Form

You are required by law to receive your benefit no later than April 1 of the calendar year following the later of the calendar year in which you attain age 72 (or age 70½ if you reached that age before 2020) or the calendar year in which you separate employment from Honda. If you reach your mandatory payment date and you have not elected a form of payment, you will receive one of the following forms of payment automatically:

- If you are single, your benefit will be paid as a life annuity; or
- If you are married, your benefit will be paid as a 50% joint and survivor annuity with your spouse as the beneficiary.

Income Taxation and Rollover of Benefits

The benefits paid to you by the Pension Plan are generally included in your federal taxable income in the year in which you receive a distribution. However, you can roll over a lump-sum distribution to an IRA or other eligible retirement plan and delay paying federal income tax on the amount rolled over until you take a distribution from the IRA or other eligible retirement plan. If you do not elect to roll over your lump-sum distribution, 20% of such lump-sum payment will be withheld for federal income taxes when it is paid to you.

In addition, distributions to you prior to your attaining age 59½ may be subject to a federal income tax penalty of 10%. Exceptions to this 10% penalty include distributions to your beneficiary after your death, distributions to you as a result of your disability and distributions after your separation of service from Honda after age 55.

You will be provided with more information about the federal income taxation of benefits when you receive your distribution paperwork. As Honda cannot provide you with tax advice, you should consult with your tax advisor prior to election to receive a distribution from the plan.

How to Apply for Benefits

You can request benefits by logging in to **myhondaconnect.com** or by calling the My Benefits Connect Center at **1-866-778-5885**.

- You must submit your request for benefits to the My Benefits Connect Center.
- You will then be sent* the appropriate pension commencement forms to complete. All forms must be completed within 180 calendar days of the date the appropriate forms are mailed or the election process must be started over.
- You must complete and return the Intent to Retire form 90 days prior to your requested retirement date. This form will be in your pension commencement kit.
- You must schedule an exit interview with Human Resources.

*Forms are sent via mail or secured email based on your preferred communication method established through **myhondaconnect.com**.

Claims Review

If your claim for benefits is denied in whole or in part, you may request a review of the decision in writing to the Honda Retirement Plan Committee. For more information, see "Claims and Appeals" on page 332 under *Administrative Information*.

If You Die Before You Begin Pension Benefits

If you are vested in the Pension Plan—that is, you have five or more years of service or have attained age 65—the Pension Plan provides a benefit in the event of your death before your retirement benefit payments begin. This applies even if you are not employed by Honda at the time of your death. Death benefit payments, to your beneficiary, may commence shortly after your death and are actuarially adjusted for commencement prior to your earliest retirement age.

If you are vested in the Pension Plan and die before beginning benefit payments, your spouse (if married) or beneficiary will receive a benefit as a lump-sum payment or lifetime payments. If you are vested in your pension benefit and die before beginning benefit payments, your surviving spouse (if married) or designated beneficiary will be entitled to a pre-retirement death benefit, which is the survivor portion of the qualified 50% joint and survivor annuity benefit that he or she otherwise would have received had the benefit commenced immediately prior to your death. If you had not reached the earliest retirement age under your Affiliate Plan, the surviving spouse death benefit will be the equivalent of the death benefit that would have been payable to your surviving spouse under your Affiliate Plan as if you terminated employment on the date of your death, you had survived to your earliest retirement age under your Affiliate Plan, you had elected to receive the qualified 50% joint and survivor annuity form of payment and you had died immediately thereafter. If at the time of your death you do not meet any vesting requirement for early retirement under your Affiliate Plan, then your earliest retirement age will be your normal retirement date if you had survived. Your spouse may elect to begin the pre-retirement death benefit at any time prior to your required beginning date had you survived.

If you had already separated employment or are early or normal retirement-eligible and if you had already initiated the pension commencement process and returned your pension options form, and you elected a 100% or 75% joint and survivor benefit, or a single lump-sum benefit, and you die within 90 days after the election form is received, then the death benefit payable to your spouse or beneficiary will be based on your benefit election.

A surviving spouse may elect to begin payment of the pre-retirement death benefit at any time prior to the mandatory benefit starting date as explained above in "Mandatory Benefit Starting Date." The surviving spouse's mandatory benefit starting date is the date that would have been your mandatory benefit starting date had you survived. If you are already receiving benefits at the time of death, payments may continue based on the form of payment you elected at retirement. If you are not married at the time of your death and you have not properly named a beneficiary, payment is made to your estate as a lump-sum.

You can name a beneficiary other than your spouse with your spouse's notarized consent. However, beginning the earlier of the first day of the plan year in which you reach age 35 or the date your Honda employment ends, any non-spouse beneficiary designation that you have made will cease to be effective and your spouse will again be your beneficiary unless you complete a new beneficiary designation.

If you are legally separated but not divorced, you can name someone other than your spouse as your beneficiary provided the court order granting legal separation does not include an order requiring your

spouse to be listed as a beneficiary. You need to submit a copy of the court order granting legal separation status to the My Benefits Connect Center.

If you designate as a beneficiary the person who is or later becomes your spouse and the marriage is later dissolved, the designation will automatically be cancelled. If you do not designate a new beneficiary upon dissolution of your marriage, your benefit would be paid to your estate upon your death.

If You Leave Honda before Retirement

If you leave Honda with less than five years of service, you are not eligible for a Pension Plan benefit.

If you leave Honda with five or more years of service, you are vested and eligible for the Pension Plan benefit you had earned as of the date you left. Your Pension Plan benefit is payable when you attain age 65. Alternatively, your benefit is payable subject to early retirement reductions as described in "Early Retirement Benefits" on page 291. You need to contact the My Benefits Connect Center to begin benefit payments.

However, if you have five or more years of service when you leave Honda and the present value of your benefit is $1,000 or less, you will receive a lump-sum payment of your benefit within a reasonable time following your termination of employment. You will be given the option to roll over the lump sum to an IRA or an eligible retirement plan. If the vested value of your benefit is more than $1,000, no distribution may be made to you prior to your normal retirement age without your consent.

If You Were Not Vested When You Left

If you were not vested when you left Honda (for example, with less than five years of service), special rules apply. These rules are based on the length of your absence after a break in service (see the "Break in Service" box below for more information).

- If you return to Honda in less than five years, your service and benefit amounts are restored. If you were rehired after September 3, 2013, you will earn no additional benefits under the plan, but you will earn service toward vesting.

  Example: If you left Honda with two years of service and returned three years later, your two years of prior service and your annual benefit amounts for each year would be restored. You will continue to earn service toward vesting but will earn no additional benefits; or
- If you return to Honda after having five or more one-year breaks in service, your service and benefit amounts are not restored and you will be treated as a new hire for the purpose of earning such service under the plan. If you were rehired after September 3, 2013, you are not eligible for the Pension Plan.

  Example: You leave Honda with four years of service and return after six years. Your four years of prior service and benefits are not restored, and you will be considered a new hire for Pension Plan purposes. If you were rehired after September 3, 2013, you are not eligible for the Pension Plan.

Break in Service

A break in service occurs if you do not work for Honda for a 365 consecutive-day period which begins on the day after your Honda employment ends for any reason. Qualified disability (except if you are associated with Affiliate Plan 3; see that appendix for details), approved leaves of absence or temporary layoffs do not end your employment unless you fail to return from the leave. For parental leaves of absence (due to birth or adoption of a child), the 12-month period begins on the first anniversary of your absence.

Rehired Retirees

If you are receiving a monthly benefit payment under the Pension Plan and you return to work for Honda, your monthly benefit payment will be suspended. You will permanently forfeit or lose your suspended monthly benefit payment for any month of re-employment in which you complete 40 or more hours of service, including any month in which severance benefits are paid. This forfeiture applies to a monthly benefit payment that was suspended before or after your normal retirement age (age 65) until the April 1 following the year you reach age 70½. Any other monthly benefit payment payable before the April 1 following the year in which you reach age 72 (or age 70½ if you reached that age before 2020) will be suspended. When you begin again to receive your monthly benefit payment, your accrued benefit will be increased by the equivalent of the suspended monthly benefit payments that were not forfeited.

While your monthly benefit payment is suspended, you are not eligible to receive any monthly Social Security Supplemental Benefit.

Once you stop working for Honda, your monthly benefit payment will no longer be suspended and you will begin again to receive your monthly benefit payment (and if you are eligible, to receive the monthly Social Security Supplemental Benefit). If you continue working for Honda after April 1 of the year in which you reach age 72 (or age 70½ if you reached that age prior to 2020), your monthly benefit payment will no longer be suspended, and you will resume your monthly benefit payment.

Your accrued benefit under the plan will be recalculated when your monthly benefit payment begins again. Your recalculated accrued benefit will be the sum of (i) the amount of your monthly accrued benefit that was being paid prior to the suspension, (ii) any additional benefit you earned while working and your monthly benefit payment was suspended and (iii) any actuarial increase in your suspended monthly benefit payment that was not forfeited, but actuarially reduced, for any previous monthly benefit payments you already received to avoid duplicating benefits. In no event will your recalculated benefit be less than the equivalent of your accrued benefit at the time you initially began payments.

If your monthly benefit payment was suspended *before* your normal retirement date, you will be required to complete a new commencement package to elect a form of payment to receive your recalculated benefit.

If your monthly benefit payment was suspended *on or after* your normal retirement date, your recalculated benefit will be paid to you in the same form of payment that your benefit was paid at the time your monthly benefit payments were suspended.

Affiliate Plan 1 Appendix—American Honda Motor Co. (AHM) Retirement Plan

The following replaces or supplements content in the Pension Plan above.

When Participation Began

Your participation in the Pension Plan began on the first day of the month on or after the date you completed one full year of Honda service. You will be credited with one month of service for each 30 days in your period or periods of service. You will be credited with a year of service for each 12 months of service.

For example, if you were hired on March 10, 2011, you completed one year of service on March 10, 2012, and Pension Plan participation began on April 1, 2012.

The service you earned before July 1, 1976, is not counted unless you were regularly employed for at least 20 hours a week and five months a year.

Calculating the Pension Plan Benefit

AHM Pension Benefit Amount as of December 31, 2013

Your benefit earned under this Affiliate Plan 1 is the sum of:

- 2.5% of your accumulated eligible compensation credited after June 30, 2009, and prior to January 1, 2014 (there is an exception to the 2.5% of accumulated eligible compensation rate described below); and
- Your annual benefit in the Normal Benefit Form at normal retirement date accrued under the predecessor plan to this Affiliate Plan 1 through June 30, 2009.

The exception to the 2.5% of accumulated eligible compensation above is 2% of accumulated eligible compensation after June 30, 2009, and prior to January 1, 2014. This exception applies to accumulated eligible compensation credited from Honda Aero, Inc. or Honda Aircraft Company, Inc. unless accruing benefits under this Affiliate Plan 1 (or its predecessor) at 2.5% of accumulated eligible compensation rate at the time you transferred to either of those companies; in which case, you will continue to accrue benefits at the 2.5% of accumulated eligible compensation rate.

Between 1984 and 2013, your monthly benefit was your accumulated eligible compensation times 2.5% divided by 12.

To get an estimate of your actual pension benefit combining the current pension formula calculation with your AHM pension benefit amount as of December 31, 2013, log in to **myhondaconnect.com** and select the “Pension” tile from the home page.

Annual Eligible Compensation

Only compensation earned while you are a participant in the Pension Plan may be recognized as eligible compensation.

Early Retirement Benefits

You receive a reduced pension benefit if you leave Honda and want Pension Plan payments to begin between the ages of 55 and 62 and you have 10 or more years of service but less than 20 years of service.

If you have less than 20 years of service, you receive your vested benefit as of your early retirement date reduced for each month that date precedes your 62nd birthday by 0.1667% per month; plus, if you are eligible, you will receive your Social Security Supplemental Benefit.

If you have 20 years of service or more, you receive your vested benefit as of your early retirement date unreduced.

