Your Benefits

Health & Welfare Benefits
Summary Plan Description

As of January 1, 2021

For APTIV U.S. Hourly Employees

Signal and Power Solutions
Warren Operations

Represented by IUE-CWA, Local 717

As set forth in the
Contractual Settlement Agreement
Effective October 19, 2020

APTIV

Message to Aptiv Hourly Employees

The information in this "Your Benefits" booklet is based upon the benefit plan provisions in effect as of January 1, 2021 as modified by the "*Warren Operations Contractual Settlement Agreement"* effective October 19, 2020. The plans and programs detailed in this booklet represent the provisions applicable to eligible hourly employees working at the Warren, Ohio facility. This booklet is not a contract. However, it summarizes the ways your Aptiv benefit plans can help you and your family.

This booklet contains an explanation of your employee benefits based on the documents, policies and negotiated Agreements by which these benefits are provided. If there is any difference between the Plan texts and this booklet, the Plan texts and negotiated Agreements always will govern.

Any reference to the payment of benefits refers to the employees who are eligible to receive them. Each of these plans or programs has its own terms and conditions which control the benefits provided.

Aptiv reserves the right to amend, change or terminate the plans and programs described in this booklet. The plans and programs can be amended only in writing by an appropriate committee or individual as expressly authorized by the Board of Directors. No other oral or written statements can change the terms of a benefit plan or program. If changes are made, you will be notified.

In general, you are <u>not</u> eligible to participate in the plans and programs described in this booklet if you are:

- a temporary hourly employee, or
- an hourly employee who is not eligible for benefits and/or who is not eligible for certain benefits in accordance with Aptiv Corporation-IUE-CWA Agreements at the Aptiv Signal and Power Solutions - Warren Operations.

If you have any questions after reading this material, contact the appropriate administrator for the benefit plan in question or your local Union Benefit Representative.

Contact information for all benefits administration activities are on page 1.

APTIV CORPORATION

Table of Contents

Common Telephone Numbers & Websites

Health Care – Administered by the Fidelity Benefits Center & various Health Care Carriers

- Eligibility, Enrollment, Contributions and Leave Continuation:
  - Fidelity Benefits Center — 1-877-389-2374 — www.netbenefits.com
- Medical:
  - National Medical Value Plan (NMVP) and Basic Plan (Blue Cross Blue Shield of Michigan) — 1-800-854-5901 — www.bcbsm.com
    - Care Management (Blue Cross Well Being) — 1-800-775-BLUE — www.bcbsm.com
    - Mental Health and Substance Abuse (New Directions) — 1-800-762-2382
    - Prescription Drugs (Express Scripts) — 1-800-711-3459 — Express-Scripts.com
- Dental:
  - ~~Traditional Dental (Cigna Dental)~~ — ~~1-800-244-6224~~ — www.cigna.com ~~or www.mycigna.com~~
- Vision:
  - Vision Plan (Davis Vision) — 1-888-463-9370 — www.davisvision.com
- COBRA Continuation Administration (WageWorks) — 1-888-678-4881 — https://mybenefits.wageworks.com/

Life and Disability – Administered by the Fidelity Benefits Center & Sedgwick

- Life Insurance Eligibility, Enrollment, Contributions, Program Continuation, Reporting a Death:
  - Fidelity Benefits Center — 1-877-389-2374 — www.netbenefits.com
- Disability Benefits
  - Sickness & Accident/Extended Disability Benefits (Sedgwick) *(Hearing or speech impaired)* — 1-877-933-5744 *1-866-665-1287*

Supplemental Unemployment Benefits (SUB)

- Aptiv SUB Administration Center — 1-248-813-1782, option #2

Other

- COBRA Continuation Administration (WageWorks) — 1-888-678-4881 — https://mybenefits.wageworks.com/
- Direct Bill for Employees on Leaves (WageWorks) — 1-888-678-4881 — https://mybenefits.wageworks.com/
- Medicare — 1-800-Medicare — www.medicare.gov
- Wage & Employment Verification — 1-866-604-6572 — www.theworknumber.com

Your benefits are made up of plans and programs designed to work together to help you meet many personal and financial needs now and in the future.

These plans can help you through various events in your lifetime. Page numbers are provided for your reference.	Lifetime Event				
	If You Need Health Care	**If You Become Disabled**	**If You Are Placed on Layoff**	**If You Die**	**If You Leave Aptiv**
	Page	Page	Page	Page	Page
Health Care	5	63	69	73	77
Life Insurance		63	68	71	78
Disability	63	55	66		
Supplemental Unemployment Benefits (SUB)			64		

Events That May Require Action

Benefit / Aptiv Service Center to Contact	Change in Marital Status	Birth or Adoption of a Child	Death of a Dependent	Death of Employee	If You are Placed on Layoff	If You Become Disabled	If You or Your Spouse Become Terminally Ill	If You Wish to Change Your Beneficiary	Employment Status Change, You or Your Spouse
Health Care **Fidelity Benefits Center** **1-877-389-2374** **netbenefits.com**	Add/ Remove Dependent	Add Dependent	Remove Dependent				Review Hospice Coverage (BCBS)		Review Enrollment Decision
Life Insurance **Fidelity Benefits Center** **1-877-389-2374** **netbenefits.com**	Review Coverage, Amount and Beneficiary	Review Coverage, Amount and Beneficiary	Report Death, Review Coverage, Amount and Beneficiary	Report Death			Review Applicability of A.B.O.	Contact the Fidelity Benefits Center	
Personal Accident Insurance **Fidelity Benefits Center** **1-877-389-2374** **netbenefits.com**	Review Coverage and Amount	Review Coverage and Amount	Report Death, Review Coverage and Amount	Report Death		Review Applicability of Benefit		Contact the Fidelity Benefits Center	
Disability **Sedgwick** **1-877-933-5744**						File Claim			
Supplemental Unemployment Benefits (SUB) **Aptiv SUB Administration Center** **1-248-813-1782 option 2**					Apply for Layoff Benefits				

Benefit Options – At-a-Glance

Benefit Codes for Warren Hourly Employees Classified as Regular (not Temporary)

W1 – Applicable to new and current production employees who have less than 60 months of seniority
W3 – Applicable to employees who have attained 60 months of seniority and new skilled trades employees
W4 – Applicable to a closed group of employees with a W4 benefit code who are eligible for benefits and 8% PSP contribution (former Level I employee under the 2012 MOU not eligible for the GM Benefit Guarantee)
W5 – Applicable to a closed group of employees with a W5 benefit code who are eligible for benefits and 8% PSP contribution (former Level I employee under the 2012 MOU eligible for the GM Pension Guarantee as determined by GM)
W6 – Applicable to a closed group of employees with a W6 benefit code who are eligible for benefits and 7% PSP contribution (former Level I employee under the 2012 MOU eligible for the GM Benefit Guarantee as determined by GM)

Benefits

Four different coverage tiers are available for each of the health care options described below. You may elect a different tier for medical, dental and vision. The coverage tiers are: employee, employee and spouse, employee and children, employee and family (spouse and children). Upon your initial eligibility for health care coverage, **you will be enrolled in the default plans noted below for employee coverage.**

Benefit	Options
Medical (Refer to page 10 for details)	• Basic Plan: default plan for employees who have attained 90 days of employment but who have less than 60 months of seniority (Applicable to Benefit Code: W1) • National Medical Value Plan (NMVP): default plan for new skilled trades employees who have attained 90 days of employment (Applicable Benefit Code: W3), and employees who have attained 60 months of seniority (Applicable to Benefit Codes: W3, W4, W5 and W6) • No coverage
Dental (Refer to page 33 for details)	• Traditional Dental: default plan for employees who have attained 36 months of seniority (Applicable to Benefit Codes: W1, W3, W4, W5 and W6) • No coverage
Vision (Refer to page 36 for details)	• Vision coverage: default plan for employees who have attained 60 months of seniority (Applicable to Benefit Codes: W1, W3, W4, W5 and W6) • No coverage
Basic Life Insurance and Optional Life Insurance – for you (Refer to pages 45 and 46 for details)	• $10,000 Basic Life Insurance: applicable to production employees who have less than 60 months of seniority (Applicable to Benefit Code: W1) • $40,000 Basic Life Insurance: applicable to new skilled trades employees (Applicable Benefit Code: W3), and employees who have attained 60 months of seniority (Applicable to Benefit Codes: W3, W4, W5 and W6) • Eligible employees may elect Optional Life Insurance in the following amounts: $10,000 $50,000 $150,000 $20,000 $75,000 $175,000 $30,000 $100,000 $200,000 $40,000 $125,000
Dependent Life Insurance – for your eligible Spouse (Refer to page 47 for details)	• Employees with Basic Life Insurance may elect Dependent Life Insurance - Spouse coverage in the following amounts: $5,000 $25,000 $45,000 $10,000 $30,000 $50,000 $15,000 $35,000 $60,000 $20,000 $40,000 $75,000
Dependent Life Insurance – for your eligible Child(ren) (Refer to page 47 for details)	• Employees with Basic Life Insurance may elect Dependent Life Insurance – Child(ren) coverage in the following amounts: $2,000 $10,000 $18,000 $4,000 $12,000 $20,000 $6,000 $14,000 $24,000 $8,000 $16,000 $30,000
Personal Accident Insurance (PAI) – Employee / Employee + Family (Refer to page 49 for details)	• Employees may elect the following Personal Accident Insurance coverage: <u>Employee coverage</u>: -Available in $10,000 increments with a maximum of $200,000, but cannot exceed 10 times your Annual Base Pay. <u>Employee and Family coverage</u>: -Employee coverage is available in $10,000 increments with a maximum of $200,000, but cannot exceed 10 times your Annual Base Pay. -Spouse coverage is 50% of the employee's amount and the child coverage is 10% of the employee's amount.

Health Care

The Health Care Program for Hourly Employees ("Program") provides comprehensive coverage for you and your eligible dependents for a wide range of health care services and expenses, including acute care services (such as surgery and hospitalizations), preventive care (such as annual physicals and physician office visits primarily for preventive care services) and catastrophic medical costs.

While coverages provided under this Program are very broad and comprehensive, the Program does not cover all health care services and expenses under all circumstances, nor is it intended to do so. You should seek guidance from the health care carrier if you have questions about whether a particular health care service or expense is covered under the Program. The following information is based upon the Program provisions as of January 2021, unless otherwise noted.

Hospital, surgical, medical, prescription drug, hearing aid, mental health and substance abuse coverages are known as "core coverages." Dental and vision coverage is also provided and is known as "non-core coverage."

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Eligibility and Enrollment for Coverage

You

If you are a regular active (permanent), full time hourly employee, you become eligible for medical, dental and vision coverage as follows:

- **Medical coverage:** On the 91st day of employment, you are automatically enrolled in employee only coverage provided you are actively at work.

- **Dental coverage:** On the first day of the month following the month after acquiring 36 months of seniority, you are automatically enrolled in employee only coverage provided you are actively at work.

- **Vision coverage:** On the first day of the month following the month after acquiring 60 months of seniority, you are automatically enrolled in employee only coverage provided you are actively at work.

For example, an eligible employee hired on January 4, 2021, who is actively at work would be eligible for:

— Medical coverage on April 4, 2021;
— Dental coverage on February 1, 2024; and
— Vision coverage on February 1, 2026

If you are not in active service on the date your health care coverages otherwise would start, your coverages become effective upon your return to work. However, if you are scheduled to be at work but are absent due to a disability leave of absence, you will be deemed at work for your health care coverages to start.

If you waive coverage for yourself or your dependents (including your spouse) because of other health care coverage, you may be able to enroll yourself or your dependents in the Program in the future, if you enroll within 31 days after your other coverage ends. In addition, if you have a new dependent (e.g., due to marriage, birth, adoption or placement for adoption), you may be able to enroll yourself and your dependents, as long as you enroll within 31 days after the event. If you contact the Fidelity Benefits Center more than 31 days, your coverage will be effective the first of the month following receipt of the request and all required documentation.

Your Dependents

Some of your dependent family members may be enrolled in coverage with Corporation contributions.

Eligible family members who may be enrolled for coverage with Corporation contributions include:

- Your spouse
- Your natural, adopted or foster children
- Your current spouse's natural, adopted or foster children

To be eligible for Program coverage with Corporation contributions, children must meet certain tests. These tests include:

- **Relationship:** The child must be yours, or your current spouse's, by birth, legal adoption or through foster care.

- **Age:** The child must not have reached the end of the month in which they turn age 26, unless:

  — the child is ***totally and permanently disabled (T&PD).*** A T&PD child may have coverage continued if they continuously meet the Program's definition of T&PD status (i.e., having any medically determinable physical or mental condition that prevents a child from engaging in substantial gainful activity and that can be expected to result in death or be of long-continued or indefinite duration), and continue to meet all other applicable eligibility requirements. To be classified as a T&PD child, a designated Aptiv Employee Benefits representative must approve the Total & Permanently Disabled election form that is completed by the child's physician and submitted prior to the date the child turns age 26. To request the form, contact the Fidelity Benefits Center at 1-877-389-2374 or login at www.netbenefits.com and go to the Health & Insurance Library.

  This total and permanent disability feature is a continuation provision. It does not apply to a child who is ineligible for coverage before the end of the month in which the child turned age

26 (e.g., the employee is not yet eligible for coverage). It does not apply to a child who first becomes totally and permanently disabled after the end of the month in which the child turned age 26. It does not apply to an individual who was eligible for coverage as a totally and permanently disabled child, who loses such eligibility (e.g., by marriage, by failing to satisfy the residency requirement or by failing to meet the definition of totally and permanently disabled) and, after the end of the month in which the child turned age 26, again satisfies the criteria (e.g., divorces, returns home, or has a relapse or a new disability).

- **Marital Status:** In the case of a totally and permanently disabled child whose coverage is continued beyond the end of the month in which the child turned age 26, the child must be unmarried.

- **Residency:** In the case of a totally and permanently disabled child whose coverage is continued beyond the end of the month in which the child turned age 26, the child must live with you, as a member of the primary enrollee's household. If you are legally responsible for the provision of health care pursuant to a court order or a Qualified Medical Child Support Order (QMCSO) as defined by the Omnibus Budget Reconciliation Act of 1993 (OBRA-93), you may be able to satisfy the residency test for a totally and permanently disabled child who does not live with you. However, if the court order that makes you legally responsible for the provision of health care is not a QMCSO, the non-resident child must meet the dependency requirement below.

- **Dependency:** In the case of a totally and permanent disabled child whose coverage is continued beyond the end of the month in which the child turned age 26, you must be able to legally claim, and do claim, an exemption for the child under Section 151 of the Internal Revenue Code, for federal income tax purposes. However, if you are legally responsible for the provision of health care for the child, pursuant to a court order, which meets the requirements for a QMCSO under OBRA '93, this dependency requirement is waived.

Refer to the "Hourly Guide to Dependent Eligibility" at www.netbenefits.com in the Health & Insurance Library to review the requirements and documentation necessary to add dependents to your health care coverage.

Enrollment

When you first become eligible for health care coverages, **you will be enrolled automatically in the applicable plan for employee coverage**.

The Fidelity Benefits Center will email or mail a notice to your address of record inviting you to enroll. **Please note: You will have to add dependents to any new coverage after becoming eligible (i.e., currently enrolled dependents on your medical coverage will not be added to your dental or vision coverage automatically; you will have to add them by calling the Fidelity Benefits Center at 1-877-389-2374 or online at www.netbenefits.com).** If you add dependents to your health care coverage, you will need to submit the required dependent documentation to HMS (Fidelity's administrator for dependent verification) upon request. Failure to provide the requested dependent documentation will result in termination of the dependent's health care coverage.

If you do not want Aptiv medical coverage, you will need to contact the Fidelity Benefits Center by phone or go online and waive coverage.

If you decline or waive coverage for yourself or your dependents (including your spouse) because of other health care coverage, you may be able to enroll yourself or your dependents in the Program in the future, through annual enrollment or a qualifying life event change.

You may change your elections during each annual enrollment period. Following the annual enrollment period, you may change elections during the year ***if you have a "qualifying life event change."*** Qualifying life event changes are those the IRS considers to be a major change in your family situation. Some of the major events that may entitle you to change some of your benefit elections during the year include the following:

- Certain changes in employment status for you or your spouse or an eligible dependent
- Marriage or divorce
- Addition of a dependent
- Death of a spouse or dependent
- Gain or loss of coverage for you or your

dependents

It is *your* responsibility to change your elections if you have a life event change. You must notify the Fidelity Benefits Center within 31 days of a life event change in order for your changes to take effect the day the life event occurred (otherwise, your change will be effective the first of the following month after you notify the Fidelity Benefits Center and submit the required documents, if applicable). **To initiate a life event change online, login at www.netbenefits.com and go to "Life Events" or call the Fidelity Benefits Center at 1-877-389-2374.**

In addition, if you or your dependent is eligible for, but not currently enrolled in, health care coverage under the Program, you may enroll for such coverage if you meet either of the following conditions and you request enrollment within 60 days after the date of the life event:

- You or your dependent loses eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage, or
- You or your dependent becomes eligible for premium assistance for group health plan coverage under the Program, due to coverage with Medicaid or CHIP.

Your and your dependents' health care coverage under the Program will be effective no later than the first day of the month following your request, provided you furnish the required documentation. This is called a "special enrollment" opportunity under the Health Insurance Portability and Accountability Act ("HIPAA").

To request special enrollment or obtain more information, including what documentation is necessary, contact the Fidelity Benefits Center at 1-877-389-2374 or login at www.netbenefits.com.

Medical Plan

The current medical plan for production employees who have attained 90 days of employment, but who have less than 60 months of employment (applicable to W1 Benefit Code) is the:

- Basic Plan

The current medical plan for production employees who have attained 60 months of employment*, and new skilled trades employees who have attained 90 days of employment (applicable to W3, W4, W5 and W6 Benefit Codes) is the:

- National Medical Value Plan (NMVP)

Descriptive materials concerning benefits provided under the Basic Plan and NMVP (i.e., the "Summary of Benefits and Coverage") is available from the Fidelity Benefits Center at 1-877-389-2374 or www.netbenefits.com in the Health & Insurance Library.

Employees will be automatically enrolled in the applicable medical plan for employee coverage when first eligible. **You must contact the Fidelity Benefits Center to add your eligible dependents** (and provide the required dependent documentation upon request), **or to waive medical coverage.**

Covered expenses and major limitations and exclusions are summarized below. ***This is a general description only and the provisions of the Program control your eligibility for coverage and specific benefits.***

Under the NMVP and Basic Plan, selected carriers handle certain administration and claims processing for the Program.

National Medical Value Plan (NMVP)

Benefits under the NMVP are based on a network of providers. The carrier for the NMVP is Blue Cross Blue Shield of Michigan (BCBSM). You may receive covered health care services from providers in the BCBS PPO network or from out-of-network providers. If you use providers participating in the network, you receive a higher level of benefits and your out-of-pocket expenses will be lower. Conversely, if you receive care from providers outside the network, you will receive a lower level of benefits, your out-of-pocket expenses will be higher, and the maximum for out-of-pocket expenses will not apply.

To locate network providers:

- Go to www.bcbsm.com
- Click "Find a Doctor"
- Click "Search without logging in"
- Enter your Location
- Select "Employer Group Plans"
- Select "PPO plans"

Or login if you are enrolled in the NMVP.

Under the NMVP:

- **Contribution:** There is no employee monthly contribution.

- **Deductible:** The in-network annual deductible amounts are $300 for an individual and $550 for a family. If you cover more than one person, each covered individual can only contribute a maximum of $300 toward satisfying the in-network family deductible.

  The out-of-network annual deductible amounts are $525 for an individual and $1,000 for a family. If you cover more than one person, each covered individual can only contribute a maximum of $525 toward satisfying the out-of-network family deductible.

- **Coinsurance:** The in-network coinsurance for expenses incurred above the deductible is 20%. The out-of-network coinsurance is 40%.

- **Out-of-Pocket Maximum:** The total annual out-of-pocket maximum for deductible and coinsurance for covered services received in-network is $1,500 for an individual and $3,200 for a family. After you reach your annual out-of-pocket maximum, charges for any remaining covered services will be paid at 100% of the reasonable and customary amount for the remainder of the year. The out-of-pocket maximum limit does not apply to out-of-network services.

- **Drug Copayments:** Prescription drugs are not subject to the deductibles and coinsurance noted above; covered prescription drugs have separate copayments. Charges incurred for prescription drugs will not be counted towards satisfying the deductible, but will be counted towards the out-of-pocket maximum. However, in accordance with the Affordable Care Act (ACA), certain preventive medications may be covered at 100% with a prescription, for enrollees who meet the age and/or gender criteria. *See the "Preventive Care" section for more details.*

- **Preventive Services:** Certain in-network preventive services, such as annual physicals, immunizations and health screenings, are covered without first meeting the deductible. They fall outside the process outlined above and are covered in full without the need to meet the deductible or pay coinsurance. *See the "Preventive Care" section for more details.*

The NMVP option has a few specialty administrators that are responsible for a specific portion of the health care program. By using specialty or "carve out" programs, Aptiv is able to access specialty networks with credentialed providers, quality and service performance requirements and improved pricing. Currently these specialty administrators include:

- Express Scripts for prescription drug coverage administration (show your Express Scripts prescription drug ID card at retail pharmacies)

- New Directions is the BCBSM vendor for Mental Health/Substance Abuse coverage administration (show your BCBSM medical ID card for these services)

- Blue Cross Coordinated Care is the BCBSM case and disease management program for chronic conditions and illnesses.

NMVP Employee Cost Sharing At-a-Glance

NMVP	In-Network (1)	Out-of-Network (2)
Annual deductible: (3,4)		
Individual	$300	$525
Family	$550	$1,000
Coinsurance: (3,4)		
Plan pays	80%	60%
You pay	20%	40%
Out-of-pocket maximum: (3)		
Individual	$1,500	Not applicable
Family	$3,200	Not applicable
Prescription Drugs		
Retail:		
Generic	$12	25% R&C per prescription plus
Preferred Brand	$48	the applicable in-network copay
Non-Preferred Brand	$96	
Mail:		
Generic	$30	Not covered
Preferred Brand	$120	
Non-Preferred Brand	$240	

(1) Annual deductibles, coinsurance and out-of-pocket maximums are calculated based on "Reasonable and Customary" (R&C) charges or allowed amounts as determined by the carrier. R&C is the amount the "participating" or approved provider has agreed to accept for covered services.

(2) Except in the case of a bona fide medical emergency, if you use an out-of-network provider, the plan will pay the out-of-network coinsurance amount on the lesser of the charge or the Plan's fee schedule, and you will pay the rest.

(3) Deductibles, coinsurance and out-of-pocket maximums apply to all covered hospital, surgical, medical and mental health/substance abuse services. The deductibles and coinsurance do not apply to covered prescription drugs, but your prescription drug copayment counts towards the in-network out-of-pocket maximum.

(4) Certain preventive services such as an annual physical, routine screening mammogram, PSA screening test and PAP smears received under Program guidelines are not subject to annual deductibles or coinsurance if received in-network. Note that preventive services and office visits primarily for preventive services must be billed and coded properly by your doctor's office for the services to be covered at 100 percent.

Basic Plan

Benefits under the Basic Plan are based on a network of providers. The carrier for the Basic Plan is Blue Cross Blue Shield of Michigan (BCBSM). You may receive covered health care services from providers in the BCBS PPO network or from out-of-network providers. If you use providers participating in the network, you receive a higher level of benefits and your out-of-pocket expenses will be lower. Conversely, if you receive care from providers outside the network, you will receive a lower level of benefits, your out-of-pocket expenses will be higher, and the maximum for out-of-pocket expenses will not apply.

To locate network providers:

- Go to www.bcbsm.com
- Click "Find a Doctor"
- Click "Search without logging in"
- Enter your Location
- Select "Employer Group Plans"
- Select "PPO plans"

Or login if you are enrolled in the Basic Plan.

Under the Basic Plan:

- **Contribution:** A monthly contribution is required (deducted from your weekly pay). Contribution amounts are set annually by Aptiv in accordance with applicable ACA regulations. Current contribution amounts are available from the Fidelity Benefits Center at 1-877-389-2374 or www.netbenefits.com.

- **Deductible:** The annual deductible amounts are $900 for an individual and $1,800 for a family (the deductible is combined for services received in-network and out-of-network). If you cover more than one person, each covered individual can only contribute a maximum of $900 toward satisfying the family deductible.

- **Coinsurance:** The in-network coinsurance rate for expenses incurred above the deductible is 25%. The out-of-network coinsurance rate is 45%.

- **Out-of-Pocket Maximum:** The total annual out-of-pocket maximum for deductible and coinsurance for covered services received in-network is $3,500 for an individual and $7,000 for a family. After you reach your annual out-of-pocket maximum, charges for any remaining covered services will be paid at 100% of the reasonable and customary amount for the remainder of the year. The out-of-pocket maximum limit does not apply to out-of-network services.

- **Prescription Drugs:** Prescription drugs are subject to the coinsurance mentioned above. Charges incurred for prescription drugs will not be counted towards the deductible, but will be counted towards satisfying the out-of-pocket maximum. In accordance with the Affordable Care Act (ACA), preventive medications may be covered at 100% with a prescription, for enrollees who meet the age and/or gender criteria. *See the "Preventive Care" section for more details.*

- **Preventive Services:** Certain in-network preventive services, such as annual physicals, immunizations and health screenings, are covered without first meeting the deductible. They fall outside the process outlined above and are covered in full without the need to meet the deductible or pay coinsurance. *See the "Preventive Care" section for more details.*

The Basic Plan option has a few specialty administrators that are responsible for a specific portion of the health care program. By using specialty or "carve out" programs, Aptiv is able to access specialty networks with credentialed providers, quality and service performance requirements and improved pricing. Currently these specialty administrators include:

- Express Scripts for prescription drug coverage administration (show your Express Scripts prescription ID card at retail pharmacies)

- New Directions is the BCBSM vendor for Mental Health/Substance Abuse coverage administration (show your BCBSM medical ID card for these services)

- Blue Cross Coordinated Care is the BCBSM case and disease management program for chronic conditions and illnesses.

Basic Plan Employee Cost Sharing At-a-Glance

Basic Plan	In-Network (1)	Out-of-Network (2)
Monthly Contributions*		
Employee	$100	
Employee and Spouse	$250	
Employee and Children	$250	
Employee and Family	$350	
Annual deductible: (3,4)		
Individual	$900	
Family	$1,800	
Coinsurance: (3,4)		
Plan pays	75%	55%
You pay	25%	45%
Out-of-pocket maximum: (3)		
Individual	$3,500	Not applicable
Family	$7,000	Not applicable

*Deducted in equal amounts each weekly pay period on an after-tax basis.

(1) Annual deductibles, coinsurance and out-of-pocket maximums are calculated based on "Reasonable and Customary" (R&C) charges or allowed amounts as determined by the carrier. R&C is the amount the "participating" or approved provider has agreed to accept for covered services.

(2) Except in the case of a bona fide medical emergency, if you use an out-of-network provider, the plan will pay the out-of-network coinsurance amount on the lesser of the charge or the Plan's fee schedule, and you will pay the rest.

(3) Deductibles, coinsurance and out-of-pocket maximums apply to all covered hospital, surgical, medical, mental health/substance abuse services and prescription drugs.

(4) Certain preventive services such as an annual physical, routine screening mammogram, PSA screening test and PAP smears received under Program guidelines are not subject to annual deductibles or coinsurance if received from a network provider. Note that preventive services and office visits primarily for preventive services must be billed and coded properly by your doctor's office for the services to be covered at 100 percent.

Medical Plan Coverages

The various medical plan coverages described in this section apply to employees enrolled in the Basic Plan (applicable to employees with a W1 Benefit Code) and the NMVP (applicable to employees with a W3, W4, W5 or W6 Benefit Code).

The Basic Plan and NMVP are self-insured plans, meaning that Aptiv is responsible for claim payments of covered services and drugs, and benefit changes; BCBS of Michigan processes claims but does not insure enrollees. As the medical carrier for the Basic Plan and NMVP, BCBS of Michigan also performs its own utilization review or precertification of services within the Plan. Aptiv (or its designated benefit administrator, the Fidelity Benefits Center) is responsible for eligibility and enrollment.

The Summary of Benefits and Coverage for the Basic Plan and NMVP are available in the Health & Insurance Library at www.netbenefits.com.

Hospital

What Is Covered

In general, for an inpatient stay to be eligible for full plan coverage, it must be: medically necessary, prescribed by your doctor and "pre-certified" by the carrier, as to the setting and length of stay. ***(Note: Precertification is not a guarantee of payment.)***

Your doctor may order surgery, tests or treatment that does not require an overnight stay. When you or a dependent receives covered services from an outpatient department of a hospital, the hospital's facility charges are generally covered on the same basis as inpatient care. Facility charges also may be covered for services performed in an ***approved*** freestanding ambulatory surgery facility. For certain outpatient procedures (such as surgeries), precertification is required before the procedure is performed.