Late Retirement Benefits

You receive the benefit amount calculated by the formulas described in “Benefits” on page 289 and the formulas referenced in “AHM Pension Benefit Amount as of December 31, 2013” above, minus your employment between your normal retirement age and the first day of the plan year beginning on or after January 1, 1988 (unless you are an AHM associate on or after January 1, 1988). The amount of benefits

accrued in a plan year after you reach your normal retirement age is reduced (but not below zero) by the equivalent of any actuarial increase required for a plan year if a timely suspension of benefits notice is not provided or you were paid any benefits in the plan year. To the extent the suspension of benefits provision does not apply, your pension benefit at late retirement will not be less than your benefit actuarially increased to the extent required under Internal Revenue Code Section 411 and Section 401(a)(9).

If You Leave Honda before You Are Retirement-Eligible

If you leave Honda for any reason before meeting the age and service requirements for normal or early retirement, you are not considered a "retiree from Honda." However, you are still eligible to receive your vested benefit after your termination of employment as follows.

- You may elect an early retirement date on or after reaching age 55 but before reaching age 65. Your early retirement benefit will be reduced by 0.5% for each month payment of your early retirement benefit precedes your normal retirement date; or
- If you elect to receive your vested benefit before reaching age 55, the vested benefit you are eligible to receive at age 55 will be actuarially adjusted to reflect your actual age when payments begin by using the Pension Plan's current actuarial interest and mortality factors.

If You Become Disabled

You are "disabled" if you are disabled under the terms of Honda's long-term disability plan by reason of a medically determinable physical or mental impairment and you are receiving benefits under such plan.

If you were disabled prior to January 1, 2014, you continue to earn service and will be credited with retirement benefits during your disability, calculated using your eligible compensation that was in effect at the time you became disabled. You will continue to earn service and benefits until the earliest of the following: (i) the date you begin receiving benefits under the Pension Plan or (ii) the date you are no longer disabled.

Affiliate Plan 2 Appendix—Honda South Carolina (HSC) Retirement Plan

The following replaces or supplements content in the Pension Plan above.

Calculating the Pension Plan Benefit

HSC Pension Benefit Amount as of December 31, 2013

Your benefit earned under this Affiliate Plan 2 is 1.5% of your accumulated eligible compensation credited prior to January 1, 2014.

To get an estimate of your actual pension benefit combining the current pension formula calculation with your AHM pension benefit amount as of December 31, 2013, log in to **myhondaconnect.com** and select the "Pension" tile from the home page.

Annual Eligible Compensation

Only compensation earned while you are a participant in the Pension Plan may be recognized as eligible compensation.

Early Retirement Benefits

You receive a reduced pension benefit if you leave Honda between the ages of 55 and 62 with 10 or more years of service.

You receive your vested HSC benefit as of your early retirement date reduced for each month that date precedes your 62nd birthday by 0.1667% per month, plus, if you are eligible, you will receive your Social Security Supplemental Benefit.

Late Retirement Benefits

You receive the benefit amount calculated by the formulas described in "Benefits" on page 289 and the formulas referenced in "HSC Pension Benefit Amount as of December 31, 2013" above, but the amount of benefits accrued in a plan year after your reach your normal retirement age is reduced (but not below zero) by the equivalent of any actuarial increase required for a plan year if a timely suspension of benefits notice is not provided or you were paid any benefits in the plan year. To the extent the suspension of benefits provision does not apply, your pension benefit at late retirement will not be less than your benefit actuarially increased to the extent required under Internal Revenue Code Section 411 and Section 401(a)(9).

If You Leave Honda before You Are Retirement-Eligible

If you leave Honda for any reason before meeting the age and service requirements for normal or early retirement, you are not considered a "retiree from Honda." However, you are still eligible to receive your vested benefit after your termination of employment as follows.

- You may elect to receive an early retirement date on or after reaching age 55 but before reaching age 65. Your early retirement benefit will be reduced by 0.5% for each month payment of your early retirement benefit precedes your normal retirement date.
- If you elect to receive your vested benefit before reaching age 55, the benefit you are eligible to receive at age 55 will be actuarially adjusted to reflect your actual age when payments begin by using the Pension Plan's current actuarial interest and mortality factors.

If You Become Disabled

You are "disabled" if you are disabled under the terms of Honda's long-term disability plan by reason of a medically determinable physical or mental impairment and you are receiving benefits under such plan.

If you were disabled prior to January 1, 2014, you continue to earn service and will be credited with retirement benefits during your disability, calculated using your eligible compensation that was in effect at the time you became disabled. You will continue to earn service and benefits until the earliest of the following: (i) the date you begin receiving benefits under the Pension Plan or (ii) the date you are no longer disabled.

Affiliate Plan 3 Appendix—Honda Transmission Mfg. of America, Inc. (HTM) Pension Plan

The following replaces or supplements content in the Pension Plan above.

Calculating the Pension Plan Benefits

HTM Pension Benefit Amount as of December 31, 2013

Your benefit earned under this Affiliate Plan 3 is the sum of:

- 2.0% of your accumulated eligible compensation credited after June 30, 2009, and prior to January 1, 2014; and
- Your annual benefit in the Normal Benefit Form at normal retirement date accrued under the predecessor plan to this Affiliate Plan 3 through June 30, 2009.

To get an estimate of your actual pension benefit combining the current pension formula calculation with your HTM pension benefit amount as of December 31, 2013, log in to **myhondaconnect.com** and select the "Pension" tile from the home page.

Annual Eligible Compensation

Compensation earned before you are a participant in the Pension Plan (for example, paid during your first year of service) may be recognized as eligible compensation.

Normal Retirement Benefits

You receive the full pension benefit if you retire on your normal retirement date after you reach age 65.

Early Retirement Benefits

You are eligible to receive an early retirement benefit if you are at least age 55 with 10 or more years of service.

You receive the greater of (i) your vested accrued benefit as of your early retirement date reduced for each month that date precedes your 62nd birthday by 0.1667% per month, or (ii) your vested accrued benefit determined based on your accrued benefit and early retirement reduction factors as of December 31, 2013.

Early Commencement of Deferred Vested Benefits

If you terminate before reaching age 55 or before completing 10 years of service, you may commence your deferred vested benefit the first day of any month following your 55th birthday (your early retirement date).

- Your accrued benefit earned before 2009 is reduced by a reduction factor for each month your early retirement date precedes your normal retirement date according to the following table:

Years of Service	Reduction Factor
At least 10 but not more than 20	0.3333%
At least 20 but not more than 25	0.2500%
25 or more	0.1667%

- Your accrued benefit earned after 2008 is reduced by 0.5% for each month your early retirement date precedes your normal retirement date.

However, if your deferred vested benefit commences before you reach age 55, the benefit will be the equivalent of the benefit payable at age 55.

Late Retirement Benefits

You receive the benefit amount calculated by the formulas described in "Benefits" on page 289 and the formulas referenced in "HTM Pension Benefit Amount as of December 31 2013" above, but the benefit will not be actuarially increased because the benefits commenced after your normal retirement date except as provided in the suspension of benefits provision. To the extent the suspension of benefits provision does not apply, your pension benefit at late retirement will not be less than your benefit actuarially increased to the extent required under Internal Revenue Code Section 411 and Section 401(a)(9).

Optional Forms of Payment

If you elect to receive an Optional Benefit Form before reaching age 55, the lump sum you would have received is converted into an equivalent single life annuity amount, which is then converted into an equivalent benefit in the Optional Benefit Form you elected.

You may elect the Monthly Installment Option to be paid on the first day of each month for the number of months you elect, not to exceed the number that would violate incidental death benefit rule under Code Section 401(a)(9). If you die during the installment period, payments will continue to your chosen beneficiary in the same amount for the remainder of the installment period.

The Social Security Level Income option and unlimited lump-sum options are available only for benefits commencing on and after January 1, 2014.

If You Leave Honda before You Are Retirement-Eligible

If you leave Honda for any reason before meeting the age and service requirements for normal or early retirement, you are not considered a "retiree from Honda." However, you are still eligible to receive your vested benefit after your termination of employment as explained above under "Early Commencement of Deferred Vested Benefits."

If You Become Disabled

You are "totally and permanently disabled," as established by a licensed physician selected by the plan administrator, if you are not able to perform your job or any job for HTM for which you are reasonably suited as a result of your education, training and experience. Total disability for a period of six months is presumed to be permanent. If you become totally and permanently disabled, qualify for Social Security disability benefits and have a vested accrued benefit, you may be eligible to elect early commencement of benefits before attaining age 55 or before completing 10 years of service. However, your Pension Plan benefit will reduce your Honda LTD benefit.

Affiliate Plan 4 Appendix—Honda of America Mfg., Inc. (HAM) Pension Plan

The following replaces content in the Pension Plan above.

Plan Participation

You will be credited with one month of service for each 30 days in your period or periods of service. You will be credited with a year of service for each 12 months of service.

Calculating the Pension Plan Benefit

HAM Pension Benefit Amount as of December 31, 2013

Your benefit earned under this Affiliate Plan 4 is:

- 2% of your accumulated eligible compensation credited after June 30, 2009, and prior to January 1, 2014; and
- Your annual benefit in the Normal Benefit Form at normal retirement date accrued under the predecessor plan to this Affiliate Plan 4 through June 30, 2009.

To get an estimate of your actual pension benefit combining the current pension formula calculation with your pension benefit amount calculation as of December 31, 2013, log in to **myhondaconnect.com** and select the "Pension" tile from the home page.

Annual Eligible Compensation

Compensation earned before you are a participant in the Pension Plan (for example, paid during your first year of service) may be recognized as eligible compensation.

Normal Retirement Benefits

You receive the full pension benefit if you are age 65.

Early Retirement Benefits

You receive a reduced pension benefit if you are at least age 55 with 10 or more years of service.

If you terminate employment on or after January 1, 2014, you receive the greater of (i) your vested accrued benefit as of your early retirement date reduced for each month that date precedes your 62nd birthday by 0.1667% per month, or (ii) your vested accrued benefit determined based on your accrued benefit and early retirement reduction factors as of December 31, 2013.

Early Commencement of Deferred Vested Benefits

If you terminate employment before reaching age 55 but after completing 10 years of service, you may commence your deferred vested benefit the first day of any month following your 55th birthday (your early retirement date). Your accrued benefit will be reduced as follows:

- Your accrued benefit earned before 2009 is reduced by a reduction factor for each month your early retirement date precedes your normal retirement date according to the following table:

Years of Service	Reduction Factor
At least 10 but not more than 20	0.3333%
At least 20 but not more than 25	0.2500%
25 or more	0.1667%

- Your accrued benefit earned after 2008 is reduced by 0.5% for each month your early retirement date precedes your normal retirement date.

However, if your benefit commences before you reach age 55, the benefit will be the equivalent of the benefit payable at age 55.

Late Retirement Benefits

You receive the benefit amount calculated by the formulas described in "Benefits" on page 289 and the formulas referenced in "HAM Pension Benefit Amount as of December 31, 2013" above, but the amount of benefits accrued in a plan year after your reach your normal retirement age is reduced (but not below zero) by the equivalent of any actuarial increase required for a plan year if a timely suspension of benefits notice is not provided or you were paid any benefits in the plan year. To the extent the suspension of benefits provision does not apply, your pension benefit at late retirement will not be less than your benefit actuarially increased to the extent required under Internal Revenue Code Section 411 and Section 401(a)(9).

If You Leave Honda before You Are Retirement-Eligible

If you leave Honda for any reason before meeting the age and service requirements for normal or early retirement, you are not considered a "retiree from Honda." However, you are still eligible to receive your vested benefit after your termination of employment as explained above under "Early Commencement of Deferred Vested Benefits."

If You Become Disabled

"Disability" is the inability to engage in your job functions by reason of a medically determinable physical or mental impairment. You will only be considered suffering a disability while you are eligible for Social Security disability benefits and while you are eligible for benefits for Honda LTD benefit.

If you were disabled prior to January 1, 2014, you continue to earn vesting service and be credited with retirement benefits calculated based on the formula in effect during your period of disability and assuming that you continue to receive your eligible compensation in effect just prior to your disability. However, you will not receive credit for vesting service (i) once you terminate employment from Honda for purposes of determining eligibility or credits under the Retiree Medical Plan described in "Other Benefits for Retirees" on page 314 or (ii) on and after the earlier of the date you elect to commence retirement benefits or the date benefits end under your Honda LTD benefit.