Facility charges covered under hospital coverage (maximum of 365 days per "benefit period," 45 days in the case of tuberculosis) include, but are not necessarily limited to the following:

- Semiprivate room, general nursing services, meals and special diets
- Private room accommodations, if medically necessary
- Use of operating rooms
- Anesthesia when administered by an employee of the hospital and anesthesia supplies, gases, and use of equipment
- Laboratory and pathology examinations under the direction of the hospital's pathologist
- Chemotherapy (chemotherapeutics, antineoplastic agents and select ancillary drugs and administration) for the treatment of malignant diseases by chemical antineoplastic agents except when treatment is research, investigational or experimental in nature
- Physical, functional occupational and speech therapy
- Oxygen and other gas therapy
- Drugs, biologicals and solutions and other supplies used in treatment while in the hospital
- Supplies and equipment used during hospital stays including:
  - Supplies for dressings and casts (gauze, cotton, fabrics, solutions, plaster and splints)
  - Durable Medical Equipment (DME)
  - Prosthetic and Orthotic (P&O) appliances
- Maternity care and routine nursery care [Generally, under federal law, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child may not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization for prescribing a length of stay not in excess of the above periods.]
- Hospital service in a special care unit
- Blood services, including transfusions of whole blood and packed red blood cells (if not replaced), blood derivatives, blood

plasma, supplies and their administration
- Hemodialysis when provided by a hospital qualified to provide hemodialysis treatment and which has a hemodialysis program approved by the carrier
- Necessary and appropriate x-rays
- Pulmonary function evaluation
- Tissue storage bank costs (e.g., skin banks and bone banks) for inpatients only
- Emergency room services and observation care (see the glossary for definition and further description of terms and conditions)

What Is Not Covered

Limitations and exclusions to the hospital coverage include, but are not necessarily limited to, the items listed below:

- Drugs, biologicals and solutions—beyond the extent they are used in connection with the inpatient or outpatient service
- Chemotherapy done on a research, investigational or experimental basis (as determined by the carrier)
- Outpatient treatment of chronic conditions that require repeated hospital visits (except hemodialysis and IV infusion therapy services)
- Follow-up care in an emergency room for treatment received initially in an emergency room (follow-up should be done in a physician's office to avoid facility charges)
- Hyperbaric oxygenation provided to treat a chronic condition
- Skin bank, bone bank and other tissue bank services for outpatients (except for certain specified procedures)
- Hospital admissions and services beyond the period which is medically necessary for the proper care and treatment of the patient, or in excess of the maximum benefit period (see glossary for definition) or inconsistent with other applicable Program provisions
- Hospital services related to domiciliary, custodial, convalescent, nursing home or rest care
- Hospital services consisting principally of dental treatment or extraction of teeth (except when either multiple extractions or the removal of one or more unerupted teeth is performed under general anesthesia and a concurrent hazardous medical condition exists)
- Inpatient hospital services when the care received consists principally of observation or diagnostic evaluations, inpatient physical, functional occupational or speech therapy, x-ray examinations, laboratory examinations, electrocardiography or basal metabolism tests, ultrasound studies, nuclear medicine studies, weight reduction by diet control with or without medication or environmental control
- Facility charges for care received in an urgent care center
- Facility charges for care received in a freestanding ambulatory surgery center, unless such center meets Program standards and is approved by the carrier
- Facility charges related to refractive eye surgery (e.g., radial keratotomy, corneal sculpting or similar surgical procedures to correct vision), sterilization reversals or non-covered plastic, cosmetic or reconstructive surgery

Preventive Care

In accordance with the Affordable Care Act (ACA), the NMVP and Basic Plan covers certain preventive services at 100% (no deductible or coinsurance/copayment required) ***if they are received from a network provider***. Preventive care services received from out-of-network providers are generally subject to deductibles and coinsurance (a few are not covered when received out-of-network). Note that preventive services and office visits primarily for preventive services must be billed and coded properly by your doctor's office for the services to be covered at 100 percent.

Covered Routine In-Network Services

The below preventive or routine services are covered at no cost when received in-network. **Please note that the stated frequency limitations and other criteria may change throughout the year as required by the ACA.** Additionally, other preventive screenings for certain risk factors, conditions and/or diseases may be added throughout the year as required by the ACA. Please check with your health care carrier to verify if a certain preventive service (i.e., procedure code) may be covered at no cost to you.

Physical Examinations

- Well Adult – one routine physician exam, including chest x-ray, EKG and routine lab work, per calendar year for ages 18 and older
- Well Baby – unlimited routine physical exams from birth through age 6
- Well Child – one routine physical exam for ages 7 through 17

Men's Routine Health

- Prostate Specific Antigen (PSA) screening – one per calendar year for age 40 and older
- Abdominal Aortic Aneurysm (AAA) screening – one per calendar year for age 65 and older

Women's Routine Health

- Gynecological exam – two per calendar year
- Cervical or vaginal cancer screening (PAP Smear) – one per calendar year
- Breast cancer screening (mammogram) – one per calendar year for women age 40 and older
- Osteoporosis screening – one per calendar year for women age 60 and older

Additional Preventive Services (for Women)

- Anxiety screening – two per calendar year
- Breastfeeding counseling– two per calendar year
- Contraceptive use counseling – five per calendar year
- Domestic violence counseling– five per calendar year
- Certain contraceptive methods:
  - Implantable contraceptive capsules
  - Non-biodegradable contraceptive drug delivery implant
  - IUD
  - IUD copper implant
  - Diaphragm
  - Cervical cap
  - Diaphragm or cervical cap fitting with instructions
  - Contraceptive hormone patch – 3 per month
  - Certain contraceptive devices and systems – one per calendar year, as follows:
    - Permanent implantable contraceptive intratubal occlusion device
    - Implantable Levonorgestrel-releasing contraceptive system
    - Etonogestreal contraceptive implant system and supplies
    - Levonorgestrel-releasing intrauterine system
    - Contraceptive intrauterine device and supplies
  - Injection of Medroxyprogesterone acetate for contraceptive use (Depo-Provera) – four per calendar year (once per quarter)
  - Certain contraceptive surgeries and anesthesia – one per calendar year:
    - Hysteroscopy, Ligation or transection of fallopian tubes, Laparoscopy
- Breast pump – one every 3 years for purchase or a 10-month rental
- Breast pump supplies with proper diagnosis:
  - Replacement adapter, tubing, breast shield and splash protector, locking ring – one per calendar year
  - Replacement polycarbonate bottle, cap for bottle – two per calendar year
- BRCA screening – one per lifetime
- BRCA genetic counseling – two per calendar year
- Antepartum care – one or more visits with specific maternity diagnosis

Prenatal Screenings (for Pregnant Women)

- Prenatal pediatrician visit – two per day, once per calendar year
- Syphilis screening – two per calendar year, depending on procedure code
- Gonorrhea screening – two per calendar year
- Chlamydia screening – two per calendar year
- Hepatitis B screening – two per calendar year
- Asymptomatic Bacteriuria (AB) screening – two per calendar year
- Iron Deficiency Anemia screening – two per calendar year
- Rh (D) Incompatibility screening – two per calendar year
- HIV/Aids screening – two per calendar year
- Gestational diabetes mellitus – two per calendar year

Children's Routine Health

- Dyslipidemia screening – two per calendar for ages 9 through 11
- Newborn metabolic screening – one per calendar year for newborns (0-60 days)
- Phenylketonuria (PKU) screening – one per calendar year for newborns (0-30 days)
- Sickle cell screening – one per calendar year for newborns (0-30 days)
- Congenital hypothyroidism screening – one for newborns (0-30 days)
- Newborn preventive laboratory services – one per calendar year from birth to age 30 days
- Hearing loss screening – one per calendar year for newborns through age 21
- Vision screening – one per calendar year for newborns through age 21
- Vision impairment screening – one per

calendar year for children under age 5
- Developmental screening – two per calendar year for newborns to age 3
- Congenital Heart Disease – one per calendar year for newborns (0-30 days)
- Dental varnish – two per calendar year through age 6

Colorectal Cancer Screening
- Proctosigmoidoscopy – one every 3 calendar years for ages 40 and older
- Colorectal screening – one of the following:
  - Colonoscopy – one per calendar year; or
  - Barium Enema - one every 5 calendar years for ages 50 and older; or
  - Sigmoidoscopy – one per calendar year

Other Routine Laboratory Screening Services (for men and women)
- Lipid disorders screening – one per calendar year
- Dyslipidemia screening – one per calendar year
- Hematocrit or hemoglobin screening – two per calendar year
- Lead screening – one per calendar year
- Tuberculin test – one per calendar year
- Type 2 Diabetes mellitus screening (if blood pressure is greater than 135/80) or Gestational Diabetes – two per calendar year
- Fecal occult blood test – one per calendar year
- Lung cancer screening – one per calendar year for ages 55-80

Immunizations
- Immunizations – routine immunizations and administration of vaccine as recommended by the Centers of Disease Control and Prevention or the Advisory Committee of Immunization Practices

Infectious Disease Screenings – one of each per calendar year, for men and women
- Chlamydia screening
- Gonorrhea screening
- Syphilis screening
- HIV/Aids screening
- Hepatitis B screening
- Hepatitis C screening
- Herpes Simplex Virus (HSV)
- Human Papillomavirus (HPV)

Counseling Services – for men and women
- Alcohol misuse screening and behavioral counseling interventions – unlimited with proper diagnosis
- Alcohol & Drug Use Assessment – one per calendar year
- Diet Behavioral Counseling – six per calendar year
- Intensive behavioral counseling – 26 per calendar year with proper diagnosis
- Tobacco use and tobacco-caused disease counseling – unlimited with proper diagnosis
- Depression Screening – one per calendar year
- Counseling for aspirin for the prevention of cardiovascular disease – one per calendar year
- Sexually transmitted infection counseling – two per calendar year

Preventive Medications (with a prescription; administered through Express Scripts)
- Aspirin –
  - For cardiovascular disease – generic and over-the-counter (325mg or less) for adults through age 69
  - For preeclampsia – generic and over-the-counter (81mg) for women through age 45
- Fluoride – generic and over-the-counter for children from 6 months through age 5 (fluoride drops up to a 50-day supply)
- Folic acid – generic (0.4-0.8mg) for women through age 50
- Smoking Cessation – generic and over-the-counter for ages 18 and over
- Contraceptives – certain medications for women through age 50, including:
  - Barrier contraceptive methods – diaphragms, cervical caps
  - Hormonal contraceptive methods – oral, transdermal, intravaginal
  - Injectable hormonal contraceptive methods
  - Emergency contraceptive methods
  - Implantable medications
  - Intrauterine contraceptives
  - Over-the-counter contraceptives (with a prescription)
- Bowel preparation agents – generic medications, including over-the-counter, for ages 50 through 75 (2 prescriptions per 365 days)
- Breast Cancer Prevention – certain generic drugs (tamoxifen or raloxifene) available at $0 to women ages 35 and over who satisfy the criteria for drug therapy based on primary prevention of breast cancer. To receive the drug at no cost, you or your

physician must initiate a coverage review and receive approval prior to or when filling the prescription.
- HIV Pre-Exposure Prophylaxis (PrEP) – Truvada until generic medications 200mg/300mg are available
- Statins – certain generic drugs, low and moderate dosage, for ages 40 through 75.
- Vaccines – routine preventive immunizations when received at network retail pharmacies.

Skilled Nursing Facility

In some cases, the patient's condition may require care in a facility but not require the extensive services available in a hospital setting. Services received from skilled nursing facilities licensed to provide such care may be covered under your Aptiv medical plan. ***When such services are recommended, they must be precertified by the carrier before the admission to determine if they are covered by the Program and to ensure that the intended provider of such services is approved by the carrier. You should call or ask your doctor, the hospital and/or discharge planning staff or the skilled nursing facility staff to make the call to obtain precertification for these services.***

The carrier also can determine whether the patient is a candidate for case management.

What Is Covered

Two days of inpatient skilled nursing facility care are available for each remaining day of inpatient hospital care within the benefit period (see glossary for definition), up to a maximum of 730 days for each continuous period of confinement. Each day of inpatient hospital care within a benefit period reduces by two the number of days of care available for skilled nursing facility services. The use of skilled nursing facility days does not reduce the number of days of inpatient hospital care available.

For skilled nursing facility care to be covered it must be:

- prescribed by a physician,
- medically necessary based on the severity of illness/injury and intensity of the service,
- received from a carrier-approved skilled nursing care facility, and
- provided and billed by the facility.

Services provided under skilled nursing facility coverage include, but are not necessarily limited to, the items listed below:

- Semiprivate room and board
- Meals and special diets
- Medical care visits (2 visits per week)
- General nursing services
- Use of special treatment rooms
- Routine laboratory exams
- Physical, functional occupational and speech therapy, when medically necessary
- Oxygen and other gas therapy
- Drugs, biologicals and solutions used while in the facility
- Supplies for dressings and casts
- Durable Medical Equipment (DME)

What Is Not Covered

Services not covered under the skilled nursing facility coverage include, but are not necessarily limited to, the items listed below:

- Care that is principally custodial or domiciliary in nature
- Treatment for tuberculosis or substance abuse

Physical, Functional Occupational and Speech Therapy and Cardiac Rehabilitation

When you or a family member requires certain therapies to restore or improve musculoskeletal, speech or cardiac performance, your Aptiv medical plan may provide coverage to help you meet these needs.

Outpatient services must be:

- approved by the carrier;
- prescribed by the physician in charge of the case;
- provided or supervised by a physician (other than a limited-practice physician) or by a registered and licensed physical, occupational or speech therapist for the specific therapy prescribed; and
- billed by a physician (other than a limited-practice physician) or a hospital, or a freestanding outpatient physical therapy facility, home health care agency, skilled nursing facility or independent therapist approved by the carrier.

What Is Covered

Covered physical, functional occupational and

speech therapy and cardiac rehabilitation services include, but are not necessarily limited to, the items below:

- Medically necessary physical, functional occupational and speech therapy up to a combined total of 60 visits per condition per year, and cardiac rehabilitation limited to 6 months immediately following certain conditions, diagnoses and surgeries
  - During a covered admission to a hospital or skilled nursing facility for the treatment of the condition for which the patient is admitted. These services normally are billed by the hospital or skilled nursing facility.
  - Care prescribed and received through an approved rehabilitation center that meets Program standards.
- Physical, functional occupational and speech therapy provided through an approved home health care agency
- Outpatient physical and functional occupational therapy to restore or improve musculoskeletal function
- Restorative speech therapy on an outpatient basis when related to the treatment of an organic medical condition or to the immediate post-operative or convalescent state of the enrollee's illness, subject to certain limitations
- Cardiac rehabilitation on an outpatient basis provided through a hospital or performed or supervised and billed by a physician (limited to services provided during the six-month period immediately following acute myocardial infarction, initial diagnosis of angina pectoris or certain heart surgeries)

What Is Not Covered

Services not covered under the physical, functional occupational and speech therapy and cardiac rehabilitation provisions include, but are not necessarily limited to, the following:

- Speech therapy for any of the following:
  - Educational learning disabilities
  - Deviant swallow or tongue thrust
  - Mild developmental speech or language disorders
  - Congenital deafness
  - Elimination of a lisp, or similar defect in articulation
  - Improving speech that is not fully developed
  - Long-standing, chronic conditions or inherited speech abnormalities except when the patient is diagnosed as having a severe communication deficit as defined by Program standards, and when speech therapy is not available through other public agencies (i.e., state or school)
- Physical and functional occupational therapy when:
  - the condition is not expected to improve in a reasonable and generally predictable period of time;
  - improvement does not occur, as documented in the patient's record on a periodic basis; or
  - progress is no longer being made or the previous level of function has been restored.
- Physical and/or functional occupational therapy provided solely to maintain musculoskeletal function
- Inpatient admissions that are principally for physical, functional occupational and/or speech therapy or cardiac rehabilitation
- Manipulation, adjustment, or massage of the musculoskeletal system
- Vision therapy or training
- Cognitive rehabilitation (including but not limited to, vocational rehabilitation, recreational therapy or learning exercises)
- Day, night or residential rehabilitation programs
- Services that could be performed by an untrained, unlicensed person, by the enrollee or by a member of the enrollee's family
- Physical and/or functional occupational therapy for first and second degree burns

Home Health Care

When a patient no longer requires constant care, a hospital or alternative treatment facility setting becomes inappropriate. In such a situation, home health care services of a part-time or intermittent nature may be prescribed by the doctor.

- ***When home health care services are recommended, they must be precertified, before incurring expenses to determine if such services are covered by the Program and to ensure that the intended provider of such services is approved by the carrier.*** The carrier also can determine whether the patient is a candidate for special Program components (such as case management).
- Coverage for home health care services is available only when the patient is essentially

homebound and the services are medically necessary.

What Is Covered

When home health care is medically necessary and appropriate, the following services are ***covered if they are provided on a part-time or intermittent basis*** during a home health care visit and billed by a home health care agency approved by the carrier. Home health care is limited to 3 visits for each unused hospital day (except for IV infusion). Services provided under home health care coverage include, but are not necessarily limited to, the items below:

- General nursing services
- Physical therapy and speech therapy
- Social service guidance, dietary guidance and functional occupational therapy
- Home health aide services (if provided in conjunction with general nursing services, or physical or speech therapy services) by an approved health care agency

The following are covered when provided and billed by an approved provider:

- Laboratory tests
- Drugs, biologicals, solutions
- Medical supplies ordered by the physician and necessary for the home medical regimen

What Is Not Covered

Services not covered under the home health care provisions include, but are not necessarily limited to, the following:

- Supplies such as elastic stockings, personal comfort or personal hygiene items or equipment, or supplies and appliances that may be covered under Durable Medical Equipment (DME) or Prosthetic and Orthotic (P&O) Appliance provisions
- Physician services, private duty nursing or housekeeping services
- Skilled nursing services and home health aide visits when the care exceeds the part-time or intermittent levels
- Home uterine monitoring
- Travel time
- Services for which the cost would exceed the daily cost for similar care in a skilled nursing facility

Surgical and Medical

You are eligible for benefits for expenses incurred for covered surgical and medical services when such services are approved by the carrier and are medically necessary. Your carrier will pay benefits for covered services based on a fee schedule, capitation schedule or its determination of reasonable and customary charges.

Note: Some provider network arrangements exist for services contained within the surgical and medical coverages. These network arrangements have been established to facilitate the quality and cost competitiveness of services provided.

What Is Covered

Services covered under surgical and medical provisions include, but are not necessarily limited to, the items below. In addition, surgery must be precertified by the carrier.

- Certain surgical services consisting of generally accepted operating and cutting procedures for the necessary diagnosis and treatment of disease, injuries, fractures or dislocations
- Certain plastic and reconstructive surgery, such as correction of deformities following cancer surgery or accidental injuries
  - In the case of a patient who undergoes a mastectomy and who elects breast reconstruction in connection with the mastectomy, under federal law, coverage must include:
    - reconstruction of the breast on which the mastectomy has been performed;
    - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    - prostheses and physical complications of all stages of mastectomy, including lymphedemas

  in a manner determined in consultation with the attending physician and the patient.
- Certain dental surgeries (e.g., multiple extractions or removal of one or more unerupted teeth) when performed in a facility setting and a concurrent hazardous condition requiring hospitalization exists
- Medically recognized human organ transplants
- Mastectomy
- Voluntary sterilization (but not reversals)

- Laser surgery if the alternative cutting procedure is covered
- Hemodialysis
- Anesthesia (by other than the operating physician), including the administration of anesthesia by a lay or nurse anesthetist in the employ of the physician who authorizes the services and who is available for immediate attendance
- Medically necessary technical surgical assistance (i.e., services of a physician who actively assists the operating physician) when the services of interns, residents or house officers are not available
- Maternity care, including prenatal and postnatal care
- Consultations when requested by the physician in charge
- Chemotherapy, both inpatient and outpatient – excluding research, investigational or experimental services (follow-up visits for outpatient chemotherapy is limited to 3 visits within 30 days of a covered treatment)
- Extra-corporeal shock wave lithotripsy (ESWL) meeting Program standards
- Therapeutic radiology
- Certain diagnostic radiology services
- Laboratory services
- Physician medical visits in the home, doctor's office, online (telemedicine), hospital or skilled nursing facility for:
  - treatment of illness or injury,
  - inpatient medical care when provided by the physician in charge of the case, and
  - treatment rendered in or at a hospital when provided by a physician who is not an employee of the hospital.
- Foot care for treatment of injuries and/or infections

What Is Not Covered

Services not covered under the surgical and medical provisions include, but are not necessarily limited to, the following:

- Certain physician medical visits for:
  - Non-covered services:
    - Acupuncture
    - Allergy testing, treatment or injections
    - Weight control
    - Manipulation, adjustment or massage of the musculoskeletal system
    - Services provided by non-physician practitioners (e.g., Christian Science practitioners)
  - Covered services that are billed separately or as a part of other covered services:
    - Prenatal and postnatal care
    - Immunizations
  - Services that are covered under other Program provisions
- Dental services, including extraction of teeth except as provided for earlier
- Examinations and tests in connection with research studies, paternity determinations, weight control, autopsies, etc.
- Charges for stand-by physicians or similar charges where no service is actually performed
- Services relating to refractive eye surgery (e.g., radial keratotomy, corneal sculpting or similar surgical procedures to correct vision)
- Growth factor treatment for wound care
- Thermography

Ambulance Service

The Program provides you with ambulance service coverage when the following three conditions are met:

- Ambulance services must be medically necessary (ambulance services are not medically necessary if any other means of transportation could be used without endangering the patient's health).
- Services are provided by an approved, licensed ambulance operation.
- A physician prescribes the services that necessitate use of an ambulance.

What Is Covered

Services covered under the ambulance service provisions include, but are not necessarily limited to, the following:

- Basic life support services that consist of services that provide for the initial stabilization and transport of a patient
- Advanced life support services (defined as acute emergency treatment procedures with physician involvement)
- Mileage charges while the patient occupies the ambulance
- Waiting time involved in round-trip transport of an enrollee from a hospital to another treatment site and return to the same hospital
- Transportation to the nearest medical facility qualified to provide treatment (transportation to other than the nearest, qualified treatment facility will be covered only in an amount equal to that for transportation to the nearest

facility)
- Certain air and boat ambulance charges. Coverage includes:
  - one-way from home or scene of incident in cases of medical emergency or accidental injury to the nearest available facility qualified to treat the patient
  - round-trip transfer of a homebound patient from the home to the nearest available facility qualified to treat the patient in the case of a medical emergency or accidental injury, or for treatment at a facility when other means of transportation cannot be used without endangering the patient's life
  - coverage for the first 100 miles will be subject to a 50% coinsurance, and coverage in excess of 100 miles will be subject to a 100% coinsurance. If it is determined that transport by ground ambulance would have sufficed, payment will be limited to the amount that would have been paid for ground ambulance

What Is Not Covered

Services not covered under the ambulance provisions include, but are not necessarily limited to, the following:

- Transportation in a vehicle not qualified as an ambulance
- Transportation for the convenience of you, your family or your physician
- Services rendered by providers whose fee is in the form of voluntary donation, for example, fire departments or rescue squads
- Transfers not medically necessary
- Services billed by physicians or other independent health care providers for care rendered to enrollees transported by ambulance
- Services when you are not actually transported while under care
- Services payable through an existing arrangement to transfer patients where no additional charge is usually made, whether or not such services were immediately available
- Services that are covered as a component of the basic or advanced life support services such as:
  - Use of specific equipment or devices
  - Gases, fluids, medications, dressings or other supplies
  - First aid, splinting or any emergency medical services or personal service procedures
  - Vehicle operators, attendants or other personnel

Prescription Drugs

Prescription drug coverage for the NMVP and the Basic Plan is delivered through retail pharmacies participating in the Express Scripts network or through mail /home delivery. Express Scripts participating pharmacies provide prescription drug services that meet high quality standards. Generally, a participating pharmacy will be located within five miles of your residence.

- If you are enrolled in the NMVP, you can receive up to a 34-day supply of medication at a participating retail pharmacy for a copayment of $12 for generic drugs, $48 for preferred brand name drugs and $96 for non-preferred brand name drugs.
- If you are enrolled in the Basic Plan, you can receive up to a 34-day supply of medication at a participating retail pharmacy at the applicable coinsurance.
- If your prescription costs less than the applicable copayment or coinsurance, you will be charged the network cost of the drug.

Express Scripts determines which drugs are preferred brands versus non-preferred brands. Additionally, subject to certain exceptions, Aptiv has an open formulary with Express Scripts, which means that drugs are usually not excluded from coverage, but may require differing copayments or coinsurance. (Please note that Express Scripts has approximately 92 drugs excluded from its National Preferred Formulary.)

Locating a Network Pharmacy

Express Scripts has over 60,000 network or participating pharmacies nationwide. You may login at Express-Scripts.com, access the Express Scripts mobile app, or call Express Scripts at 1-800-711-3459 to locate a network pharmacy anywhere in the country. When you are traveling out of your home area, or if you have dependents living away from home, an Express Scripts customer service representative will help you locate the nearest network pharmacy.

Using a Non-Network Pharmacy

If you have a prescription filled at a non-network pharmacy, you will pay the pharmacist the full cost of the prescription. When you submit a claim form to Express Scripts, you will be

reimbursed for 75% of the reasonable and customary charge after your copayment or coinsurance has been deducted. Claim forms may be obtained at Express-Scripts.com, or by calling Express Scripts Customer Service at 1-800-711-3459.

In the event of any emergency, or if you are traveling and cannot locate or access a network pharmacy, your non-network claim for covered prescriptions will be reimbursed at 100% of the reasonable and customary charge after your copayment or coinsurance has been deducted.

Home Delivery

The NMVP and Basic Plan require home delivery for certain long-term medications (e.g., drugs to treat high blood pressure or high cholesterol). Here's how it works:

- Your original prescription plus two refills (each up to a 34-day supply) may be obtained from a participating retail pharmacy.
- Thereafter, you are required to fill your prescription through home delivery and receive up to a 90-day supply for one copayment or coinsurance. If you continue to fill your prescription at a retail pharmacy, you will pay 100% of the cost for the drug.

Refer to the Maintenance at Mail Information below for additional information.

You also may wish to use home delivery for other maintenance drugs to save time and money. It's convenient to have your prescription delivered right to your home, and you can obtain up to a 90-day supply of medication for one copayment or coinsurance.

Keep in mind that when using home delivery, it can take up to two weeks for you to receive your prescription. Please make sure you have at least a 14-day supply of medication on hand to use until your home delivery medication arrives.

When you order your prescriptions by mail, you will not have to submit claim forms or wait for reimbursement. Your medication is delivered to your home, postage-paid, within 14 days from the date you mail your prescription.

- If you are enrolled in the NMVP, you can receive up to a 90-day supply of medication for a copayment of $30 for generic drugs, $120 for preferred brand name drugs and $240 for non-preferred brand name drugs.
- If you are enrolled in the Basic Plan, you can receive up to a 90-day supply of medication at mail at the applicable coinsurance.
- If your prescription costs less than the applicable copayment or coinsurance, you will be charged the network cost of the drug.

How to Use the Home Delivery Option

1. Your doctor may prescribe ongoing medications for up to a 90-day supply, plus refills. If you are now taking medication on a long-term basis and are **not** currently using the home delivery option, ask your doctor for a new prescription.
2. Complete the patient profile questionnaire with your first order. Be sure to answer all the questions.
3. Send the completed patient profile, your original prescription(s) and the appropriate copayment(s)/coinsurance in the order envelope provided. Make sure you sign and complete all the information on the order envelope.
4. The Express Scripts Pharmacy will promptly process your order and send your medications to you via U.S. mail or UPS, along with instructions for future refills. You should receive your medication within 14 days from the date you mail your prescription.
5. You can order refills online at Express-Scripts.com or on the Express Scripts mobile app, or by calling 1-800-711-3459.

Pharmacy Management Programs

The Prescription Drug coverage for the NMVP and Basic Plan uses several different pharmacy management programs for safety, quality and cost reasons.

Please note: The below pharmacy management programs and the prescription drugs included in pharmacy management programs are reviewed regularly and may be modified by Express Scripts throughout the year. If you have a question about a particular drug, login at Express-Scripts.com or call 1-800-711-3459 to confirm if any pharmacy management applies.

- **Maintenance at Mail** encourages home delivery for certain long-term medications, such as for high blood pressure, high cholesterol, diabetes, asthma, oral contraceptives, etc., usually at a reduced cost to you.

  If you continue to fill a prescription on the Maintenance at Mail drug list at a participating retail pharmacy after the original fill plus two refills (after 1 fill for

certain specialty drugs), you must pay 100% of the cost for the drug (and the 100% cost does not count your in-network out-of-pocket maximum because the drug is not covered under the Program for exceeding the maximum number of retail fills). You will receive a reminder letter about the home delivery program when you fill a prescription for one of the applicable drugs at retail.

Please visit Express-Scripts.com or call Express Scripts customer service to determine if a particular drug is on the maintenance drug list. You may also use home delivery for other long-term drugs you may currently be taking.

- **Prior Authorization** helps ensure medications are utilized according to the current medical guidelines and FDA approvals. The program confirms the diagnosis and other clinical information before your prescription is filled. To initiate a coverage review for retail prescriptions, your physician should contact Express Scripts at 1-800-753-2851 to provide additional information. Express Scripts determines whether or not coverage is approved.

  The following drug categories must have a coverage review and be approved by Express Scripts before they will be covered. *This is not a complete list and may be subject to change throughout the year at Express Scripts' discretion*.
  - Asthma
  - Bone conditions
  - Cancer
  - Diabetes
  - Growth hormones
  - Hepatitis-C
  - High cholesterol
  - Inflammatory conditions
  - Multiple sclerosis
  - Narcotic pain
  - Osteo-arthritis
  - Osteoporosis
  - Rheumatoid arthritis
  - Skin Conditions
  - Sleep disorders
  - Testosterone
  - Topical acne

- **Step Therapy** is evidence-based or follows commonly-accepted guidelines and requires a trial with first-line therapies (generic or a preferred medication) before a non-preferred medication will be covered. If your medication requires step therapy, your physician should contact Express Scripts at 1-800-753-2851 to provide additional information. After receiving this information, Express Scripts determines whether or not coverage is approved.

  The following are common drug categories containing medications that require step therapy. Each drug category will also have one or more clinically effective alternatives which do not require step therapy. For information on your specific medication, refer to the Express Scripts website, mobile app or call Express Scripts member services listed on the back of your prescription drug ID card. *This is not a complete list and may be subject to change throughout the year at Express Scripts' discretion.*
  - Allergies
  - Alzheimer's
  - Asthma
  - Attention deficit disorder
  - Depression
  - Diabetes
  - Growth hormones
  - High blood pressure
  - High cholesterol
  - Hypnotics
  - Migraine headaches
  - Multiple sclerosis
  - Osteoporosis
  - Overactive bladder
  - Pain / inflammation
  - Rheumatoid arthritis
  - Skin conditions
  - Sleep disorders
  - Topical acne
  - Ulcers

- **Drug Quantity Management** promotes dosing or length of therapy consistent with recommended or commonly acceptable medical practice and limits quantity per prescription fill to FDA-recommended or common dosing guidelines.

  The following are drug categories that have quantity limitations. *This is not a complete list and may be subject to change throughout the year at Express Scripts' discretion.*
  - Allergies
  - Antifungals

- Asthma
- Bone conditions
- Contraceptives
- Depression
- Hepatitis C
- High blood pressure
- High cholesterol
- Migraine headaches
- Multiple sclerosis
- Oncology
- Pain
- Sleep disorders

- **Specialty Drug Access Program** promotes the purchase of certain specialty drugs through Express Scripts' specialty care pharmacy, Accredo Health Group. Similar to the Maintenance at Mail program, if you continue to purchase certain specialty drugs at a retail pharmacy other than Accredo, you will be responsible for the full cost of the drug. A letter will be mailed to you about this program when you purchase certain specialty drugs from a retail pharmacy other than Accredo.