Affiliate Plan 5 Appendix—Honda Manufacturing of Alabama, LLC (HMA) Pension Plan

The following replaces or supplements content in the Pension Plan above.

Calculating the Pension Plan Benefit

HMA Pension Benefit Amount as of December 31, 2013

Your benefit earned under this Affiliate Plan 5 is:

2.5% of your accumulated eligible compensation credited prior to January 1, 2014.

To get an estimate of your actual pension benefit combining the current pension formula calculation with your HMA pension benefit amount as of December 31, 2013, log in to **myhondaconnect.com** and select the "Pension" tile from the home page.

Annual Eligible Compensation

Compensation earned before you are a participant in the Pension Plan (for example, paid during your first year of service) may be recognized as eligible compensation.

Early Retirement Benefits

You are eligible to receive an early retirement benefit if you are at least age 55 with 10 or more years of service.

You receive the greater of (i) your vested accrued benefit as of your early retirement date reduced for each month that date precedes your 62nd birthday by 0.1667% per month, or (ii) your vested accrued benefit determined based on your accrued benefit and early retirement reduction factors as of December 31, 2013.

Early Commencement of Deferred Vested Benefits

If you terminate employment before reaching age 55 but after completing 10 years of service, you may commence your deferred vested benefit the first day of any month following your 55th birthday (your early retirement date). Your accrued benefit will be reduced as follows:

- Your accrued benefit earned before 2014 payable at your normal retirement date is reduced by 0.3333% per month for each month that your early retirement benefit begins before your normal retirement date (if you have less than 20 years of service) or your 62nd birthday (if you have at least 20 years of service).
- Your accrued benefit earned after 2013 is reduced by 0.5% for each month your early retirement date precedes your normal retirement date.

However, if your benefit commences before you reach age 55, the benefit will be the equivalent of the benefit payable at age 55.

Late Retirement Benefits

You receive the benefit amount calculated by the formulas described in “Benefits” on page 289 and the formulas referenced in “HMA Pension Benefit Amount as of December 31, 2013” above, but the amount of benefits accrued in a plan year after you reach your normal retirement age is reduced (but not below zero) by the equivalent of any actuarial increase required for a plan year if a timely suspension of benefits notice is not provided or you were paid any benefits in the plan year. To the extent the suspension of benefits provision does not apply, your pension benefit at late retirement will not be less than your benefit actuarially increased to the extent required under Internal Revenue Code Section 411 and Section 401(a)(9).

If You Leave Honda before You Are Retirement-Eligible

If you leave Honda for any reason before meeting the age and service requirements for normal or early retirement, you are not considered a “retiree from Honda.” However, you are still eligible to receive your vested benefit on the first day of any month following your termination of employment.

Effective January 1, 2014, the retirement reduction factors for associates who leave Honda before they are retirement-eligible (age 55 with at least 10 years of service or age 65) were changed.

- Your accrued benefit earned before 2014 payable at your normal retirement date is reduced by 0.3333% per month for each month that your early retirement benefit begins before your normal retirement date (if you have less than 20 years of service) or your 62nd birthday (if you have at least 20 years of service).
- Your accrued benefit earned after 2013 is reduced by 0.05% for each month your early retirement date precedes your normal retirement date.

If you elect to receive your vested benefit before age 55, the benefit you are eligible to receive at age 55 will be actuarially adjusted to reflect your actual age when payments begin by using the Pension Plan's current actuarial interest and mortality factors.

The chart below shows the reduction factors for benefits earned before January 1, 2014, and benefits earned on and after January 1, 2014, for each month that benefits begin before age 65 but not before age 55. If you elect to receive your retirement benefits before age 55, the amount of your benefit will be actuarially adjusted by using the Pension Plan's current actuarial interest and mortality factors.

Years of Service	Reduction Factor for Benefits Earned before January 1, 2014	Reduction Factor for Benefits Earned on and after January 1, 2014
10 – 19	0.3333% each month preceding age 65	0.05% each month early retirement date preceding age 65
20 or more	0.3333% each month preceding age 62*	0.05% each month early retirement date preceding age 65

*No reduction if benefits begin on or after age 62.

If You Become Disabled

"Disability" is the inability to engage in your job functions by reason of a medically determinable physical or mental impairment. You will only be considered suffering a disability while you are eligible for Social Security disability benefits and while you are eligible for benefits for Honda LTD benefit.

If you were disabled prior to January 1, 2014, you continue to be credited with retirement benefits calculated based on the formula in effect during your period of disability and assuming that you continue to receive your eligible compensation in effect just prior to your disability. However, you will not receive disability accruals on and after the earliest of (i) the date you are no longer eligible to receive benefits under the Honda LTD Plan, (ii) the date you elect to commence retirement benefits or (iii) the date you are no longer eligible for Social Security disability benefits.

Retirement Medical Program

In addition to the 401(k) Savings Plan and Pension Plan (if applicable), Honda offers you other benefits after you retire, including:

- A Retiree Medical Plan; and
- Retiree Medical credits; and
- The Retiree Reimbursement Account Lump Sum Contribution.

*For a full description of the healthcare benefits described in this section, please refer to the Summary Plan Description for the Honda Retirement Medical Program. You can view this SPD at **myhondaconnect.com** or by calling the My Benefits Connect Center at **1-866-778-5885**.*

Highlights

Eligibility	If you retire from Honda and are age 55 or older with 10 or more years of continuous service or age 65 or older with five or more years of continuous service, you may be eligible for retiree medical coverage through the Retirement Medical Program, which includes the Retiree Medical Plan, Retiree Medical credits, and the Retiree Reimbursement Account Lump Sum Contribution
Benefits and Cost	Retiree medical coverage helps pay for medical expenses—including prescription drugs—for you and your eligible dependents. • If you are not Medicare-eligible, the Retiree Medical Plan is available for you and your eligible dependents; Honda provides a fixed dollar amount every month (called the Retiree Medical Plan credit), which is used toward the cost of premiums. • Once you or your covered dependents become Medicare-eligible, you are no longer eligible for the Retiree Medical Plan. Eligible retirees instead receive a monthly post-Medicare Retiree Medical credit as a deposit in a Retiree Reimbursement Account (RRA). You must have reached age 50 by December 31, 2020, to be eligible for this credit. Spouses and covered dependents are not eligible for post-Medicare credit. • Associates who retire on or after January 1, 2014, will receive a one-time RRA Lump Sum Contribution.
Administered By	Retirement Medical Program: • Retiree Medical Plan: UMR (a division of UnitedHealthcare company) or Blue Cross Blue Shield of Alabama (BCBSAL) • Retiree Reimbursement Account (RRA): UMR

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Retirement Medical Program

You are eligible for the Honda Retirement Medical Program if you retire from active service with Honda and:

- Are at least age 55 to 64 with at least 10 years of continuous* service; or
- Attained age 65 or older with at least 5 years of continuous* service.

Your Retirement Medical Program benefits are different depending on your Medicare eligibility.

If…	The Retirement Medical Program Provides…
You or your spouse are: • Under 65; and • Not Medicare-eligible	• A Retiree Medical PPO Plan for retirees and eligible dependents* who are not Medicare-eligible. Retirees and eligible* dependents are automatically enrolled in the Retiree Medical Plan at retirement unless you call the My Benefits Connect Center to opt out of coverage. • Monthly Retiree Medical Credits to help pay for a portion of the premium for the Honda Retiree Medical Plan.
You are: • 65 or older; or • Medicare-eligible; and • Age 50 or older by December 31, 2020	• An automatic monthly post-Medicare credit once a retiree becomes Medicare-eligible. • Post-Medicare monthly Retiree Medical Credits that can be used to purchase your own coverage through Medicare, Medigap and Medicare Advantage Plans available from private insurers or to cover out-of-pocket expenses. **Things to Remember:** • To receive the post-Medicare Retiree Medical Credits, once you become eligible for Medicare, you must have participated in the Honda Retiree Medical Plan or the active associate plan until you became eligible for Medicare and were age 50 or older by December 31, 2020. • Once you become eligible for Medicare, you are no longer eligible to participate in the Honda Retiree Medical Plan. • Split enrollment will occur if the retiree becomes Medicare-eligible and his or her spouse is not. If you are 65 or Medicare-eligible due to disability and your spouse is under 65 or not Medicare-eligible, your spouse will remain in the Honda Retiree Medical Plan. The same is true if your spouse is 65 or Medicare-eligible due to disability and you are under 65 or not Medicare-eligible. Once your spouse becomes Medicare-eligible, he or she is no longer eligible to participate in the Retirement Medical Program.

Note: Retirees are also eligible for a one-time Retiree Reimbursement Account Lump Sum Contribution into their RRAs even if they waive or opt out of the Honda Retiree Medical Plan. This contribution can be used at any time.

***Continuous service is defined as your most recent employment history without a break in service.** For example, if you worked at Honda for six years, left to work at another non-Honda company and were later rehired at Honda, only your service from your most recent date of hire forward would be counted toward eligibility.

If you are enrolled in the Retirement Medical Program:

- You can cover your spouse and eligible dependents. (**Note:** Dependents are not eligible for the post-Medicare RRA.)
- Coverage begins the first day of the month following your retirement date (your active coverage continues through the end of the month you retire, so there is no gap in coverage). Honda helps cover

the monthly premium cost through the Retiree Medical Credit, which is based on your continuous years of Honda service.

For a full description of the Retiree Medical Plan, please refer to the Summary Plan Description for the Honda Retirement Medical Program. You can view this SPD at **myhondaconnect.com**, or by calling the My Benefits Connect Center at **1-866-778-5885**.

Retiree Medical Plan

The Retiree Medical Plan is available to you and your eligible dependents who are not Medicare-eligible. The chart below shows the coverage offered. The claims administrator for the plan is either UMR or Blue Cross Blue Shield of Alabama, depending on which you had as an active associate. It is administered by Alight Solutions for non-claims-related information.

Preventive Services Covered at 100%

Make sure you take advantage of the preventive benefits (such as wellness exams) covered under both options. The plan pays 100% of the cost—you pay nothing for eligible services.

	Retiree Medical Plan	
Retiree Monthly Premium		
• Honda covers part of the premium through the Retiree Medical Credit; the remainder is paid by the retiree		
Deductible Paid by retiree	**In-Network**	**Out-of-Network**
• Individual	$800	$1,000
• Family	$1,600	$2,000
Maximums		
Total Out-of-Pocket Includes deductible (paid by retiree)	**In-Network**	**Out-of-Network**
• Individual	$3,200	$4,000
• Family	$6,400	$8,000
Medical Lifetime	Unlimited	
Services		
Preventive Care	100% coverage (in-network and out-of-network)	
Other Services	**In-Network**	**Out-of-Network**
• Office visit — primary care	$30 copay	60% after calendar year deductible
• Office visit — specialist	$50 copay	60% after calendar year deductible
• Outpatient surgery	70% after calendar year deductible	60% after calendar year deductible
• Lab and X-ray	70% after calendar year deductible	60% after calendar year deductible
• Inpatient hospital	70% after calendar year deductible	60% after calendar year deductible
• Emergency care	70% after calendar year deductible; 50% if non-emergency	

Key Points

- For associates with any balance remaining in the Special HRA Account, it will be rolled over into your Retiree Reimbursement Account (RRA).
- You and your eligible dependents* will automatically be enrolled in the Retiree Medical Plan under the claims administrator network you are currently in, unless you call the My Benefits Connect Center and opt out of coverage or switch between UMR and BCBSAL.

- If you opt out of retiree medical coverage, you will not be eligible to enroll at a later date and will forfeit the retiree post-Medicare monthly credits.
- If you are married to another Honda active associate, you must make the decision, at the time of your retirement, to go onto your own retiree medical coverage or become a dependent on your spouse's active coverage. If you elect to go on your spouse's active coverage, you must notify the My Benefits Connect Center of your choice to opt out of retiree medical coverage.
- Preventive care is paid 100%.
- Dental and vision coverage is not available for retirees under the Retirement Medical Program.