  This program also provides access to Accredo's specially trained pharmacists 24 hours a day, 7 days a week; personalized counseling; expedited, scheduled delivery of your medication at no extra charge; refill reminder calls and free supplies to administer your medication such as needles and syringes.

- **Specialty Drug Interval Dispensing** results in dispensing a specific list of specialty medications obtained through the Express Scripts Pharmacy (home delivery) in smaller day-supply increments. When one of the identified specialty medications is interval dispensed in a 30-day supply, for example, your copay will be prorated to 1/3 of the standard 90-day copay. Therefore, over a 90-day period, you still will receive up to a 90-day supply for the same total standard 90-day copay.

  The Specialty Drug Interval Dispensing Program delivers the medication without lapses in treatment, manages the high potential for waste due to a change or discontinuation in treatment and/or when a patient cannot tolerate the medication, and provides additional service support (special drug handling and storage; therapy monitoring, outreach and consultation; and refill coordination).

- **My Rx Choices** is an interactive tool available at Express-Scripts.com to help you identify potential cost-saving alternatives for current or future prescriptions. If there are money-saving alternatives available to you, you'll find a list of the drugs you're taking on an ongoing basis, your current out-of-pocket costs and lower-cost alternatives — such as lower-cost brands and generic drugs. You may print the information to discuss it with your doctor. From time to time, Express Scripts may mail awareness letters to you if you are taking a medication on a regular basis so you can discuss the available alternatives with your doctor.

What Is Covered

Items covered under prescription drug coverage include, but are not necessarily limited to:

- Federal legend drugs that are medically necessary to treat an illness or injury and are prescribed by a doctor (This includes most recognized pharmaceuticals and generic substitutions for federal legend drugs.)
- Contraceptive pills and diaphragms
  Up to a 34-day supply of a covered drug at retail; up to a 90-day supply of a covered drug if dispensed through home delivery (covered drug means insulin or any prescription legend drug, except as excluded by the Program, that is dispensed according to a prescription.)
- An appropriate supply of disposable syringes and needles when prescribed for self-injection with a supply of insulin or an antineoplastic or chemotherapeutic agent
- Transdermal nicotine patches, covered medications or prescription legend drugs used for or in connection with the control or cessation of smoking

What Is Not Covered

Items not covered under the prescription drug coverage include, but are not necessarily limited to:

- Any research or experimental agent
- Any medication being used for a cosmetic purpose
- Any medication for the purpose of attempting to induce pregnancy
- Drugs prescribed for weight control or appetite suppression
- Drugs classified as non-sedating

antihistamines (NSA) and NSA combinations
- Drugs classified as erectile dysfunction drugs, except to treat certain medical conditions such as Pulmonary Arterial Hypertension (PAH) when appealed to and approved by Express Scripts
- Devices (other than diaphragms) or appliances (e.g., orthotics)
- Any charge for the administration of covered drugs
- A covered drug in excess of the quantity specified by the physician
- More than a 34-day supply of a covered drug provided by a retail pharmacy, or for more than a 90-day supply of a covered drug supplied through the home delivery option
- Drugs received before the effective date of the enrollee's health care coverage

Supplemental Discount Program

The Supplemental Discount Program provides discounts on prescription drugs not covered under the Program (e.g., Allegra®, Viagra®) when ordered through mail order.

Specifically, the Supplemental Discount Program provides:

- Discounts on all FDA-approved prescription drugs that are dispensed through the Express Scripts Pharmacy (i.e., home delivery) for drugs not covered under the Program
- Up to a 90-day supply of your discounted medication using the same Express Scripts mail-order form you normally would use
- The security that all your medications will go through the clinical safety checks and drug utilization review edits and alerts
- Added privacy by having non-covered medications of a potentially sensitive nature (such as erectile dysfunction drugs and cosmetic drugs) delivered directly to you
- Around-the-clock access to prescription refill and renewal orders at Express-Scripts.com, and access to Express Scripts' pharmacists for consultation
- Integrated, one-stop shopping for covered and non-covered prescription items
- Access to check the availability and prices for these medications at Express-Scripts.com or by contacting Express Scripts Member Services at 1-800-711-3459

The Supplemental Discount Program discounts are available only through mail/home delivery at Express-Scripts.com. They are not available through a retail pharmacy.

Medications that are covered under the Program, but require Prior Authorization or other limitations of coverage, are not included in the Supplemental Discount Program.

The Maximum Allowable Cost Feature

Your prescription drug coverage includes a Maximum Allowable Cost (MAC) feature that is a generic substitution program. Generic drugs must have the same active ingredients in the same dosage, meet the same quality standards and have the same medical effect as brand name drugs, though generic drugs generally cost substantially less. The MAC feature is designed to encourage use of generic drugs by limiting the amount that will be paid for certain drugs. ***If a prescription is written for a drug included on the MAC list and the doctor has not specified that the prescription must be dispensed as written, a generic drug will be dispensed. If you request the brand name drug, you will be required to pay the applicable copay for the brand name drug (or the cost of the drug if it's less than the applicable copay).***

Dispensing a Brand-Name Drug When a Generic Version is Available

If a brand-name drug is dispensed instead of its generic version, you must pay the appropriate copay plus the difference in price between the brand name and generic drug. Your doctor or pharmacist can advise you about whether a generic drug is available.

- If your doctor has specified a brand-name drug (by indicating "Dispense As Written" or DAW), pharmacist filling the prescription may contact your doctor to authorize the generic version. If your doctor agrees, you will receive the generic drug for the generic copay. If the doctor disagrees or cannot be contacted, you will be given the brand-name drug and charged the applicable brand copay plus the difference in cost between the brand and generic, up to a maximum of $10, for the first fill. After that, you will pay the generic copay plus the full difference in cost between the brand-name and the generic drugs until your doctor provides satisfactory clinical information supporting your need to take the brand-name drug. Express Scripts will contact your doctor to try to obtain this information.
- When your doctor provides clinical information that supports your need to take

the brand-name drug rather than the generic version, you will be refunded the appropriate amount automatically and will receive the brand-name drug thereafter. If the information provided does not support your need to take the brand-name you and your doctor will be informed and provided information on the appeals process.

There are a certain brand-name drugs that have generic equivalents, but for which small variation in the dose could result in changes in drug safety. These drugs are not subject to the generic dispensing provision. When these brand-name drugs are dispensed, only the brand copayment or coinsurance will apply. Unless your doctor has indicated "Dispense As Written" or "DAW", your prescription automatically will be filled with a generic drug. If you still want the brand-name drug, you will pay the generic copayment or coinsurance plus the full difference in cost between the brand-name and generic drug.

If you have a question about your ***prescription drug coverage***, call Express Scripts at ***1-800-711-3459***, go to Express-Scripts.com or access their mobile app.

Hearing Aids

Aptiv provides coverage to address hearing deficiencies or loss once you have been examined by an ear specialist (otologist or otolaryngologist).

What Is Covered

If the examination by an ear specialist determines that your hearing problem may be corrected by use of a hearing aid, benefits may be provided. Following this examination, payment will be made for the following services ***when obtained from a participating or approved provider*** and when provided in the order below, once during any period of 36 consecutive months:

- Audiometric examination (up to the reasonable and customary charge)
- Hearing aid evaluation test (up to $169 as of October 1, 2018, subject to periodic review and adjustment)
- One standard hearing aid of the following designs (up to the acquisition cost plus dispensing fee):
  - In-the-ear
  - Behind-the-ear (including air and bone conduction types)
  - On-the-body
- Replacement ear molds for children seven years of age and under:
  - four ear molds per year for children under the age of three
  - two ear molds per year for children ages three through seven

What Is Not Covered

Services not covered under hearing aid provisions include, but are not necessarily limited to, the following:

- Audiometric examinations by an audiologist that are not ordered by a physician
- Medical or surgical treatment
- Drugs or other medication
- Audiometric examinations, hearing aid evaluation tests and hearing aids:
  - ordered before the enrollee's eligibility for coverage; after termination of the enrollee's coverage; or while covered but delivered more than 60 days after termination of coverage;
  - for which no charge is made to the enrollee or for which no charge would be made in the absence of hearing aid coverage;
  - which are not recommended or approved by a physician;
  - which do not meet professionally accepted standards of practice, including any service or supplies that are experimental in nature;
  - received as a result of ear disease, defect, or injury due to an act of war;
  - provided by any governmental agency that are obtained by the enrollee without cost;
  - provided under any applicable workers' compensation law
- Replacement of hearing aids that are lost or broken
- Replacement parts for and repairs of hearing aids
- Eyeglass-type hearing aids, to the extent the charge exceeds the expense for one standard hearing aid
- Binaural hearing aids except as provided to correct or prevent speech impairment for ***children under age 19*** who have hearing loss in both ears
- Digital-controlled/programmable hearing devices, to the extent the charge for such device exceeds the covered expense for a standard, conventional hearing aid

Durable Medical Equipment (DME) and Prosthetic and Orthotic (P&O) Appliances

When a patient needs equipment or appliances that are prescribed by a doctor, they may be covered by your medical plan—whether used in a hospital or skilled nursing facility or after discharge. Coverage is provided when the attending physician prescribes such equipment and it is approved by the carrier.

You should obtain durable medical equipment and prosthetic and orthotic appliances through network providers to reduce your out-of-pocket expenses.

If you receive covered DME and P&O services from non-network providers, you may be responsible for paying the provider up front and submitting the claim and supporting documentation to the carrier for reimbursement. The carrier will then send payment to you based upon the amount applicable to network providers. You may be required to pay the amount charged by the non-network provider that is in excess of the network fee schedule. ***Additionally, Aptiv payments toward the Medicare deductible or coinsurance for those individuals enrolled in the Medicare Program will only be made when services are received from a network provider***.

Durable Medical Equipment (DME) – What Is Covered

Equipment and services covered under DME provisions include, but are not necessarily limited to, the following:

- Equipment that meets Program standards that include being approved for reimbursement under Medicare Part B and being appropriate for use in the home
- Equipment used in a hospital or skilled nursing facility or used outside the hospital or skilled nursing facility and rented or purchased from such hospital or facility
- Repairs necessary to restore the equipment to a serviceable condition when such equipment is purchased (this does not include routine maintenance)
- Neuromuscular stimulators
- Positioning transportation chairs as alternatives to traditional wheelchairs for children under 14 years of age, who suffer from neuromuscular disorders, closed head injuries, spinal cord disorders or congenital abnormalities
- External electromagnetic bone growth stimulators, in certain cases
- Portable insulin infusion pumps and home glucose monitors for certain disabilities
- Pressure gradient supports for certain patients
- Pronged and standard canes (when purchased)

Prosthetic and Orthotic (P&O) Appliances – What Is Covered

Appliances and services covered under the P&O provisions include, but are not necessarily limited to, the following:

- P&O appliances that are furnished by an accredited facility and meet Program standards, including being approved for reimbursement under Medicare Part B
- Orthopedic shoes, inserts, arch supports and shoe modifications when the shoes are part of a covered brace
- Appliances or devices that are surgically implanted permanently within the body (except for experimental or research appliances or devices) or those which are used externally while in the hospital as part of regular hospital equipment or when prescribed by a physician for use outside the hospital
- Replacement, repair, fitting and adjustments of the appliance
- For enrollees under age 18, wigs and appropriate related supplies for hair loss caused by chemotherapy or radiation therapy or other cancer treatments, up to $200 for the first purchase and up to $125 for subsequent purchases after each period of 12 months has elapsed
- Through your medical plan carrier, the first set of prescription lenses (eyeglasses or contact lenses) following a cataract operation for any disease of the eye or to replace the organic lens missing because of congenital absence

Durable Medical Equipment (DME) – What Is Not Covered

Equipment not covered under these provisions includes, but is not necessarily limited to, the following:

- Rented equipment that extends beyond the expiration of the original prescription, unless the physician recertifies with another prescription that the equipment continues to be reasonable and medically necessary

- Deluxe equipment such as motor-driven wheelchairs and beds, unless medically necessary
- Comfort, convenience, self-help and environmental items not primarily medical in nature, such as adjust-a-beds, elevators, air conditioners, sauna baths and non-medical supplies such as paging systems
- Physician's equipment
- Exercise and hygienic equipment
- Experimental, investigational or research equipment

Prosthetic and Orthotic (P&O) Appliances – What Is Not Covered

Items not covered under this coverage include, but are not necessarily limited to, the following:

- Dental appliances, hearing aids, eyeglasses, elastic stockings or corrective footwear
- Foot orthotics
- Experimental, investigational or research devices

Hospice

The Program's hospice coverage addresses the needs of terminally ill patients who do not require the continuous level of care provided in a hospital or skilled nursing facility. For terminally ill patients to be eligible for covered hospice expenses:

- the services must be provided and billed by a hospice program that meets Program standards and is approved by the carrier,
- the enrollee must be admitted to the hospice program by order of a physician who certifies that the patient requires this type of care and has a life expectancy of six months or less, and
- the enrollee must voluntarily elect to participate in the hospice program and agree to accept the services provided as treatment of the terminal condition.

An approved hospice program is limited to 2 days of hospice care for each remaining inpatient hospital stay, up to a lifetime maximum of up to 210 days.

Services covered under hospice provisions include, but are not necessarily limited to, the following:

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a social worker under the direction of a physician
- Physician services
- Counseling services provided to the patient, family members and/or other persons caring for the patient at home
- General inpatient care provided in a hospice inpatient unit
- Medical appliances and supplies
- Physical, occupational and speech therapies
- Continuous home care provided during periods of crisis, as necessary to maintain the patient at home
- Respite care (5 days per episode or less in a 30-day period)
- Bereavement counseling
- Care rendered in a nursing home with hospice support
- Home health aide services

Mental Health and Substance Abuse

In the NMVP and Basic Plan, BCBSM uses New Directions to provide and authorize covered services (note that inpatient / hospitalization services require precertification). Your provider or facility will contact New Directions to obtain precertification. Enrollees should call BCBSM directly with any questions about coverage.

All non-emergency inpatient services must be delivered by a participating provider to be eligible for maximum coverage. Emergency detoxification is the only substance abuse treatment service that may be delivered by a non-participating provider. ***Remember, you must use network providers to receive full benefits.***

Covered services provided under the mental health/substance abuse coverage are subject to the same cost sharing provisions (e.g., deductibles, copayment or coinsurance, out-of-pocket maximums) as other covered services under your medical coverage.

Treatment Options

Mental health and/or substance abuse treatment is generally delivered in one of two ways to receive the maximum benefit under the Program:

- Inpatient – with an admission to a participating or network facility
- Outpatient – by periodic visits to a participating or network provider or facility

Inpatient Care – What Is Covered

Note: Inpatient treatment can be delivered as hospital care or in one of several alternative treatment facilities. To be covered, your stay at an inpatient treatment facility must be approved by the carrier within 24 hours of your admission. Treatment at a residential facility must always be approved before treatment begins.

To receive the maximum benefit under the Program, you must use participating or network providers and facilities.

Services covered under the mental health and substance abuse treatment provisions include, but are not necessarily limited to, the following:

- Approved hospital care or treatment in an approved partial hospitalization facility including:
  - Semiprivate room with general nursing services, meals and special diets
  - Laboratory and pathology (hospital care only) examinations
  - Drugs, biologicals, solutions, use of equipment and supplies related to the treatment
  - Professional and ancillary services
  - Individual and group therapy
  - Counseling for family members
  - Electroshock therapy
  - Supplies and use of equipment required for detoxification or rehabilitation of substance abuse patients (hospital care only)
- Psychological testing when administered by a panel psychologist and approved by the carrier
- Treatment of mental disorders, limited to individual and group psychotherapeutic treatment, family counseling, psychological testing prescribed or performed by a physician and electroshock therapy
- Approved skilled nursing facility care

When both inpatient hospital services and treatment in a partial hospitalization or skilled nursing facility are required, each day of inpatient hospital care for any condition (including non-mental health or substance abuse conditions) is equivalent to two days of partial hospitalization facility treatment or skilled nursing care.

Outpatient Care – What Is Covered

*Note: Outpatient treatment does **not** require a hospital stay or admission to a treatment facility. It is delivered during visits to a participating provider. Emergency outpatient treatment requires authorization through the carrier within 24 hours of your first visit.*

- Outpatient services provided and billed by a facility:
  - Professional staff and ancillary services to ambulatory patients
  - Prescribed drugs and medications dispensed by a facility in connection with treatments
  - Electroshock therapy for a mental health patient
- Outpatient services provided and billed by facilities or professional providers, including:
  - Individual psychotherapeutic treatments, group mental health and substance abuse treatment and family counseling to members of patient's family

What Is Not Covered

Certain health care services and charges described in the mental health and substance abuse coverage are excluded or limited, as set forth below:

- Providers are required to verify eligibility and receive prior authorization for all non-emergency substance abuse treatment
- Coverage is not available for the following:
  - Services for treatment of mental disorders that are not amenable to favorable modification, except for the period necessary to determine that the disorder is not amenable to favorable modification
  - Substance abuse treatment professional services such as dispensing methadone, testing urine specimens or performing physical or x-ray examinations, unless therapy, counseling or psychological testing are provided on the same day
  - Family counseling rendered by a provider other than the provider for the family member in the course of treatment
  - Diversional therapy
  - Psychological testing in connection with vocational guidance, training or counseling
  - Tobacco use disorder

General Limitations and Exclusions

Certain health care services and charges

described in the previous sections are excluded or limited. The following are some, but not necessarily all, of these services:

- Services provided and admissions commenced prior to an enrollee's effective date of coverage under the Program
- Services provided after an enrollee's coverage under the Program is terminated except for physician and hospital, skilled nursing facility or residential substance abuse facility services for continuous precertified and approved inpatient admissions that commence before the termination date of the coverage
- Preservation and storage of body components (e.g., blood) for future use
- Private duty nursing services
- Upgraded room accommodations
- Dental services
- Treatment for temporomandibular joint (TMJ) dysfunction
- Chemotherapy services or supplies when the treatment is research, investigational or experimental in nature
- Services, care, treatment or supplies that are not medically necessary according to accepted standards of medical practice
- Care, services, supplies or devices that are experimental, research or investigational in nature
- Personal or convenience items
- Services for premarital or pre-employment examinations
- Charges determined by the carrier to be unreasonable
- Services related to any condition, disease ailment or injury arising out of or in the course of employment for which the employer pays or provides reimbursement under the provisions of any law of the U.S.
- Services for which a charge would not have been made if no coverage existed
- Services available through other programs (e.g., Medicare)
- Services provided to the enrollee by members of the enrollee's household or immediate relatives of the enrollee
- Services related to corrective eye surgery (refer to Vision Plan Coverages)
- Care, services, supplies or devices related to custodial or domiciliary care provided in an institutional setting
- Care, services, supplies, drugs or devices for the purpose of inducing pregnancy
- Travel time or expenses
- Special education facilities and tutoring for learning disabilities or correction of behavioral problems
- Food and certain dietary supplements or vitamins
- Services, supplies, or equipment not performed by, prescribed by or rendered by a physician
- Charges for miscellaneous services, such as acupuncture, massage, hypnotherapy, etc.
- Charges for missed appointments, room or facility reservations, completion of any claim forms or record processing
- Bone marrow transplant services under certain conditions

Dental Plan Coverages

Aptiv covers certain expenses for services and supplies necessary for the treatment of many dental conditions if such services are rendered in accordance with accepted standards of dental practice and are covered by the plan.

Dental coverage is available to employees who have attained 36 months of seniority (applicable to employees with a W1, W3, W4, W5 or W6 Benefit Code).

Aptiv's Traditional Dental Plan coverage has cost-sharing components for certain services. It also includes limits on the benefits you may receive. ***If a course of treatment is expected to involve covered dental expenses of $200 or more, carrier predetermination is required.***

The carrier for Aptiv's Traditional Dental Plan coverage is Cigna Dental. The Traditional Dental plan allows you to see any dentist and receive benefits for covered services. Reimbursement for dental services obtained from a provider is limited to the Reasonable and Customary (R&C) charge for that specific service. Your coinsurance amount will be based on the R&C.

The benefit plan summaries of services covered under the Traditional Dental Plan are available in the Health & Insurance Library at www.netbenefits.com.

Traditional Dental Plan

Traditional Dental Plan coverage is available to employees who have attained 36 months of seniority (applicable to W1, W3, W4, W5 and W6 Benefit Code).

If your dentist recommends treatment with an expected cost of $200 or more, a description of the procedure and estimate of the charges should be filed with Cigna Dental before treatment begins. After considering alternate procedures, services and courses of treatment, your carrier will inform you and your dentist of the charges to be covered for the course of treatment in question.

The predetermination process is not necessary for courses of treatment under $200 or for emergency treatment, routine oral examinations, x-rays, prophylaxes and fluoride treatments.

Failure to file a description and estimate of your course of treatment before treatment could result in higher than anticipated out-of-pocket expenses.

What Is Covered

Services covered under dental provisions include, but are not necessarily limited to, the following:

- ***Preventive*** dental services (reimbursed at 100% of R&C)
  - Two routine oral examinations and cleanings (scaling and cleaning of teeth) within a calendar year (up to three cleanings per calendar year will be allowed if you have a documented history of periodontal disease. Up to four cleanings per calendar year will be covered for two full calendar years following periodontal surgery.)
  - Fluoride treatments, only if under 20 years of age
  - Space maintainers to replace prematurely lost teeth for children under 19 years of age
  - Emergency treatment for temporary relief of pain
- ***Minor restorative*** services (reimbursed at 90% of R&C; you pay 10% of R&C)
  - Dental x-rays, including: full mouth x-rays once in any five-consecutive calendar-year period; bitewing x-rays once per calendar year; other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment
  - Extractions
  - Oral surgery
  - Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations
  - General anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery
  - Treatment of periodontal and other

diseases of the gums and tissues of the mouth
  - Endodontic treatment, including root canal therapy
  - Injection of antibiotic drugs by the attending dentist
  - Initial installation of crowns
  - Repair or recementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, limited to one relining or rebasing in any three-year period
  - Inlays, onlays, gold fillings or crown restorations, only when the tooth cannot be restored with other filling restoration
  - Cosmetic bonding of eight front teeth for children 8 through 19 years of age, under certain conditions, but not more frequently than once in any 3-year period

- ***Major Restorative*** services (reimbursed at 50% of R&C; you pay 50% of R&C)
  - Initial installation of fixed bridgework (including inlays and crowns as abutments)
  - Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation)
  - Replacement of an existing partial or full removable denture or fixed bridgework when:
    - The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or
    - The existing denture or bridgework cannot be made serviceable and if it was installed under this coverage, at least five years have elapsed prior to the replacement; or
    - The existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture

- ***Orthodontic*** procedures and treatment (reimbursed at 50% of R&C; you pay 50% of R&C), including related oral examinations, for a covered individual ***under 19 years of age when treatment commences, up to a lifetime maximum of $2,000 per enrollee***

- ***Accidental dental injury*** services for repair and/or care of ***natural teeth***. For this component to apply:
  - the annual maximum benefit must be exhausted;
  - the accident must be documented;
  - the services must be a direct result of the accident and be provided within one year of the accident;
  - services are reimbursed at 80% of R&C and are subject to a maximum benefit payment of $12,000 per qualified occurrence and per lifetime.

The ***maximum benefit*** payable for ***all*** covered dental expenses during any calendar year is $1,700 per covered person under Traditional Dental. For expenses in connection with orthodontics, including related oral examinations, the maximum ***lifetime*** benefit per eligible covered individual is $2,000. For accidental injury, the ***lifetime*** maximum is $12,000.

What Is Not Covered

Services not covered under dental provisions include, but are not necessarily limited to, the following:

- Charges for services covered under other health care coverages
- Charges for the following:
  - Treatment by someone other than a dentist
  - Veneers or similar properties of crowns and pontics for certain teeth
  - Services or supplies that are cosmetic in nature
  - Prosthetic devices, crowns, inlays and onlays and their fitting ordered while you were not covered
  - Replacement of a lost, stolen or missing prosthetic device
  - Failure to keep a scheduled visit with a dentist
  - Replacement or repair of an orthodontic appliance
  - Services or supplies compensable under workers' compensation or employer's liability
  - Services rendered through a facility provided or maintained by Aptiv

- Services or supplies that the enrollee is not legally obligated to pay or for which no charge would be made in the absence of dental coverage
- Services or supplies that are not necessary, recommended, or approved by the attending dentist
- Services or supplies that are experimental in nature
- Services or supplies received as result of dental disease, defect or injury due to an act of war, declared or undeclared
- Services or supplies from any governmental agency obtained by the enrollee without cost by compliance with laws or regulations
- Any duplicate prosthetic device or appliance
- Completion of any insurance forms
- Sealants, oral hygiene and dietary instruction
- A plaque control program
- Implants
- Services or supplies related to periodontal splinting
- Orthodontia

A Closer Look at the Traditional Dental Plan

	Traditional Dental Coverage	
Deductible	None	
Coinsurance • Preventive • Minor restorative • Major restorative • Orthodontics	Plan Pays* 100% 90% 80% 50%	You Pay* 0% 10% 20% 50%
Maximum annual benefit	$1,700 per covered person	
Maximum lifetime orthodontic benefit	$2,000 per covered person under age 19	
Maximum lifetime accidental dental injury benefit	$12,000 per covered person	

** Based on the Reasonable and Customary (R&C) amount determined by Cigna Dental.*

Vision Plan Coverages

Vision coverage is provided by Davis Vision. Aptiv's vision coverage provides assistance toward the cost of routine eye exams, lenses, and frames through a national network of participating providers, which includes ophthalmologists, optometrists, and optical facilities.

Vision coverage is available to employees who have attained 60 months of seniority (applicable to employees with a W1, W3, W4, W5 or W6 Benefit Code).

The benefit plan summary of services covered under the vision plan are available in the Health & Insurance Library at www.netbenefits.com.

What Is Covered

Services covered under vision provisions include, but are not necessarily limited to, the items below:

- One vision examination (by an optometrist or an ophthalmologist) per calendar year including refraction, case history, coordinating measurements, and tests
- Prescription of glasses where indicated
- Examination by an ophthalmologist, upon referral by an optometrist, within 60 days of a vision examination by the optometrist
- Materials and professional services connected with the order, preparation, fitting of frames and lenses, and initial adjusting of:
  - Normal size lenses (single vision, bifocals, trifocals, lenticular) once per calendar year
  - Number 1 or 2 tint for lenses
  - Contact lenses in lieu of regular lenses:
    - Following cataract surgery;
    - When visual acuity cannot be corrected to 20/70 in the better eye;
    - When medically necessary due to keratoconus, irregular astigmatism, or irregular corneal curvature; or
    - Up to $80 when prescribed for any other reason than those listed above
  - Frames once during two consecutive calendar years
    Note: Usually, the first pair of lenses, either regular or contacts, following cataract surgery are covered under the medical plan.
- Limited coverage for corrective eye surgery (e.g. LASIK, PRK, RK). Upon proof of payment to a corrective eye surgery provider, the vision carrier will reimburse an enrollee for covered expenses, up to the lesser of the provider's charges or the maximum benefit of $295 in any four-year period. The enrollee may not receive benefits for both corrective eye surgery and for frames and/or lenses (including contact lenses) in the same calendar year. If the enrollee receives benefits for corrective eye surgery in any calendar year, the enrollee will not be eligible for lenses (including contact lenses) and/or frame benefits for that year and for three subsequent years. During that time, that enrollee will be eligible for benefits for an annual eye exam, will have access to the participating provider fee schedule for non-covered services and for lenses and/or frames for which no benefit is available, and other covered family members will remain eligible for full vision benefits.

What Is Not Covered

Services not covered under vision provisions include, but are not necessarily limited to, the following:

- Any lenses that do not require a prescription
- Medical or surgical treatment of the eye
- Drugs or any other medication
- Procedures determined by the carrier to be special or unusual (e.g., orthotics, vision training)
- Vision examinations, lenses, or frames obtained without cost to you
- Vision examinations performed and lenses and frames ordered before you become eligible for coverage or after the termination of your coverage

Vision Network

The Davis Vision network is made up of vision providers who have agreed to accept reimbursement, to meet certain contractual standards for quality, and to provide a selection of frames available to enrollees at no cost.

Going to a participating network provider will reduce your out of pocket expenses. First, you will have no copayments or out of pocket expense for covered vision services such as a routine vision exam, regular size lenses, any "Fashion" frame from the Davis Vision Tower Collection, or medically necessary contacts. Secondly, you may upgrade your frame selection by choosing a designer or premium frame from the Davis Vision Tower Collection for a nominal fixed charge. Finally, there are many popular non-covered lens features whose prices are discounted under the participating provider agreement.

In addition, participating providers can check on your eligibility, file your claim and be authorized by you to receive the reimbursement for covered services directly from Davis Vision. A list of participating providers may be received by calling 1-888-463-9370.

Out of Network

Generally, if you choose to receive covered vision services from a non-participating provider you will have to pay the provider and file your own claim with Davis Vision. The carrier will reimburse you directly based on a fee schedule. However, there is one exception: Your reimbursement for vision exams provided by a non-participating ophthalmologist will be based on the reasonable and customary charge as established by the carrier minus a $7 copayment.

Out of Area

If you live more than 25 miles from a participating provider and choose to receive covered services from a non-participating provider, your reimbursement will be based on reasonable and customary charges as determined by the carrier minus a $7 copayment for exams and a $10 combined copayment for lenses and frames.

Summary

The chart shown below summarizes the benefit frequency and the level of reimbursement for covered vision services when received In Network, Out of Network, or Out of Area.

Benefit	Frequency	Network Provider	Out of Network	Out of Area
Vision Exam - Optometrist	Once every calendar year	Covered in Full	Enrollee reimbursed based on regional fee schedule	Enrollee reimbursed based on R&C** minus $7 copay
- Ophthalmologist			Enrollee reimbursed based on R&C** minus $7 copay	Enrollee reimbursed based on R&C** minus $7 copay
Frames	Once every two consecutive calendar years	**Davis Vision Collection Frames**: - Fashion - covered - Designer - $10 copay - Premier - $25 copay, or up to $60 allowance for non-plan frames	Enrollee reimbursed $24	Enrollee reimbursed $24 minus a $10 copay, if applicable***
Lenses	Once every calendar year	Covered lenses available at no cost; Standard lens options at set copays	Enrollee reimbursed based on regional fee schedule	Enrollee reimbursed based on R&C** minus $10 copay
Contact Lenses	Once every calendar year in place of regular lenses	Enrollee pays difference between provider charge and $80 allowance	Enrollee reimbursed $65	Enrollee reimbursed $80 minus a $10 copay
Corrective Eye Surgery	Once every four consecutive calendar years	Enrollee reimbursed up to $295. Enrollee is not eligible for frames, lenses or contacts for three (3) subsequent years.	Enrollee reimbursed up to $295. Enrollee is not eligible for frames, lenses or contacts for three (3) subsequent years.	Enrollee reimbursed up to $295. Enrollee is not eligible for frames, lenses or contacts for three (3) subsequent years.