*Eligible dependents are those who are covered under your active Honda medical plan at the time of your retirement.

Prescription Drug Coverage

Prescription drugs are covered under the Retiree Medical Plan. If you elect medical coverage, you automatically receive prescription drug coverage.

Retail Pharmacy

When prescriptions are filled at any of the plan's participating pharmacies, the following copays apply for up to a 30-day supply of medication:

Retiree Medical Plan Copays—30-Day Supply

	Retiree Medical Plan
Generic Drug	$7
Preferred Formulary	$35
Non-Preferred Formulary	$70
Specialty	$125

Additional Copay at Retail Pharmacy after the Third Retail Refill

You will pay a $25 copay in addition to your regular copay or coinsurance if you refill a 30-day prescription at a retail pharmacy, beginning with the fourth fill. To avoid an additional $25 copay, the mail order program and the CVS/Caremark retail pharmacy 90-day program allow you to receive up to a three-month (90 days) supply of most maintenance medications for reduced copays.

90-Day Supplies: Mail Order or CVS/Caremark Retail Pharmacy

You can order up to a 90-day supply of prescriptions for conditions such as diabetes and high blood pressure through the mail. You may also obtain a 90-day prescription at a CVS/Caremark retail pharmacy. To do so, the prescription must be written *to dispense in a 90-day supply* and taken to a CVS/Caremark retail pharmacy, just as you would a short-term supply. This gives you the flexibility to use a CVS/Caremark retail pharmacy at no additional cost to you.

The following copays apply:

Retiree Medical Plan Copays—90-Day Supply

	Retiree Medical Plan
Generic Drug	$14
Preferred Formulary	$70
Non-Preferred Formulary	$140
Specialty	$250

Discounts for Smoking Cessation Prescriptions

You can receive a discount for smoking cessation prescriptions as a part of Honda's prescription plan benefit. You can save money by using your Honda medical/prescription drug ID card at any retail discount pharmacy or through the mail order program. You pay 100% of the drug price, but at a reduced, negotiated cost. You are limited to two treatments per year.

Retiree Medical Credit

Honda provides a fixed credit dollar amount each month (based on your continuous years of service) called the Retiree Medical Credit. Credits are provided to the retiree, spouse and eligible dependents. (Credits for dependents are provided until both parents become Medicare-eligible, at which time dependent coverage is no longer available through Honda's Retirement Medical Program.)

- **For Pre-Medicare Retirees, Spouses and Dependents:** Your Retiree Medical Credit is used toward your Retiree Medical Plan premiums. (See the table below to calculate your Retiree Medical Credit amount.) The amount you pay in Retiree Medical Plan premiums is determined by subtracting the Retiree Medical Credit you receive from Honda from your monthly premium costs. Your cost for Honda's Retiree Medical Plan coverage is based on the medical plan option you choose, your level of coverage and your years of service.
- **For Medicare-Eligible Retirees:** Your Retiree Medical Credit dollars are deposited into your Retiree Reimbursement Account (RRA) each month. These dollars can be used toward the cost of a Medicare supplement plan or any qualified medical expenses. There is no cost to participate in the RRA. See "Retiree Reimbursement Account (RRA)" on page 313 for more information.

The amount of your monthly Retiree Medical Credit is calculated as follows. These amounts are reviewed and subject to change annually.

Retiree Medical Credits—For Retirees

Pre-Medicare-Eligible	*Medicare-Eligible*
$473 per month for the first 10 years of continuous service + $22 per month for each additional year of continuous service for years 11 – 20 + $13 per month for each additional year of continuous service for years 21 – 30	$7 for each year of continuous service up to 20 years of service + $5 for each additional year of continuous service for years 21 – 30

Your eligible dependents will receive 50% of your pre-Medicare Retiree Medical Plan monthly credits.

Retiree Reimbursement Account (RRA)

Who Is Eligible for an RRA

If you 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 five years of continuous service, you are eligible for an RRA. (If you retire before you are Medicare-eligible, you must participate in the Retiree Medical Plan until you become Medicare-eligible to be eligible for the post-Medicare RRA credit.).

If you were an active associate who had funds rolled over from the Special HRA Account under your medical plan to an RRA, you have access to these funds regardless of your Medicare eligibility. You can use these funds to reimburse yourself after paying your insurance premiums or other eligible healthcare expenses.

To calculate the Retiree Medical Credit for you and your spouse/dependent, see the tables in the "Retiree Medical Credit" section on page 312.

Retiree Medical Credit for Medicare-Eligible Retirees

Once you become eligible for Medicare and meet Honda's RRA eligibility criteria, you will receive a monthly post-Medicare RRA credit. You may use the credits to be reimbursed for out-of-pocket healthcare expenses such as premiums, deductibles, copays and coinsurance, and prescriptions, as well as out-of-pocket dental and vision expenses. Unused credits in your RRA will roll over from month to month and year to year.

If you were not at least age 50 on December 31, 2020, you are not eligible for this credit.

Retiree Reimbursement Account Lump Sum Contribution

If you retire on or after January 1, 2014, Honda will make a one-time lump-sum contribution to your RRA. Similar to the Retiree Medical Credit, it is based on your years of continuous service when you retire. The amount of your Retiree Reimbursement Account Lump Sum Contribution will be calculated using the formula below.

Retiree Reimbursement Account Lump Sum Contribution
$1,000 × Years of continuous service (capped at 30 years)

Expenses Eligible for Reimbursement

Your RRA funds can be used to pay for most medical expenses, including:

- Health and qualified long-term care insurance premiums; and
- Medicare premiums for Part B and Part D coverage; and
- Medigap plan premiums used to supplement your Medicare Part A and Part B coverage; and
- Medicare Advantage premiums or Medicare Advantage Prescription Drug Plan premiums.

Items That Are Eligible Expenses	Items That Are *Not* Eligible Expenses
• Doctor and hospital charges, prescription expenses (including insulin) that are not reimbursed by Medicare or any other plan • 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 • Over-the-counter medications	• Cosmetic surgery • Previously deducted or reimbursed expenses • Expenses incurred while an individual was not 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

Reimbursements from Your RRA

To be reimbursed for eligible healthcare expenses from your Retiree Reimbursement Account (RRA), you may file a claim online at **umr.com** or you may fax a completed retiree reimbursement request claim form with supporting documentation to **1-877-390-4782**. You may also mail the completed form and supporting documentation to:

UMR
P.O. Box 8022
Wausau, WI 54402-8022

If you have any questions regarding your RRA, including obtaining copies of any forms, please see below:

- Pre-Medicare-eligible retirees: Contact Quantum Health at **1-866-778-5885**
- Medicare-eligible retirees: Contact UMR at **1-800-826-9781**

Waiver of RRA Participation

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 Retiree Reimbursement Account Lump Sum Contribution to your RRA is irrevocable and will result in forfeiture of any remaining RRA credit balance. (The IRS considers an RRA to be employer-sponsored health coverage, and you will not 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 Retiree Reimbursement Account Lump Sum Contribution to the RRA before you become Medicare-eligible will not constitute a waiver of Retiree Medical Credits to your RRA when you and/or your spouse become Medicare-eligible.

Other Benefits for Retirees

As a Honda retiree, you also have access to the following benefits. For more information, please contact the My Benefits Connect Center at **1-866-778-5885** or see the sections listed below.

Benefit	Purpose
Supplemental Life Insurance	Allows you to continue coverage for you and your eligible dependents if elected prior to retirement. Continuation rates are determined by MetLife. (See “Supplemental Insurance Plans” on page 225 for more details.)
Group Legal Plan	Allows you to participate in the plan after your retirement by contacting ARAG at **1-800-247-4184**.
Group Auto and Homeowners Insurance	Allows you to purchase coverage at group rates; you can enroll at any time (See “Supplemental Insurance Plans” on page 225 for more details.)
Associate Assistance Program	Provides up to six confidential visits per incident per year to help manage various personal situations for you and your dependents/household (See “Other Benefits” on page 252 for more details.)

Administrative Information

This section contains information about the administration and funding of Honda benefit plans, as well as your rights as a plan participant. Although you will not need this information on a day-to-day basis, it is important for you to understand your rights and the procedures you need to follow should certain situations arise.

Important Note!

Honda's practices, policies and benefits for U.S. associates are outlined here and in other sections of this guide for your information as required by law. However, this document does not constitute an implied or express contract or guarantee of employment.

Please read the information presented in this guide carefully and keep it for future reference. If you have questions about this information or your Honda benefit plans, contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET.

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Health and Welfare Plans

The information below applies to the health and welfare benefit plans (healthcare, disability and life and accident insurance) sponsored by American Honda Motor Co., Inc.

Plan sponsor and 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.
Sponsor Employer Identification Number (EIN)	95-2041006
Participating Employer Identification Number (EIN)	• American Honda Motor Co. Inc. (AHM): 95-2041006 • American Honda Education Corporation (EDU): 33-0447685 • American Honda Foundation (FND): 95-3924667 • American Honda Finance Corp. (HFC): 95-3472715 • Drivemode, Inc. (DM): 46-3830399 • Honda Aircraft Company, LLC (HACI): 45-2820736 • Honda Aero, Inc. (HAI): 33-1099075 • Honda Development & Manufacturing of America, LLC (HDMA): 31-0925242 • Honda Performance Development, Inc. (HPD): 95-4406387 • Honda Power Equipment Manufacturing LLC (HPE): 56-1384425 • Honda Research Institute USA, Inc. (HRI): 48-1283217 • Honda R&D Innovations, Inc. (HISV): 82-0692156 • Honda Trading America Corp. (HTA): 95-2793569
Agent for service of legal process	American Honda Motor Co., Inc. Attn.: General Counsel 24025 Honda Parkway Marysville, OH 43040-9251 Telephone: 937-642-5000 Service of legal process may also be made upon a plan trustee or plan sponsor.
Plan year	Calendar year for all plans
Plan trustee (Voluntary Employees' Beneficiary Association (VEBA) trustee used for funding the Survivor Medical Insurance Program)	The Northern Trust Co. 50 South LaSalle St. Chicago, IL 60675

When referring to the benefit plans in claims appeals or other correspondence, you will need to identify a plan by its official name and number. This information is summarized below for all health and welfare plans sponsored by American Honda Motor Co., Inc.

Official Plan Name and Plan Number	Plans Included	Claims Administrator	Funding	Subject to ERISA
Honda Health & Welfare Benefits Plan Plan Number 515	Medical • HSA Plan and PPO Plan	**Pre-service medical claims (pre-certification) and appeals of both pre-service and post-service medical claims:** Quantum Health Care Coordinators by Quantum Health 7450 Huntington Park Drive, Suite 100 Columbus, OH 43235 **Post-service medical claims:** 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	General assets	Yes
	Medical • HMO Plan	**California:** Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004 **Georgia:** Kaiser Permanente Claims Administration P.O. Box 370010 Denver, CO 80237-9998 **Northwest:** Kaiser Permanente Claims Administration P.O. Box 370050 Denver, CO 80237-9998	Insured for Kaiser plans	Yes
	Associate Assistance Program	ComPsych NBC Tower, 13th Floor 455 N. Cityfront Plaza Drive Chicago, IL 60611-4020	General assets	Yes
	Prescription Drug	CVS/Caremark Customer Care Correspondence P.O. Box 6590 Lee's Summit, MO 64064-6590	General assets	Yes
	Dental	Delta Dental P.O. Box 9089 Farmington Hills, MI 48333-9089	General assets	Yes
	Vision	Vision Service Plan P.O. Box 385018 Birmingham, AL 35238-0518	General assets	Yes

Official Plan Name and Plan Number	Plans Included	Claims Administrator	Funding	Subject to ERISA
	Healthcare and/or Limited Purpose Flexible Spending Account	UMR P.O. Box 30541 Salt Lake City, UT 84130-0543	General assets	Yes
	Company-Paid Long-Term Disability (LTD)	New York Life P.O. Box 70915 Dallas, TX 75370-9015	Insured	Yes
	Associate Paid Long-Term Disability (LTD)	New York Life P.O. Box 70915 Dallas, TX 75370-9015	Insured	Yes
	Basic Life Insurance	MetLife Insurance P.O. Box 6100 Scranton, PA 18505-6100	Insured	Yes
	Accident Insurance	MetLife Insurance P.O. Box 6100 Scranton, PA 18505-6100	Insured	Yes
	Company-Paid Short-Term Disability (STD)	Sedgwick Claims Management Services, Inc. P.O. Box 14669 Lexington, KY 40512-4669	Self-funded	No
	Honda Disability Allowance	Sedgwick Claims Management Services, Inc. P.O. Box 14669 Lexington, KY 40512-4669	Self-funded	No
	Business Travel Insurance	AIG Domestic A&H Claims Department P.O. Box 25987 Shawnee Mission, KS 66225	Insured	Yes
Honda Dependent Care Reimbursement Plan Plan Number 508	Dependent Care Flexible Spending Account	UMR P.O. Box 30541 Salt Lake City, UT 84130-0543	General assets	No
Honda Supplemental Life Plan Plan Number 512	Supplemental Life Insurance	MetLife Insurance P.O. Box 6100 Scranton, PA 18505-6100	Insured	Yes
Honda Group Legal Plan Plan Number 513	Group Legal Plan	ARAG Group 500 Grand Ave. Suite 100 Des Moines, IA 50309	Insured	Yes
Honda Survivor Medical Program Plan Number 514	Extended medical coverage for surviving family members	Same as your post-service medical claims administrator or HMO claims administrator. Refer to the top of this table for contact information.	VEBA	Yes

Note: This guide is the official summary plan description of the plans and benefits identified as subject to ERISA in the table above. With the exception of the 401(k) Savings Plan and the Pension Plan, none of the other plans and benefits described in this guide are subject to ERISA.

Plan welfare benefits may not be pledged, assigned or garnisheed in payment of debt. A claims administrator may pay benefits directly to a service provider. However, the payment of benefits to a service provider is not an assignment of rights or benefits. The plan does not permit the assignment of rights or benefits.

Family and Medical Leave Act (FMLA)

According to federal law and Honda's policy, you may be eligible for an unpaid leave of up to 12 work weeks within a 52-week period for reasons covered by the Family and Medical Leave Act (FMLA)—or a one-time 26-week unpaid leave of absence to care for a covered service member. Please see your *Associate Handbook* for details.

During your FMLA leave, your Honda healthcare coverage (medical, prescription drug, dental and vision plans and Associate Assistance Program,) for yourself and your eligible dependents will be maintained under the same conditions as if you had been continuously working at Honda during your entire FMLA leave. You will be required to make payments for your benefits if applicable. Please see *Life* on page 8 of this SPD for more details on direct billing while on leave of absence.

How to Request an FMLA Leave

For information about how to request an FMLA leave, see your Associate Handbook.

If you acquire a new dependent while your healthcare coverage is continued during an approved FMLA leave, you may enroll your new dependent by calling the My Benefits Connect Center per the Life Events guidelines.

As is also the case for an associate not on FMLA leave, your healthcare coverage will end at the earliest of:

- The date you (or your dependent) cease being eligible for coverage
- The date the healthcare plan terminates
- The date as of which you stop making required contributions

If you do not return to work and you have a separation of employment, coverage will end according to plan guidelines. You may be eligible for healthcare coverage continuation under COBRA, as described under *COBRA* on page 204.

If you return to work upon the completion of your FMLA leave, your coverage will continue as though you had continued in employment.

The FMLA makes it unlawful for any employer to interfere with, restrain or deny the exercise of any right provided under the FMLA or discharge or discriminate against any person for opposing any practice made unlawful by the FMLA, or for participating in any proceeding under or related to the FMLA. An employee who believes his or her rights under the FMLA have been violated may file a complaint with the U.S. Department of Labor or may bring a civil action against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law that provides greater family or medical leave rights.

Honda Health Plan Notice of Privacy Practices

Important

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.

Notice of Privacy Practices—Application

This notice describes the privacy practices of the medical, prescription drug, dental and vision plans, Healthcare FSA and the Associate Assistance Program included in the Honda Health & Welfare Benefits Plan (the "Health Plan"). This notice does not apply to disability benefits, life insurance or any non-health-related 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 Health Plan in connection with your eligibility for or receipt of medical benefits under the Health Plan. Federal law requires that the Health Plan maintain the privacy of protected health information, give you this notice of the Health 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 Health Plan services. The current claims administrators are listed under "Contact Information" starting on page 326. 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 "Health Plan" includes third parties when performing services for the Health Plan. Protected health information may be shared among the components of the Health Plan, and the third parties providing services for components of the Health Plan, in the course of paying benefits and conducting Health Plan operations.

Use of Protected Health Information for Payment, Operations and Treatment

The Health Plan uses and discloses your protected health information for payment of benefits, Health Plan operations and treatment activities. The following paragraphs describe the ways that the Health Plan might use your protected health information for payment, Health 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 Health 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; coordinating benefits, reimbursement and subrogation; and responding to questions, complaints and appeals. For example, the Health 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 Health Plan may disclose information to your provider. The Health Plan may mail Explanation of Benefits (EOB) forms and other information to the associate, retiree or former associate at the address it has on record for the associate, retiree or former associate. You can also receive your EOB electronically at either **umr.com**, **bcbsal.org** or **kp.org**.

Health Plan Operations

The Health Plan will use and disclose your protected health information for Health 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 Health 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 Health Plan is prohibited from using or disclosing protected health information that is genetic information for underwriting purposes.

Treatment

The Health Plan may use or disclose your protected health information to facilitate medical treatment or services by providers. The Health Plan may disclose protected health information to doctors, dentists, pharmacies, hospitals and other healthcare providers who take care of you. For example, doctors may request medical information from the Health Plan to supplement their own records. The Health Plan may also send certain information to doctors for patient safety or other treatment-related reasons.

Disclosure to Others Involved in Your Healthcare

The Health 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 healthcare or payment for that care. For example, if a family member or a caregiver calls the Health Plan with prior knowledge of a claim, the Health Plan may confirm whether the claim has been received and paid. You have the right to stop or limit this kind of disclosure. See *Contacts* on page 354 for a list of current claims administrators.

Disclosures Authorized by You

The Health Plan will not use or disclose your protected health information for any reason other than those described in this notice unless you provide written authorization. For example, unless you provide written authorization, the Health 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 Health Plan.

You may give the Health Plan written authorization to use and/or disclose your protected health information to anyone for any purpose. If you give the Health 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 Health Plan will share enrollment information about you and your family members with Honda. The Health Plan will also periodically disclose protected health information to the My Benefits Connect Center and American Honda Benefits Department so that the My Benefits Connect Center and/or the American Honda Benefits Department can assist participants with benefit questions and oversee the administration of the Health Plan. The My Benefits Connect Center and American Honda Benefits

Department will only use the protected health information for participant assistance and Health 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-related benefits or another employee benefit plan sponsored by Honda affiliates
- 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 subcontractors) to whom Honda provides protected health information received from the Health Plan agree to the same restrictions and conditions that apply to Honda with respect to such information
- Report to the Health Plan's Privacy Officer any use or disclosure of protected health information that is inconsistent with the uses or disclosures provided in this notice of which Honda becomes aware
- Confirm that the Health Plan makes your protected health information available to you for access, amendment and/or accounting
- Make internal practices, books and records relating to the use and disclosure of protected health information received from the Health Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Health Plan with federal law
- Return protected health information to the Health 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 health 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 the My Benefits Connect Center and American Honda Benefits Department and the other departments of Honda by utilizing reasonable and appropriate security measures so that protected health information received by the My Benefits Connect Center and/or American Honda Benefits Department is not disclosed to associates in other departments of Honda in violation of this notice. Honda staff members who work 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 the My Benefits Connect Center and American Honda Benefits Department creates, receives, maintains or transmits on behalf of the plan
- Ensure that any agents (including subcontractors) who provide such electronic protected health information agree to implement reasonable and appropriate security measures to protect such electronic protected health information
- Report to the Health Plan any security incident of which any agent becomes aware

Other Uses of Protected Health Information

- **Communications about Benefits.** The Health 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 Health 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 Health Plan may disclose protected health information to federal, state and local law enforcement officials. The Health Plan may release protected health information if asked to do so by a law enforcement official in response to a court or administrative order, valid subpoena, warrant, summons or similar process, to identify or locate a suspect, fugitive, material witness or missing person, about the victim of a crime if, under certain limited circumstances, the Health Plan is unable to obtain the victim's agreement, about a death the Health Plan believes may be the result of criminal conduct, and, in emergency circumstances, to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **Legal Proceedings.** The Health 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 Health Plan may disclose your protected health information in response to a court or administrative order. The Health 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 Health Plan may disclose protected health information to address matters of public interest as required or permitted by law. The Health 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, for 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 Health Plan believes a patient has been the victim of abuse, neglect or domestic violence.
- **Governmental Regulation.** The Health 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, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor group health plans, the healthcare system, government programs and compliance with civil rights laws.
- **Coroners, Medical Examiners and Funeral Directors.** The Health 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 Health Plan may also release protected health information to funeral directors as necessary to carry out their duties.
- **Organ and Tissue Donation.** The Health 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 Health 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 Health Plan may disclose protected health information to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent or lessen the threat. For example, the Health Plan may disclose your protected health information in a proceeding regarding the licensure of a physician.
- **Military and Veterans.** The Health Plan may disclose protected health information if you are a member of the armed forces, as required by military command authorities. The Health Plan may also disclose protected health information about foreign military personnel to the appropriate foreign military authority.
- **National Security and Intelligence Activities.** The Health Plan may disclose protected health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
- **Inmates.** The Health Plan may disclose protected health information to a correctional institution or law enforcement official if you are an inmate of the correctional institution or under the custody of the law enforcement official. This disclosure would be necessary (a) for the institution to provide you with healthcare; (b) to protect your health and safety or the health and safety of others; or (c) for the safety and security of the correctional institution.
- **Workers' Compensation.** The Health 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 Health 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 Health 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 Health Plan is incorrect or incomplete, you may ask the Health Plan to amend that information. Your request must be made in writing and include the reason for the request. The Health Plan may deny your request if you ask the Health Plan to amend information that:
  - Is not part of the protected health information kept by or for the Health Plan;
  - Was not created by the Health Plan, unless the person or entity that created the information is no longer available to make the amendment; or
  - Is not part of the information that you would be permitted to inspect and copy—or is accurate and complete. If the Health Plan denies the request, you may file a written statement of disagreement with the plan administrator.
- Get a list of certain disclosures the Health 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

healthcare operations. Your request must be made 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 Health Plan will charge a reasonable fee.

- Request that the Health Plan communicate with you at an alternative location (for example, by sending materials to a P.O. box instead of the associate's home address) if you believe that normal communications would endanger you or you have other good cause. The Health Plan will accommodate reasonable requests.
- Request restrictions as to the ways that the Health Plan uses or discloses your protected health information. The Health 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 Health 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 Health 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 benefits:

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

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

  Blue Cross Blue Shield of Alabama
  Legal Support Services Department
  450 Riverchase Parkway East
  P.O. Box 995
  Birmingham, AL 35298-0001

California:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

Georgia:
Kaiser Permanente
Claims Administration
P.O. Box 370010
Denver, CO 80237-9998

Northwest:
Kaiser Permanente
Claims Administration
P.O. Box 370050
Denver, CO 80237-9998

Kaiser plans include prescription drug benefits as well.

- For matters concerning prescription drug benefits (HSA and PPO Plans only):

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

- For matters concerning dental benefits:

  Delta Dental
  P.O. Box 9089
  Farmington Hills, MI 48333-9089

- For matters concerning vision benefits:

  Vision Service Plan
  3333 Quality Drive
  Rancho Cordova, CA 95670

- For matters concerning the Associate Assistance Program:

  ComPsych
  NBC Tower, 13th Floor
  455 N. Cityfront Plaza Drive
  Chicago, IL 60611

- For matters concerning the Healthcare FSA:

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

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

  My Benefits Connect Center
  P.O. Box 661155
  Dallas, TX 75266-1155

Questions and Complaints

If you have questions regarding this notice, you may contact the Health Plan's Privacy Officer, c/o American Honda Motor Co., Inc., 24025 Honda Parkway, Marysville, Ohio 43040-9251, **1-937-642-5000**, extension 47082. You may also direct questions to the claims administrators listed under "Contact Information" starting on page 326.