** Out of Area occurs when there is no network provider within 25 miles of the enrollee's residence.*
*** R&C stands for Reasonable and Customary charges.*
**** There is a combined annual copayment of $10 for lenses and frames.*

Coordination of Benefits

The purpose of coordination of benefits (COB) is to avoid duplicate payment of benefits in the event an individual is covered by more than one employer's health care plan. If you or your dependents are covered by another employer's medical, dental or vision plan, the benefits/coverages will be coordinated between the two plans. To determine how to coordinate the coverage under the two plans, it is necessary to determine which plan pays first.

The primary plan will pay first, without consideration to any other plan, according to the guidelines of its coverage. The secondary plan does not consider a claim for benefits until the primary plan pays or denies the claim. The secondary plan then follows its procedure to determine its payment, coordinated with the payment already made by the primary plan.

It is the carrier's responsibility to identify if another health care plan is primary and to administer the coordination of benefit provisions in accordance with the Program provisions and their normal administrative practices. It is your responsibility to notify your carrier and to respond to inquiries from the carrier about other possible coverage. Failure to provide the necessary information could result in your claim not being processed for payment.

Because you are an employee, your Aptiv plan will be primary for most of **your** health care claims. If you are also covered as a dependent under your spouse's plan, you should submit your claim to the carrier of their plan after your claim has been processed under the Aptiv plan.

If your dependent child(ren) is covered by both your plan and your spouse's plan, the "Birthday Rule" applies.

The Birthday Rule

The primary plan for your child(ren)'s coverage is the plan of the parent whose birthday comes first in the calendar year. If you and your spouse have the same birthday, then the plan that has covered your child(ren) for the longer period of time is primary.

If you are ***divorced or legally separated***, the plan of the parent who has legal custody of the dependent child(ren) is that child(ren)'s primary plan unless an appropriate court order states otherwise, and the plan of a step-parent with whom the child(ren) resides will pay before the plan of the parent without custody.

If none of these rules establish which plan is primary, the plan that has covered the person for the longer time becomes the primary plan.

When the Program Is Secondary for a Claim

The Program calculates the amount it would pay, in accordance with the Program provisions and the carrier's normal administrative practices, as if there were no other coverage. The amount of benefits actually payable by the other plan for services covered by the Aptiv plan is then subtracted from the amount the Aptiv plan would have paid. The Aptiv plan pays the difference, if any. In other words, if the primary plan's payment meets or exceeds the amount the Aptiv plan would have paid alone, no further payment is made. ***Through the coordination of benefits process, you cannot receive any more than the total amount of the charge***.

When there are multiple coverages, you must first file the claim with the primary health care plan. After you have received written notification of payment or denial from the primary carrier, you should make a copy of it and submit it to the carrier of the secondary plan.

The Program will not coordinate with individual or family policies of insurance (e.g., personal automobile insurance) purchased by the enrollee.

How to File a Claim

When you receive services from network providers, claims are filed electronically, and you generally will not need to file a claim. However, if you do need to file a claim, claims should be filed with the appropriate carrier as services are rendered and expenses are incurred. ***Claims for all health care services must be submitted no later than the end of the calendar year following the year in which services are rendered.*** Claim forms are available from the carrier.

Your medical card contract number or ID number is always needed when you communicate with any of the carriers. If you are a dependent, the contract number or ID number of the employee or surviving spouse through whom you have the coverage is needed. You also may need a carrier group number. Check your medical ID card for these numbers. In some cases, your Social Security Number may be needed.

Hospital, Medical and Surgical Claims

Under the NMVP and Basic Plan, the carrier is responsible for the administration of all the covered services under the Program, except for Prescription Drug Coverage.

Show your medical identification card when you go to the hospital, residential or outpatient treatment facility, physician or other provider of covered services anywhere in the country. Usually, a hospital or other facility is paid directly by Blue Cross for covered services. Blue Shield generally pays physicians directly for covered services. In any situation where a provider of a service is not paid directly by Blue Cross-Blue Shield, please send the information to BCBS of Michigan: Aptiv Customer Service Center, PO Box 33241, Detroit, MI 48232-5241.

Prescription Drug Claims

When you use a network provider, the provider will file claims for prescription drugs electronically with Express Scripts (show your prescription drug identification card to the retail pharmacy). If you obtain services from a non-network provider, you will be required to pay the full charge and file a claim. You can obtain claim forms by calling Express Scripts or by visiting Express-Scripts.com. You and/or the provider may complete all the required information on the form. You may then mail the claim to the address noted on the form. Express Scripts will then reimburse you the appropriate amount minus your cost share (e.g., copayment or coinsurance).

Mental Health and Substance Abuse Claims

If it becomes necessary for you, instead of the facility or provider, to submit a claim form to BCBS of Michigan (e.g., when you receive mental health or substance abuse services from a non-participating provider), you are required to send the originals of either itemized bills, statements or receipts for each of the medical expenses for which you are claiming payment with a letter indicating date of service, member ID number, charge and diagnosis. Claim forms are not necessary if the letter is explicit. Please send the information to BCBS of Michigan: Aptiv Customer Service Center, PO Box 33241, Detroit, MI 48232-5241.

Hearing Aid Claims

Because only approved or participating providers are eligible for reimbursement, such providers generally will have the necessary hearing aid claim forms. Benefits will be paid directly to the provider by the carrier. ***Benefits are payable only if you obtain hearing aid services from a participating provider, and only if they are obtained in the appropriate sequence.*** Ask the provider if he or she is participating ***before*** you receive services. If you need the name of a participating provider, contact BCBS of Michigan.

Durable Medical Equipment (DME) and Prosthetic and Orthotic (P&O) Claims

You should only obtain Durable Medical Equipment and Prosthetic and Orthotic Appliances from a network provider. By using network providers, you will not have to file claim forms, nor will you receive balance due billings from providers. If you receive covered items or services from non-network providers, you will be responsible for paying the provider and submitting the claim and supporting documentation to the carrier. The carrier will then send payment to you based upon the amount applicable to network providers. You may be required to pay the amount due to the provider that is in excess of

network fee schedules.

Dental Claims

Cigna does not mail dental identification cards. When you visit your dentist, let them know that you have Cigna Dental coverage for Aptiv hourly employees. They will call a dental provider hotline to confirm your eligibility and coverage. Alternatively, you may login at www.mycigna.com to obtain your Cigna Dental ID number and/or print your ID card.

In areas of the country where Aptiv has business operations, most local dentists are able and willing to file claims on behalf of Aptiv enrollees. However, if you need to file a dental claim with Cigna Dental, forms are available through www.cigna.com or www.mycigna.com.

If a course of treatment is expected to involve dental expenses amounting to $200 or more, before the commencement of treatment, you should have your dentist submit a description of the procedures to be performed and an estimate of the charges to Cigna Dental. Cigna Dental will notify the dentist and you of estimated benefits payable, with consideration given to alternate procedures that may be performed to accomplish the desired results.

Appealing a Claim

Initial Claim Determination

When you receive a covered service, you must file a claim with the appropriate carrier. Generally, your provider will file the claim for you. Once a complete claim is received, the carrier must make an initial determination within a set time limit. There are different time limits depending on the type of claim that is presented. Claims are classified as post-service claims, pre-service claims, urgent care claims and concurrent care claims.

Most claims will be considered post-service claims. A **post-service** claim is a claim made for a service that has already been provided. Carriers have 30 days after receiving the initial claim to provide an initial claim determination. The carrier may take up to 45 days to respond if the claim does not provide enough information and if an extension notice is mailed to you.

A **pre-service** claim is a claim for a benefit under a group health plan where the terms of the plan require approval of the service in advance of obtaining care. Generally, a service requiring precertification as a condition of payment would be considered a pre-service claim. Carriers have 15 days after receiving the initial claim to provide an initial claim determination. The carrier may take up to 30 days to respond if the claim does not provide enough information and if an extension notice is mailed to you. If you do not follow procedure (e.g., misdirect the claim, but provide sufficient information to an individual responsible for benefits administration), the health plan or carrier must inform you of the proper procedure within 5 days.

An **urgent care claim** is generally a type of pre-service claim, where the application of normal claims processing time limits could “seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function,” or where a physician determines that the claimant would be subjected to “severe pain” without the care or treatment. If a pre-service claim is determined to be an urgent claim, the carrier must provide a response to an initial claim for urgent care as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim to provide a response. If you do not follow procedure (e.g., misdirect the claim, but provide sufficient information to an individual responsible for benefits administration), the health plan or carrier must inform you of the proper procedure within 24 hours.

A **concurrent care claim** is a claim for ongoing treatment over a period of time or a number of treatments. For example, if you have been authorized to receive seven treatments from a therapist and during the treatment, your therapist suggests 10 treatments, your claim is a concurrent care claim. For a concurrent care claim involving urgent care, you will receive a decision as soon as possible, taking into account the medical urgency, but no later than 24 hours after the carrier receives your claim – regardless of whether the claim is approved or denied, in whole or in part – provided you file the claim at least 24 hours before the end of the initially approved period of time or number of treatments. Any other request to extend an ongoing course of treatment will be subject to the applicable time limits for urgent care claims, pre-service claims and post-service claims.

If you disagree with the decision about your benefit claim, have any question regarding lack of coverage or are concerned about an anticipated claim, you should first contact your carrier.

Mandatory Appeal Process or Internal Review Procedure

If you wish to appeal a claim denial, you have at least 180 days to submit a written appeal after the carrier notifies you of the denial or “adverse benefit determination”. An "adverse benefit determination" includes a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a benefit, or a rescission of coverage.

If the carrier makes an adverse benefit determination, the carrier will inform you in writing:

- the specific reasons for the denial or adverse benefit determination;
- references to the specific Plan provisions on which the adverse benefit determination was 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 your claim;
- information sufficient to identify the claim, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and each code’s corresponding meaning;
- any internal procedures or clinical information upon which the adverse benefit determination was based (or a statement that this information will be provided free of charge, upon request);
- if the adverse benefit determination is based on a medical necessity, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant's medical circumstances (or a statement that this explanation will be provided free of charge, upon request);
- the Plan’s available review procedures and that you have the right to bring a civil action under Section 502(a) of ERISA after your claims and appeals process is exhausted; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal review and external review processes.

Follow the instructions provided on the Explanation of Benefit (EOB) statement you receive from the carrier, and send your written appeal to the address of the appropriate carrier.

In the case of a claim involving urgent care, when the services in question require pre-authorization, you may start the appeal by a telephone call to the appropriate carrier.

To appeal a determination regarding <u>eligibility</u> under the Program, you must direct your appeal to the Fidelity Benefits Center at 1-877-389-2374.

The carrier (or the Fidelity Benefit Center, if the issue pertains to eligibility) will review the appeal internally and provide a decision on the appeal within the applicable time period. Some carriers may use a two-step process for such appeals. If you are enrolled in an option that has a two-step process, you should follow the instructions on the first appeal response you receive to elevate your appeal to the second step.

Under the mandatory appeal process, the carrier has been delegated authority to construe, interpret, apply and administer the Program.

Although there is no review procedure with Aptiv, you still have the ability to consult Aptiv directly to discuss a carrier’s decision under the mandatory appeal process.

External Review Procedure (for medical and prescription drug claim denials)

Once you have completed the mandatory appeal process offered by the medical or prescription drug carrier and the carrier upholds the decision following its internal review, you may request an external review of medical or prescription drug claim denials through the carrier (the carrier’s denial letter will instruct you how to initiate the external review procedure).

The type of claims for which external review is available generally includes claims involving medical judgment, as determined by the external reviewer, or a rescission of coverage, but not claims involving a denial of coverage based upon eligibility for participation under a plan.

Your request for external review must be filed within 4 months after receiving notice of an adverse benefit determination. The external review will be completed by an Independent Review Organization (IRO). The IRO will provide written notice to you of its decision within 45 days after receiving your request for external review.

Following the IRO’s review, you have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974.

Effect of Medicare

General Information

You become eligible for Medicare at age 65, whether or not you choose to continue working. However, if you continue to work after age 65, Social Security will not notify you of your eligibility to enroll for Medicare. ***It is your responsibility to contact the local Social Security Administration office to apply for Medicare***, whether or not you are working when you attain age 65. It is suggested this contact be made three months before you turn age 65. This will allow enough time to process your application so you will not miss your initial opportunity for enrollment.

If you or one of your dependents has a severe long-term disability or end-stage renal disease, or undergoes a kidney transplant, you may be eligible for Medicare coverage before age 65. Contact your nearest Social Security Administration office to have your case evaluated.

Generally, you or your dependents will want to enroll for Medicare Part A and Part B when you first are eligible to do so. This is true not only because of penalties that may be incurred in Medicare premiums, but also because Medicare may cover services not covered by any other coverage you may have.

Medicare Part A and Part B are coordinated with your Aptiv coverage while you are actively at work and enrolled in the Program. According to current Medicare regulations, Medicare coverages are secondary to employer coverages for active employees. Therefore, as long as you are actively at work and enrolled in the Program, your Aptiv coverages will be your primary coverage. Conversely, if you have Medicare due to age and have been on an approved disability leave for more than 6 months (i.e., you are no longer an active employee; only the first 6 months of employer disability benefits are subject to FICA taxes), Medicare is primary per current Medicare regulations and your Aptiv medical coverage is secondary.

Unlike Medicare Part A and Part B, Medicare Part D (which provides prescription drug coverage) is not coordinated with the Program. In general, the Aptiv prescription drug coverage is, on average for all plan participants, as good as or better than the standard Medicare drug coverage, and you should carefully consider your options before enrolling in a Medicare Part D plan.

You may choose to delay enrolling in Medicare Part B and Part D because you are actively employed and covered under the Program. However, when you cease working and lose your Aptiv coverage, you only have a limited period of time to enroll in Medicare Part B and Part D. If you delay enrollment beyond the prescribed timeframe, you may have to pay more for Medicare Part B and Part D coverage. You should consult the Medicare information available on www.medicare.gov for the specific Medicare enrollment rules and other important information about Medicare while actively employed and enrolled in an employer group health plan.

All Medicare Beneficiaries will receive annual mailings and information from the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare.

Reimbursement for Third-Party Liability (Subrogation)

You or a covered family member may be injured and incur health care expenses because of another party's wrongdoing. While Aptiv will continue coverage while liability is being determined, Aptiv should not bear the financial burden if another party is responsible. Consequently, if Aptiv pays benefits on behalf of you or one of your dependents and you recover any monies from a third party for the same expenses, you are expected to reimburse the Program.

You must notify the Corporation (or your health care carriers on behalf of the Corporation) of any such recovery (or effort to recover) from a third party. You must help in the recovery effort. Note:

- Aptiv assumes your right to recover payment from any third party, up to the extent of such third party's liability.
- If you recover any monies through lawsuit, settlement or other means, you must reimburse Aptiv for benefits paid.
- You grant Aptiv a lien on any monies you or your beneficiaries may recover, either through settlement or otherwise, whether the recovery is designated economic or non-economic damages.
- You grant Aptiv the right to intervene in a lawsuit for the purpose of enforcing Aptiv's lien.
- You grant Aptiv the right to recover its legal fees and costs that exceed Aptiv payment of benefits from any recovery.
- You agree to inform Aptiv when you engage an attorney to pursue a claim, and to inform

your attorney of Aptiv's rights under the Program.