You have the right to file a written complaint with the Health 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 Health Plan's Privacy Officer will investigate and address any issues of noncompliance with this notice of which he or she is notified or becomes aware.

Changes to This Notice

This notice is effective April 1, 2021. Honda may change the terms of this notice and the Health 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 Health 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.

Retirement Plans

The information below applies to the Honda Pension and 401(k) Savings Plans.

	Pension Plan	**401(k) Savings Plan**
Plan sponsor	American Honda Motor Co., Inc. 1919 Torrance Blvd. Torrance, CA 90501-2746 Telephone: 1-310-783-2000	American Honda Motor Co., Inc. 1919 Torrance Blvd. Torrance, CA 90501-2746 Telephone: 1-310-783-2000
Sponsor Employer Identification Number (EIN)	95-2041006	95-2041006
Participating Employer EIN*	American Honda Motor Co., Inc.: 95-2041006	American Honda Motor Co., Inc.: 95-2041006
Agent for services of legal process	American Honda Motor Co., Inc. Attn: Secretary 1919 Torrance Blvd. Torrance, CA 90501-2746 Telephone: 1-310-783-2000 Service of legal process may also be made upon the Honda Retirement Plan Committee or the Trustee of the Plan.	American Honda Motor Co., Inc. Attn: Secretary 1919 Torrance Blvd. Torrance, CA 90501-2746 Telephone: 1-310-783-2000 Service of legal process may also be made upon the Honda 401(k) Savings Plan Committee or the Trustee of the Plan.
Plan year	Fiscal year (April 1 – March 31)	Calendar year (January 1 – December 31)

	Pension Plan	401(k) Savings Plan
Plan administrator	The Pension Plan is administered by the Honda Retirement Plan Committee. Correspondence or inquiries may be addressed to: Honda Retirement Plan Committee c/o Benefits Department American Honda Motor Co., Inc. 24025 Honda Parkway Marysville, OH 43040-9251 Telephone: 1-937-642-5000	The 401(k) Savings Plan is administered by the Honda 401(k) Savings Plan Committee. Correspondence or inquiries may be addressed to: Honda 401(k) Savings Plan Committee c/o Benefits Department 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 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.

*A list of other participating employers and EINs is available upon request by contacting the AHM Benefits Department at **regional_retirement@ahm.honda.com**.

When referring to the benefit plans in claims appeals or other correspondence, you will need to identify a plan by its official name and number.

Official Plan Name and Plan Number	Type of Plan	Trustee
Honda Retirement Plan Plan Number 334	Pension Plan, a defined benefit plan	The Northern Trust Company 50 South LaSalle Street Chicago, IL 60675 All plan assets are held in trust by the trustee.
Honda 401(k) Savings Plan Plan Number 335	401(k) Savings Plan, a defined contribution 401(k) plan	Fidelity Investments Institutional Operations Company, Inc. 82 Devonshire Street Boston, MA 02109 1-800-835-5095 401k.com All plan assets are held in trust by the trustee.

Pension and 401(k) Savings Plan Limits

Federal tax laws impose certain limitations on the benefits and contributions under tax-qualified pension and savings plans. For example, the IRS limits are:

- Your combined pre-tax and Roth 401(k) contributions to the Honda 401(k) Savings Plan and other individual account plans (for 2021, this limit is $19,500 if an individual is not eligible to make catch-up contributions, and $26,000 if an individual is eligible to make catch-up contributions)
- Total annual 401(k) Savings Plan contributions made by you and Honda if you are under age 50 (for 2021, this limit is $58,000 or 100% of pay if less)
- Total annual 401(k) Savings Plan contributions made by you and Honda if you are age 50 or over (for 2021, this limit is $64,500 or 100% of pay if less)
- The annual benefit the Pension Plan can pay to a participant (for 2021, this amount is $230,000)
- The amount of compensation that can be used to determine your benefits under each plan (for 2021, this limit is $290,000)

The limitations imposed are subject to change annually. Further restrictions on benefit payments may apply to highly paid employees. More information on these limits can be found at **irs.gov/pub/irs-tege/cola_table.pdf**.

If the Plans Become Top-Heavy

Tax laws require the Pension and 401(k) Savings Plans to include provisions that would take effect if the plans become "top-heavy." A plan is considered top-heavy if 60% or more of the value of all plan benefits are allocated to a small group of senior associates. It is unlikely that the Honda Pension Plan or 401(k) Savings Plan will become top-heavy. A more detailed explanation of these provisions will be provided if necessary.

Assignment of Benefits Under a Qualified Domestic Relations Order (QDRO)

Call the My Benefits Connect Center at **1-866-778-5885** and request a transfer to the Qualified Order Team or email the team at **QOCenter@alight.com**. You will receive a response within two business days.

My Benefits Connect Center
Attention Qualified Order Center
P.O. Box 7144
Rantoul, IL 61866-7144
Fax: **1-847-883-9313**

Alternatively, orders may be uploaded to the Qualified Order Center website at **QOCenter.com**. Except as required by law or applicable court order (such as a QDRO), your benefits under the Pension and 401(k) Savings Plans may not be pledged, assigned or garnisheed in payment of any debts.

A QDRO is a legal judgment, decree or order that may be issued if you become legally separated or divorced. The QDRO may assign a portion of your benefit under the Pension Plan, Savings Plan, or both, to a spouse, former spouse, child or other dependent.

The QDRO must meet specific requirements to be recognized by the plan administrator.

Fees Associated with QDROs for the 401(k) Savings Plan

A QDRO processing fee of $650 will apply after the initial order is received. The order cannot assign the fee to the Alternate Payee.

If the Pension or 401(k) Savings Plan Ends

In the event the *Pension Plan* is ended, you will have a vested right to the accrued benefit you have earned. The amount of your benefit, if any, will depend on plan assets and terms and will be allocated according to rules set by the Pension Benefit Guaranty Corporation (PBGC), see below for information. After benefits have been paid and legal requirements met, the plan will turn over any remaining assets to the plan sponsor and its participating employers.

In the event the *401(k) Savings Plan* terminates, you have a right to receive your entire account balance.

Pension Benefit Guaranty Corporation (PBGC)

Your benefits under the Pension Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most individuals receive all of the pension benefits they would have received under their plan, but some individuals may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits
- Deferred vested benefits
- Disability benefits if you become disabled before the plan terminates
- Certain benefits for your survivors

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates
- Some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than five years at the time the plan terminates
- Benefits that are not vested because you have not worked long enough for Honda
- Benefits for which you have not met all of the requirements at the time the plan terminates
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay

Even if certain benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the plan has and on how much the PBGC collects from Honda.

Benefits under the 401(k) Savings Plan are held in an account for your benefits under the plan. Because you are entitled to your entire account if the 401(k) Savings Plan is terminated, benefits under the plan are not insured by the PBGC.

For more information about the PBGC and the benefits it guarantees, contact the plan administrator or the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000**. Additional information about the PBGC's pension insurance program is available through the PBGC's website at **pbgc.gov**.

Claims and Appeals

In General

Contact information for claims administrators for health and welfare benefits

- For medical benefits:

  Pre-service medical claims (pre-certification):

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

  An urgent pre-service claim can be filed by calling Quantum Health at **1-866-778-5885**.

  Post-service medical claims:

  UMR or Blue Cross Blue Shield of Alabama
  Use the address on your ID card.

  Not applicable to the Kaiser HMO.

  Appeals of both pre-service and post-service medical claims:

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

  An urgent appeal of a pre-service claim can be filed by calling Quantum Health at **1-866-778-5885**.

- For prescription drug benefits:

  Prescription drugs other than specialty drugs:

  CVS/Caremark, Inc.
  Appeals Department
  MC109
  P.O. Box 52084
  Phoenix, AZ 85072-2084
  Fax number: **1-866-443-1172**

  Specialty prescription drugs:

  CVS/Caremark, Inc.
  Specialty Guideline Management
  Appeals Department
  800 Biermann Court, Suite B
  Mt. Prospect, IL 60056
  Fax number: **1-855-230-5548**

  If the appeal is urgent, please have the physician call **1-866-443-1183** to have an appeal started over the phone.

Not applicable to the Kaiser HMO.

- For a Kaiser HMO (medical and prescription drug benefits):

  Kaiser Permanente (Northern California):

  Kaiser Foundation Health Plan, Inc.
  P.O. Box 23219
  San Diego, CA 92193-3219

  An urgent pre-service appeal can be filed by calling **1-800-464-4000**.

  Kaiser Permanente (Southern California):

  Kaiser Foundation Health Plan, Inc.
  P.O. Box 23758
  San Diego, CA 92193-3758

  An urgent pre-service appeal can be filed by calling **1-800-464-4000**.

  Kaiser Permanente (Georgia):

  Kaiser Permanente
  Appeals Department
  3495 Piedmont Rd. NE
  Atlanta, GA 30305

  An urgent pre-service appeal can be filed by calling **1-800-464-4000**.

  Kaiser Permanente (Northwest):

  Kaiser Permanente
  Claims Administration
  P.O. Box 370050
  Denver, CO 80237-9998

  An urgent pre-service appeal can be filed by calling **1-800-464-4000**.

- For dental benefits:

  Delta Dental
  Dental Director
  P.O. Box 30416
  Lansing, MI 48909-7916

- For vision benefits:

  Vision Service Plan
  Attn: Appeals Dept.
  P.O. Box 2350
  Rancho Cordova, CA 95741
  Phone number: **1-800-877-7195**

- For the Associate Assistance Program:

  ComPsych
  NBC Tower, 13th Floor

455 N. Cityfront Plaza Drive
Chicago, IL 60611

Note: For appeals, be sure to add "Attention: Appeals."

- For Flexible Spending Accounts:

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

- For long-term disability:

  New York Life
  P.O. Box 709015
  Dallas, TX 75370-9015
  Fax number: **1-800-642-8553**

- For short-term disability and Honda Disability Allowance:

  Sedgwick National Appeals Unit (NAU)
  P.O. Box 14446
  Lexington, KY 40512-4446
  Fax number: **1-888-488-9536**

- For life and accident insurance:

  MetLife Group Life Claims
  P.O. Box 6100
  Scranton, PA 18505-6100

- For business travel insurance:

  AIG Domestic
  A&H Claims Department
  P.O. Box 25987
  Shawnee Mission, KS 66225

- For Group Legal Plan:

  ARAG Group
  500 Grand Ave., Ste 100
  Des Moines, IA 50309

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 plans in accordance with their terms and applicable law. Honda has the right to delegate its discretionary authority and responsibilities for the administration of the plans to others and employ others to carry out or give advice with respect to its responsibilities under the plans. Honda has, through this document, delegated discretionary authority for the administration and determination of claims and appeals to any and all claims administrators for its health and welfare plans. 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 for a health or welfare plan is the insurer or third-party administrator that administers the plan and decides claims and appeals for benefits under that

plan. In all circumstances relating to any claim or appeal for benefits under any 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 healthcare provider with knowledge of your condition may act as your authorized representative. An appeal filed by a healthcare provider is not an appeal under the plan unless the healthcare 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 any 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 any of the plans must be brought in the United States District Court for the Southern District of Ohio, Eastern Division.

Exhaustion of internal appeals process for medical and prescription drug benefits

Generally, you are required to complete all appeal processes of the plan before being able to bring an action in litigation (or, in the case of certain medical and prescription drug claims, external review). However, if the claims administrator for a medical or prescription drug plan, 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 Section 502(a) of ERISA (or, in the case of certain medical and prescription drug claims, external review).

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to litigation (or external review) 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 (or external reviewer) 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 (or external reviewer) 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 will begin to run upon your receipt of such notice.

Insured benefits

If you are enrolled in an insured plan, also consult your insurance certificate for additional information on filing a claim for benefits and appealing the denial of a claim.

Claims and Appeals for Pre-Service Health Benefits

Application

If a health 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 made in writing and will include:

- Information identifying the claim involved;
- The reasons for the denial and, if applicable, the denial code and its meaning;
- 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.

In the case of an urgent claim, notice of the decision may be provided orally 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 the claim was 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 made in writing and will include:

- Information identifying the claim involved;
- Reasons for the decision and, if applicable, the denial code and its meaning;
- 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;
- A discussion of the decision and, 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 provided orally 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 healthcare professional. The healthcare professional will not be a healthcare professional who was consulted in connection with the decision on the claim (or a subordinate of a healthcare 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.

For certain claims, you have the option to request a voluntary second appeal and/or external review. However, the decision on your first appeal exhausts the appeals process. You are not required to request a voluntary second appeal or external review before taking legal action.

Voluntary Second Appeal for Pre-Service Claims

A voluntary second appeal is available if the first appeal of a medical, prescription drug, or vision claim is denied (with the exception of the Kaiser HMO, which does not offer a voluntary second appeal). If your pre-service claim is denied on first appeal and the plan offers a voluntary second appeal, you may ask the claims administrator for a second review. 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 the claim was 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 healthcare professional. The healthcare professional will not be a healthcare professional who was consulted in connection with the decision on the claim or the first appeal (or a subordinate of a healthcare professional who was consulted in connection with the decision on the claim or the first appeal).

Concurrent Care Decisions for Health Benefits

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

A claim for health benefits is a claim under a medical, prescription drug, dental or vision plan, Healthcare FSA or Associate Assistance Program. Except where a health plan requires that you pre-certify an expense in order to receive coverage, reimbursement or avoid a reduction in reimbursement, a claim for benefits under the health plan will be subject to the procedures in this section. See "Claims and Appeals for Pre-Service Health Benefits" on page 336 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 one-year time 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 made in writing and will include:

- Information identifying the claim involved;
- The reasons for the denial and, if applicable, the denial code and its meaning;
- 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.

The claims administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with your claim.

You will also receive notice, and the appeal process described below will apply, in the event of a rescission of coverage.

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 the claim was 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 made in writing and will include:

- Information identifying the claim involved;
- Reasons for the decision and, if applicable, the denial code and its meaning;
- 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;
- A discussion of the decision and, 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 healthcare professional. The healthcare professional will not be a healthcare professional who was consulted in connection with the decision on the claim (or a subordinate of a healthcare 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.

For certain claims, you have the option to request a voluntary second appeal and/or external review. However, the decision on your first appeal exhausts the appeals process. You are not required to request a voluntary second appeal or external review before taking legal action.

Voluntary Second Appeal

A voluntary second appeal is available if the first appeal of a medical, prescription drug, or vision claim is denied (with the exception of the Kaiser HMO, which does not offer a voluntary second appeal). If your claim is denied on first appeal and the plan offers a voluntary second appeal, you may ask the claims administrator for a second review. 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 the claim was 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).

External Review of Denied Appeal for Certain Health Benefits

If your appeal for health benefits is denied, you may have the option for an independent external review of the denial. A request for external review of a post-service or non-urgent pre-service denied appeal must be submitted, in writing, to the claims administrator within four months (123 days) after the date of the notice of denial of the final internal appeal. This deadline is tolled while a voluntary appeal is pending. In the case of an urgent pre-service appeal, you have the option to simultaneously pursue an internal appeal and external review. The request for external review of an urgent pre-service claim or appeal may be oral. You must contact the claims administrator with sufficient information to identify the claimant and the claim and the reasons for the expedited process.

External review is generally limited to denied appeals for medical and prescription drug benefits that involve medical judgment (for example, medical necessity or a determination whether a treatment is experimental or investigational) or rescission. A rescission is a cancellation or discontinuance of coverage that has retroactive effect for a reason other than the failure to make contributions. External review is not available for decisions related to an individual's eligibility, Healthcare FSA benefits, dental benefits, vision benefits or the Associate Assistance Program.

Preliminary Review

Within five business days following the date of receipt of the request, the claims administrator must provide a preliminary review determining whether you were covered under the plan at the time the service was requested or provided; the determination does not relate to eligibility; you have exhausted the internal appeals process (unless Deemed Exhaustion applies); and you have provided all paperwork necessary to complete the external review and you are eligible for external review.

Within one business day after completion of the preliminary review, the claims administrator will notify you in writing. If the request is complete but not eligible for external review, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (**1-866-444-EBSA** (3272)). If the request is not complete, the notice will describe the information or materials needed to make the request complete, and the claims administrator will allow you to finalize the request for external review within the four-month (123-day) filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to an External Review Organization (ERO)

The claims administrator will assign an accredited external review organization (ERO) to conduct the external review. The assigned ERO will notify you in writing of the request's eligibility and acceptance for external review. The ERO will provide an opportunity for you to submit in writing, within the 10 business days following the date of receipt of the notice, additional information that the ERO must consider when conducting the external review.

Decision by the ERO

Within one (1) business day after making the decision, the ERO will notify you, the claims administrator and the plan.

The ERO will review all of the information and documents received in a timely manner. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending healthcare professional's recommendation;
- Reports from appropriate healthcare professionals and other documents submitted by the plan or issuer, you or your treating provider;
- The terms of your plan to ensure that the ERO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;

- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the external review decision within 45 days after the ERO receives the request for the external review. The notice will include:

- A general description of the reason for the request for external review;
- Date of assignment to the ERO;
- References to evidence or documentation considered in reaching a decision;
- Discussion of principal reasons for decision; and
- Statement that the ERO's determination is binding except that judicial review may be available.

The ERO must deliver the notice of external review decision to you, the claims administrator and the plan. Upon receipt of a notice of an external review decision reversing the denial of a final appeal, the plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

After an external review decision, the ERO must maintain records of all claims and notices associated with the external review process for six years. An ERO must make such records available for examination by the claimant, plan or federal oversight agency upon request, except where such disclosure would violate federal privacy laws.

Expedited external review process

The plan will allow you to request an expedited external review at the time you receive:

- An adverse benefit determination on a claim if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- An adverse benefit determination on a final internal appeal, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the adverse benefit determination on the appeal concerns an admission, availability of care, continued stay, or healthcare item or service for which you received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the claims administrator will determine whether the request meets the reviewability requirements set forth above for standard external review. The claims administrator must immediately send you a notice of its eligibility determination.

Upon a determination that a request is eligible for external review following preliminary review, the claims administrator will assign an ERO. The ERO will render a decision as expeditiously as your

medical condition or circumstances require but in no event more than 72 hours after the ERO receives the request for an expedited external review. If the notice is not provided in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, the claims administrator and the plan.

Informal Inquiries Regarding Dental Benefits

If you receive notice of an adverse benefit determination and you think that Delta Dental incorrectly denied all or part of your claim, you or your dentist may contact Delta Dental's Customer Service Department and ask them to check the claim to make sure it was processed correctly. You can do this by calling, **1-866-863-7522** and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems or submit an explanation or additional information that might indicate your claim was improperly denied and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to recheck its initial determination, you can request a formal review using the formal claims appeal procedure.

Claims and Appeals for Disability Benefits

Application

Claims for disability benefits and claims that would require a finding of disability (such as a request for a waiver of premiums for life insurance during a period of disability) will be subject to the procedures in this section. Note that this section does not apply to all disability benefits. This section does not apply to benefits that are exempt from ERISA (such as short-term disability benefits paid out of Honda's general assets). Contact Sedgwick for the appeals process applicable to disability benefits that are exempt from ERISA.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, you are asked not to provide any genetic information when responding to a request for medical information in connection with disability benefits. "Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Processing a Claim

When a claim for benefits is presented to the claims administrator for payment, it will usually be processed within 45 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 up to two 30-day extensions. 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 your claim is denied. The notice will be made 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);
- Either: (a) a copy of the specific rule, guideline, protocol, standard or other similar criterion relied upon in making an adverse determination; or (b) a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- A discussion of the decision, including the basis for disagreeing with your treating physician, other medical or vocational experts who gave advice to the claims administrator, and/or a disability determination by the Social Security Administration.

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.

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 the claim was 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.

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 healthcare professional. The healthcare professional will not be a healthcare professional who was consulted in connection with the decision on the claim (or a subordinate of a healthcare professional who was consulted in connection with the decision on the claim). The claims administrator will give you any new evidence generated in connection with your appeal so that you will have the opportunity to respond to the new evidence.

Review Procedure

A decision on your appeal will normally be made within 45 calendar days. If the claims administrator needs to take an extension due to special circumstances, you will be notified of the circumstances requiring the delay and the date that the claims administrator expects to make a decision. The extension will not exceed an additional 45 calendar days.

If the claims administrator reviews your disability claim based on new or additional rationale, the claims administrator will provide you, free of charge, with the rationale sufficiently in advance of the date of the notice of adverse benefit determination to give you a reasonable opportunity to respond. Similarly, if the claims administrator plans to issue an adverse benefit determination regarding your disability claim, the claims administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim sufficiently in advance of the date of the notice of adverse benefit determination to give you a reasonable opportunity to respond.

Notice of the decision will be made 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;
- A statement of your right to bring an action under Section 502(a) of ERISA and the deadline for bringing an action;
- Either: (a) the specific rule, guideline, protocol, standard or other similar criterion relied upon in making an adverse determination; or (b) a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- A discussion of the decision, including the basis for disagreeing with your treating physician, other medical or vocational expert who gave advice to the claims administrator, and/or a disability determination by the Social Security Administration.

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.

Claims and Appeals for Life Insurance and Other Welfare Benefits

Processing a Claim

For insured benefits, check your insurance certificate for how much time you or your beneficiary have after a loss to file a claim.

When a claim for benefits is presented to the claims administrator for payment, it will usually be processed within 90 calendar days. If due to special circumstances the claims administrator needs more time to decide a claim, it may take up to a 90-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 your claim is denied. The notice will be made 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; and
- An explanation of the appeal procedure (including your right to file suit following an appeal).

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 60 calendar days after the date the claim was 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

A decision on your appeal will normally be made within 60 calendar days. If the claims administrator needs to take an extension due to special circumstances, you will be notified of the circumstances requiring the delay and the date by which the claims administrator expects to make a decision. The extension will not exceed an additional 60 calendar days.

Notice of the decision will be made in writing and will include:

- Reasons for the decision;
- References to specific plan provisions on which the decision is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claimant's claim for benefits; and
- A statement of the claimant's right to bring an action under Section 502(a) of ERISA.

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 the claimant is 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.

Retirement Benefits

Claims and Appeals Procedure—Other Than Disability

If you file a claim for your benefit under the Pension Plan or the 401(k) Savings Plan and your claim is denied in whole or in part, you will be notified in writing. The notification will include:

- The reason for the denial;

- The specific references to the plan provisions on which the denial is based;
- A description of any more material needed to complete your claim and why it is needed; and
- An explanation of the plan's claims review procedures, including an explanation of your right to bring a civil action under section 502(a) of ERISA following an adverse determination on appeal.

Generally, you should receive the notice 90 days after the claim is filed or in special cases, within 180 days after the claims administrator receives your request. In the event an extension is necessary, the claims administrator will notify you before the original deadline explaining the circumstances requiring the delay and the date when the claims administrator expects to make a decision.

If your claim is denied and if you believe that you were improperly denied benefits under the plan, you have the right to have your claim denial reviewed. To do so, you must submit a written request to the claims administrator of that plan within 60 days of receiving the notice of denial. For Pension Plan and 401(k) Savings Plan appeals, the claims administrator is the plan administrator. If possible, you should include any documents or records that support your appeal. You have the right to review all pertinent plan documents.

You will receive a written decision on your appeal within 60 days of the date the claims administrator receives your request or in special cases, within 120 days after the claims administrator receives your request. If special circumstances require a delay, you will be notified of the extension during the 60 days following the receipt of your request or request for review.

If your appeal is denied, in whole or in part, the Plan Administrator or its official will send you a notification in writing. That notification will include:

- The specific reason or reasons for the decision;
- The specific references to the 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; and
- A statement regarding your right to bring an action under Section 502(a) of ERISA.

Claims and Appeals Procedure—Disability

Certain claims under the Pension Plan require the Plan Administrator to make a determination as to whether you are "disabled" under the terms of the Pension Plan. These claims have a different claims and appeals procedure than other claims under the Pension Plan. These disability claims will generally follow the procedures set forth in "Claims and Appeals for Disability Benefits," above. However, the claims administrator for claims involving determinations of disability under the Pension Plan shall be the Plan Administrator.

Statute of Limitations and Venue

Any legal proceeding to recover denied benefits under the Pension Plan or the 401(k) Savings 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. Lawsuits brought against any of the plans, Honda or the Plan Administrator must be brought in the United States District Court for the Southern District of Ohio, Eastern Division.

If a claim for benefits or request for review is denied, you have certain rights under the law. For more information, see the "Statement of ERISA Rights" on page 350.

Notice Regarding Wellbeing Program

Connect to Your Wellbeing is a voluntary wellbeing program available to all associates and spouses covered by Honda's medical plan. The program is administered according to federal rules permitting employer-sponsored wellbeing programs that seek to improve associate health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act of 1996, as applicable, among others. If you choose to participate in the wellbeing program, you will be asked to complete a voluntary Wellbeing Assessment that asks a series of questions about your health-related activities and behaviors and your health status. You will also be asked to complete a Know Your Numbers biometric screening, which will include a blood test to assess blood glucose and cholesterol levels as well as blood pressure and body mass index (BMI) measurement. Additionally, you will be asked to join at least one wellbeing challenge from among various choices and receive a preventive exam by your primary care physician. You are not required to complete the Wellbeing Assessment, to participate in the blood test or other medical examinations, or to join a wellbeing challenge.

Note: Because of the COVID-19 pandemic, some wellbeing challenges are being replaced with alternatives that can be met in safer, more socially distant conditions. See *Connect to Your Wellbeing* on page 83.

Although you are not required to complete the Wellbeing Assessment or participate in the biometric screening, preventive exam or join a challenge, only associates who do so and earn the required number of points will be eligible for the medical plan contribution reduction. All associates are eligible for the same medical plans and the same medical plan contribution reductions.

Additional points and incentives are available for associates who participate in other health-related activities. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the My Benefits Connect Center at **1-866-778-5885**.

The information from your Wellbeing Assessment and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and make decisions about your own health. You also are encouraged to share your results or concerns with your doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellbeing program and Honda may use the aggregate information it collects to design a program based on identified health risks in the population, *Connect to Your Wellbeing* will never disclose any of your personal information either publicly or to Honda, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellbeing program, or as expressly permitted by law. Any medical information that personally identifies you that is provided in connection with the wellbeing program will not be provided to your supervisors or managers and can never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellbeing program. Also, you will not be required to waive the confidentiality of your health information as a condition of participating in

the wellbeing program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellbeing program will abide by the same confidentiality requirements. Only biometric screeners and health coaches will receive your personally identifiable health information in order to provide you with the wellbeing program services in which you have voluntarily enrolled.

In addition, all medical information obtained through the wellbeing program will be maintained separately from your personnel records, information stored electronically will be encrypted and no information you provide as part of the wellbeing program will be used in making any employment decision. Strict precautions are taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellbeing program, we will notify you immediately.

You will not be discriminated against in employment because of the medical information you provide as part of participating in the wellbeing program, nor will you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the My Benefits Connect Center at **1-866-778-5885**.

Statement of ERISA Rights

As a participant in Honda's associate benefit plans, you have certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. The benefit programs offered under the following plans are subject to ERISA:

- Honda Health & Welfare Benefits Plan (Plan Number 515)
- Honda Supplemental Life Plan (Plan Number 512)
- Honda Group Legal Plan (Plan Number 513)
- Honda Survivor Medical Program (Plan Number 514)
- Honda Retirement Plan (Plan Number 334)
- Honda 401(k) Savings Plan (Plan Number 335)

ERISA provides that all plan participants will be entitled to:

Receive Information about Your Plan and Benefits

You can examine, without charge, at the plan administrator's office and at other specified locations, all documents governing the plan. These documents include:

- **Plan Documents and Insurance Contracts.** You can obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, a list of participating employers and an updated Summary Plan Description. The administrator may make a reasonable charge for the copies. You can also obtain, without charge, a copy of the plan's qualified domestic relations order or medical child support order procedures.
- **A Copy of the Latest Annual Report (Form 5500 Series)** filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. You can 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.

- **Statement Showing Your Estimated Benefits, If Any, at Normal Retirement.** A benefit statement must generally be provided at least once every three years (or, in lieu of statements every three years, an annual notice that the statement is available can be provided) to each participant in the Pension Plan with a nonforfeitable accrued benefit and who is employed by the employer maintaining the plan at the time the statement is to be furnished, and to a participant or beneficiary upon written request. A benefit statement must generally be provided at least once each calendar quarter to each participant or beneficiary in the 401(k) Savings Plan who has the right to direct the investment of assets in his or her account, or upon written request to all other beneficiaries.

  For the Pension Plan, the statement must indicate, on the basis of the latest information available, the total benefits accrued and the nonforfeitable benefits, if any, that have accrued or the earliest date on which benefits will become nonforfeitable. For the 401(k) Savings Plan, the statement must also include the value of each investment to which assets have been allocated, determined as of the plan's most recent valuation date, an explanation of any limitations or restrictions on any right of the participant or beneficiary to direct the investment, and the importance of a well-diversified portfolio.

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 benefits 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, 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 you have a claim for benefits that is ignored, or a final appeal that is denied or ignored in whole or in part, you may file suit in a state or federal court. 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 court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, 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 domestic relations order or 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

You have the right to continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may need to pay for such coverage. Review this *Guide to Your Benefits* and the documents governing the plan on the rules governing your 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 at **dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices** or 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 can also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

Plan Documents

This guide serves as the Summary Plan Description of the 401(k) Savings Plan and the Pension Plan, but it is not considered the plan document for the 401(k) Savings Plan or the Pension Plan. The guide is a summary of the most important provisions of the Pension Plan and 401(k) Savings Plan. It does not state all of the terms and conditions of the plans but is intended to provide you with a general understanding of how the plans operate. The detailed provisions are found in the official plan documents, which legally govern the operation of the plans. A copy of the official plan documents can be obtained upon request from the Plan Administrator.

The Honda Health & Welfare Plan is subject to ERISA. Insured welfare plans are also subject to the terms of the insurance certificates. For the insured welfare plans subject to ERISA, this Summary Plan Description plus the insurance certificates serve as the official plan documents. For the other welfare plans subject to ERISA, this Summary Plan Description also serves as the official plan document.

Future of the Plans

This guide describes the benefits currently available to associates of the participating employers.

Honda reserves the right to terminate, suspend, withdraw, amend or modify the plans, covering any active associate or retiree in whole or in part at any time. Any such change or termination in benefits:

- Will be based solely on the decision of the plan sponsor; and
- May apply to all active associates and/or retirees.

No amendment or termination would eliminate or reduce benefits accrued to date under the Pension Plan or the 401(k) Savings Plan. If either the Pension Plan or the 401(k) Savings Plan were to be terminated, accrued benefits or account balances of affected participants would become 100% vested. All amendments to the Pension Plan and the 401(k) Savings Plan will be adopted in writing by the plan sponsor.

Contacts

If you have questions about the information in this guide, contact the My Benefits Connect Center at **myhondaconnect.com** or by calling **1-866-778-5885**, Monday through Friday, from 8:30 a.m. to 10 p.m. ET.

Table of Contents

The following tables show you where to go for questions about your benefits.

Income Protection

For questions about…	Contact…	By calling…	Or visit…
Basic Life Insurance	• My Benefits Connect Center*	• 1-866-778-5885	• myhondaconnect.com
Accident Insurance	• My Benefits Connect Center*	• 1-866-778-5885	• myhondaconnect.com
Business Travel Insurance	• AIG Domestic Accident and Health Claims Department	• 1-800-551-0824	• N/A
Company-Paid Short-Term Disability	• Sedgwick	• 1-888-538-2732 (HDMA) • 1-866-409-2576 (AHM subsidiaries)	• mysedgwick.com/honda (HDMA)
Honda Disability Allowance	• Sedgwick	• 1-888-538-2732 (HDMA) • 1-866-409-2576 (AHM subsidiaries)	• mysedgwick.com/honda (HDMA)
Company-Paid Long-Term Disability	• New York Life Group Benefit Solutions (formerly Cigna Group Insurance)	• 1-888-842-4462	• N/A
Associate-Paid Long-Term Disability	• New York Life Group Benefit Solutions (formerly Cigna Group Insurance)	• 1-888-842-4462	• N/A

*Monday – Friday, 8:30 a.m. – 10 p.m. ET

Health Benefits

For questions about…	Contact…	By calling…	Or visit…
Medical Plan	• Quantum Health*	• 1-866-778-5885	• myhondaconnect.com
	• Kaiser Permanente (for medical and prescription drug)	• California: 1-800-464-4000 • Georgia: 1-888-865-5813 • Northwest: 1-800-813-2000	• kp.org
Teladoc	• Teladoc	• 1-866-778-5885 or 1-800-835-2362	• myhondaconnect.com or • teladoc.com/honda
Associate Assistance Program	• ComPsych	• 1-866-778-5885 or 1-800-232-6357	• myhondaconnect.com or • guidanceresources.com Organization web ID: HONDA
Prescription Drug Plan	• Quantum Health* • CVS Caremark	• 1-866-778-5885 • 1-866-778-5885 or 1-800-386-1575	• myhondaconnect.com or • caremark.com

For questions about…	Contact…	By calling…	Or visit…
Dental	• Delta Dental	• 1-866-778-5885 or 1-866-863-7522	• myhondaconnect.com or • deltadentaloh.com
Vision	• VSP	• 1-866-778-5885 or 1-800-877-7195	• myhondaconnect.com or • vsp.com
COBRA and Direct Billing Vendor	• Alight Solutions*	• 1-866-778-5885 or 1-866-778-5885	• myhondaconnect.com

*Monday – Friday, 8:30 a.m. – 10 p.m. ET

Voluntary/Supplemental Benefits and Other Benefits

For questions about…	Contact…	By calling…	Or visit…
Healthcare Flexible Spending Account	• UMR	• 1-866-778-5885	• myhondaconnect.com
Limited Purpose Flexible Spending Account	• UMR	• 1-866-778-5885	• myhondaconnect.com
Dependent Care Flexible Spending Account	• UMR	• 1-866-778-5885	• myhondaconnect.com
Survivor Medical Insurance Program	• My Benefits Connect Center*	• 1-866-778-5885	• myhondaconnect.com
Supplemental Life Insurance	• My Benefits Connect Center*	• 1-866-778-5885	• myhondaconnect.com
Voluntary AD&D	• My Benefits Connect Center*	• 1-866-778-5885	• myhondaconnect.com or
Group Auto and/or Homeowners Insurance	• Mercer Voluntary Benefits	• 1-866-778-5885 or 1-800-441-5572	• myhondaconnect.com or • personal-plans.com/honda
Group Legal Plan	• My Benefits Connect Center*	• 1-866-778-5885 or 1-800-247-4184	• myhondaconnect.com or • araglegal.com/myinfo Organization access code: 10536hoa
Stock Purchase Plan	• Computershare	• 1-866-778-5885 or 1-800-331-9597	• myhondaconnect.com or • www-us.computershare.com/employee

*Monday – Friday, 8:30 a.m. – 10 p.m. ET

Retirement Benefits

For questions about…	Contact…	By calling…	Or visit…
401(k) Savings Plan	• Fidelity	• 1-866-778-5885 or 1-800-835-5095	• myhondaconnect.com or • 401k.com
Pension Plan	• My Benefits Connect Center*	• 1-866-778-5885	• myhondaconnect.com
Retirement Medical Program	• My Benefits Connect Center*	• 1-866-778-5885	• myhondaconnect.com

*Monday – Friday, 8:30 a.m. – 10 p.m. ET

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To access ***A Guide to Your Benefits*** online,
visit **www.myhondaconnect.com**

connect Let's do this.