- You agree not to settle any claim or take any action that would prejudice Aptiv's rights or interests.

Life Insurance

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Life Insurance Program

If you are a regular active (permanent) employee (applicable to employees with a W1, W3, W4, W5 or W6 Benefit Code), you are eligible for Basic Life, Extra Accident, Optional Life and Dependent Life Insurance and Personal Accident Insurance coverages.

The Fidelity Benefits Center is the administrator for Life Insurance eligibility, enrollment and continuation during an eligible leave of absence. MetLife is the insurance carrier for the Basic Life, Optional Life, Dependent Life and Personal Accident Insurance plans. These plans will be administered in compliance with applicable state laws to the extent legally required and to the extent such laws are not pre-empted by federal law.

Basic Life Insurance, Optional Life Insurance, Dependent Life Insurance and Personal Accident Insurance is term insurance, which provides no paid-up insurance or loan or cash value.

Basic Life Insurance and Extra Accident Coverage

When Coverage Starts

You are eligible for Basic Life and Extra Accident coverage the first day of the month following your date of hire provided you are actively at work (applicable to W1, W3, W4, W5 and W6 Benefit Codes). If you are not at work on the day your coverages would otherwise start, these coverages begin the day you return to active employment.

Amount of Coverage

Basic Life Insurance

If you are a production employee and have less than 60 months of seniority, you are eligible for Basic Life Insurance in the amount of $10,000 (applicable to W1 Benefit Code). New skilled trades employees are eligible for Basic Life Insurance in the amount of $40,000 (applicable to W3 Benefit Code).

When you attain 60 months of seniority you are eligible for Basic Life Insurance coverage in the amount of $40,000 (applicable to W3, W4, W5 and W6 Benefit Codes).

Extra Accident Insurance

Extra Accident Insurance may be payable to your beneficiary for death, or to you for loss of certain bodily members, or loss of eyesight as the result of an accident. Extra Accident Insurance is equal to one-half of your Basic Life Insurance amount in effect.

For the Extra Accident benefit to be payable, your death must occur within one year after the covered accident, and a loss of certain bodily members or eyesight must occur within two years of the covered accident and cannot be caused wholly or partly, directly or indirectly by:

- physical or mental illness, diagnosis of or treatment for the illness or diagnosis thereof; or
- any infection, except infection caused by an external visible wound accidentally sustained; or
- hernia, no matter how or when sustained; or
- war (declared or undeclared) or any act of war; or
- intentional self-destruction or intentionally self-inflicted injury, while sane or insane.

If death results from an accidental bodily injury caused solely by employment with Aptiv, three times the scheduled benefit amount of Extra Accident Insurance may be payable.

Cost of Coverage

Aptiv pays the entire cost of your Basic Life and Extra Accident coverage while you are actively at work, and during an approved leave of absence up to a specified length of time. See page 75 for details.

Federal law requires the value of Corporation-paid life insurance coverage, which includes Basic Life over $50,000 to be included as income to you, subject to Federal Income Tax and Federal Insurance Contributions Act (FICA) tax withholding. This is known as Imputed Income. The Fidelity Benefits Center systematically calculates imputed income and submits the amount to payroll for tax withholding, if applicable.

Beneficiaries

You may name anyone you wish as your beneficiary(ies), and you may change your beneficiary at any time. If circumstances in your

life change (such as marriage, birth of a child, divorce or death or a spouse), you may want to change your beneficiary designation. To change a beneficiary, contact the Fidelity Benefits Center at 1-877-389-2374 or www.netbenefits.com.

If you die from any cause while coverage is in force, your beneficiary will receive a benefit equal to the amount of your Basic Life Insurance in effect, less any Accelerated Benefits Option payment you may have received (see the next section).

The Basic Life and Extra Accident Insurance, if any, shall be paid in one sum in one of the following forms:

- 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.

Other modes of payment may be available upon request.

If you do not have a beneficiary when you die, MetLife may, at its discretion, pay all or part of that amount, generally in the following order, to one or more of the following persons who are related to you and who survive you:

- Spouse
- Child
- Parent
- Estate

Any payment will discharge MetLife's liability for the amount so paid.

To ***apply for life insurance benefits***, a beneficiary must call the Fidelity Benefits Center at 1-877-389-2374. A certified copy of the death certificate will ultimately be required by MetLife.

Accelerated Benefits Option

If you are diagnosed as having a terminal illness with a life expectancy of 12 months or less, you may be eligible to receive an Accelerated Benefits Option payment of up to 50%, but not less than $1,000, of your Basic Life Insurance.

The total of an Accelerated Benefits Option payment and the amount of Basic Life Insurance payable at your death may not be more than the amount of Basic Life Insurance that would have been payable without the Accelerated Benefits Option payment.

An Accelerated Benefits Option payment will be made:

- as of the date the insurance company certifies all eligibility requirements are met;
- only once, regardless of the amount elected;
- only in one lump sum; and
- only if you are living when payment is made.

Payment will be reduced by any benefits paid to you under any Aptiv benefit plan that should not have been paid or should have been paid in a lesser amount.

An accelerated benefit will not be payable if all or a portion of your Basic Life Insurance is to be paid to a former spouse and/or children as part of a divorce agreement.

The Accelerated Benefits Option is subject to state availability and regulation.

Years of Participation Under the Life and Disability Benefits Program

Years of Participation will equal your seniority.

Optional Life Insurance

In addition to the coverages provided with Aptiv Corporation contributions, you may buy additional protection under the Life and Disability Benefits Program.

When You Are Eligible

You are eligible for Optional Life Insurance the later of October 19, 2020 or the first day of the month following your date of hire provided Basic Life Insurance is in force (applicable to W1, W3, W4, W5 and W6 Benefit Codes).

Amounts of Coverage Available

You may elect Optional Life Insurance for yourself in the following amounts: $10,000; $20,000; $30,000; $40,000; $50,000; $75,000; $100,000; $125,000; $150,000; $175,000; or $200,000.

Effective Date of Coverage

The date your coverage takes effect depends upon when the Fidelity Benefits Center receives your election. If your election is received:

- **within 31 days after your eligibility date,** insurance takes effect the first day of the month following the date your election is received, if you are actively at work.
- **more than 31 days after your eligibility date,** you will be required to furnish proof of your good health, satisfactory to MetLife. Once your application is approved by MetLife, coverage will go into effect on the first of the month following the date such proof is approved by MetLife, provided you are actively at work on that date.

You may apply to add or increase coverage at any time. You will be required to furnish proof of your good health, satisfactory to MetLife. Once your application is approved by MetLife, coverage will go into effect on the first of the month following the date such proof is approved by MetLife, provided you are actively at work on that date.

If you apply to add or increase coverage during the 31-day period after a change in family status, the requirement to furnish proof of your good health may be waived. Insurance takes effect on the first day of the month following the receipt of your election, provided you are actively at work on that date.

If you are not actively at work on the date that coverage would otherwise start, coverage will start on the date you return to active work.

Cost of Coverage

You pay the full cost of Optional Life Insurance. Your monthly contribution is based on the amount of coverage elected and your age as of January 1 of the applicable Plan Year following your birthday (i.e., for the 2021 Plan Year, contributions are based on your age as of January 1, 2022).

The Fidelity Benefits Center can inform you of the current monthly contribution rates. Rates are subject to change by the insurance company.

Beneficiaries

You may name anyone you wish as your beneficiary(ies), and you may change your beneficiary at any time. The beneficiary of Optional Life Insurance does not have to be the same beneficiary you have named for your Basic Life Insurance. However, if you do not name a beneficiary, the proceeds will be paid to the beneficiary designated for Basic Life Insurance. If circumstances in your life change, you may want to change your beneficiary designation.

If you die from any cause while coverage is in force, your beneficiary will receive a benefit equal to the amount of your Optional Life Insurance in effect, and will automatically be paid to your beneficiary.

If you do not have a beneficiary when you die, MetLife may, at its discretion, pay all or part of that amount, generally in the following order, to one or more of the following persons who are related to you and who survive you:

- Spouse
- Child
- Parent
- Estate

Any payment will discharge MetLife's liability for the amount so paid.

To ***apply for life insurance benefits***, a beneficiary must call the Fidelity Benefits Center at 1-877-389-2374. A certified copy of the death certificate will ultimately be required by MetLife.

Dependent Life Insurance

When You Are Eligible

You are eligible for Dependent Life Insurance the later of October 19, 2020 the first day of the month following your date of hire provided Basic Life Insurance is in force and you have an eligible dependent (applicable to W1, W3, W4, W5 and W6 Benefit Codes). If you do not have an eligible dependent (spouse and/or child) when you are first eligible, you can elect Dependent Life Insurance on the date you meet all the above requirements.

Definition of an Eligible Dependent

Under the plan, an eligible dependent is defined as:

- Your legal spouse
- Your dependent child who is over 14 days of age and satisfies **all** the following tests:
    - **Relationship:** The child must be yours or that of your spouse, by birth or legal adoption (a child pending adoption will satisfy this relationship test as of the date the adoptive parents take custody pursuant to the adoption process, referred to as "the date of petition and residency").

— **Age:** Unless qualifying as "Totally and Permanently Disabled" as defined below, the longest a child will remain eligible is the end of the calendar year in which they turn age 25. After the end of the calendar year in which the child turns age 19, the child must be a full-time student for at least one full school term during the calendar year to be eligible.

  A Totally and Permanently Disabled child will continue to satisfy this requirement after age 19, provided the child was covered under the Program and becomes Totally and Permanently Disabled prior to age 19 and continues to satisfy the totally and permanently disabled criteria ("Totally and Permanently Disabled" means having any medically determinable physical or mental condition that prevents a child from engaging in substantial gainful activity and that can be expected to result in death or be of long-continued or indefinite duration).

— **Marital status:** The children must not be married.

— **Residency:** The child must live with **you** (or be temporarily away from home while attending school full time) or **you** must be legally responsible for the child's health care expenses per a divorce decree or court order, paternity order or a Qualified Medical Child Support Order (QMCSO) as defined by the Omnibus Budget Reconciliation Act of 1993 (OBRA-93). If the legal responsibility is established pursuant to a paternity order or any other order that does not meet the requirements for a QMCSO, then the child must be dependent upon you, meaning that you must legally claim an exemption for the child under Section 151 of the Internal Revenue Code for federal income tax purposes.

— **Dependency:** The child must be dependent upon the employee within the meaning of the U.S. Internal Revenue Code and must legally reside with, and be a member of the household of, the employee after the end of the calendar year in which the child attains age 19.

A child may not be covered as a dependent of more than one Aptiv employee. **Additionally, any person insured as an employee will not be considered an eligible dependent.** In no event will two claims be paid for one individual.

The definition of an eligible dependent may be subject to determination in accordance with applicable state insurance laws.

Amount of Coverage Available

You may elect Dependent Life Insurance for your spouse and/or eligible children in the following amounts:

Dependent Life Insurance Coverage Amounts	
Spouse	**Child(ren)**
$5,000	$2,000
$10,000	$4,000
$15,000	$6,000
$20,000	$8,000
$25,000	$10,000
$30,000	$12,000
$35,000	$14,000
$40,000	$16,000
$45,000	$18,000
$50,000	$20,000
$60,000	$24,000
$75,000	$30,000

Effective Date of Coverage

The date your coverage takes effect depends upon when your election is received by the Fidelity Benefits Center.

If your election is received:

- **within 31 days after your eligibility date,** insurance takes effect the first day of the month following the date your election is received, if you are actively at work.
- **more than 31 days after your eligibility date,** you will be required to furnish proof of good health for each dependent, satisfactory to MetLife. Once your application is approved by MetLife, coverage will go into effect on the first of the month following the date such proof is approved by MetLife, provided you are actively at work on that date.

If you elect an amount of coverage for your

spouse in excess of $50,000, you must provide proof of your spouse's good health in order for any coverage amount in excess of $50,000 to take effect.

Coverage amounts in excess of $50,000 will take effect on the first day of the month following the date the evidence is approved, as long as your dependent is still eligible and you are actively at work.

If you apply to add or increase coverage during the 31-day period following the addition of your first dependent, insurance takes effect on the first day of month following the date your election is received, if you still have an eligible dependent and you are actively at work on that date.

If you are not actively at work on the date that coverage would otherwise start, coverage will start on the date you return to active work.

Cost of Coverage

You pay the full cost of Dependent Life Insurance. Your monthly contribution for Dependent Life Insurance for your spouse is based on your age as of January 1 of the applicable Plan Year following your birthday (i.e., for the 2021 Plan Year, contributions are based on your age as of January 1, 2022). If you elect Dependent Life Insurance for your eligible child(ren), the cost is based on the amount of coverage you elect and is the same regardless of the number of children covered.

If your surviving spouse continues coverage through MetLife, the monthly contribution rate will be based on the age of the surviving spouse during the applicable Plan year.

The Fidelity Benefits Center can inform you of the current monthly contribution rates. Rates are subject to change by the insurance company.

Beneficiaries

You are always the beneficiary for Dependent Life Insurance. If your surviving spouse continues coverage after your death, the beneficiary will be the beneficiary he or she designates.

If an eligible dependent dies from any cause, benefits will automatically be paid to you.

Personal Accident Insurance

When You Are Eligible

Employees (applicable to W1, W3, W4, W5 and W6 Benefit Codes) are eligible for Personal Accident Insurance the later of October 19, 2020 or the first day of the month following your date of hire provided Basic Life Insurance is in force.

You may elect employee coverage or family coverage. Family coverage includes coverage you, your spouse and your eligible child(ren), but you must have an eligible dependent as defined under Dependent Life Insurance. If you do not have an eligible dependent when you first become eligible, you can elect Personal Accident Insurance for your dependents on the date you meet all the above requirements.

A child may not be covered as a dependent of more than one Aptiv employee. Additionally, any person insured as an employee will not be considered an eligible dependent. In no event will two claims be paid for one individual.

Amount of Coverage Available

You may elect Personal Accident Insurance for yourself and your eligible dependents in the following amounts:

Personal Accident Insurance Amounts	
Employee Coverage	**Employee + Family Coverage**
$10,000 $20,000 $30,000 $40,000 $50,000 $60,000 $70,000 $80,000 $90,000 $100,000 $110,000 $120,000 $130,000 $140,000 $150,000 $160,000 $170,000 $180,000 $190,000 $200,000	Employee: Refer to the amounts in under "Employee Coverage" Spouse: 50% of the employee PAI coverage amount Child(ren): 10% of the employee PAI coverage amount

Note: Effective January 1, 2015, the maximum amount of PAI coverage was reduced from $500,000 to $200,000. Employees with PAI

coverage in excess of $200,000 were grandfathered; that is, grandfathered employees are able to continue their current level of coverage until they elect to reduce it or cease to make the premium payments.

Additionally, you may not elect a coverage amount for your eligible dependents that exceeds the amount of your personal coverage. If you later choose to reduce your personal coverage, any dependent coverage that exceeds this lower amount will be reduced accordingly. If an amount of coverage equal to this lower amount is not available for your child(ren), child coverage will be reduced to the next lower available amount.

Schedule of Benefits

If you or any insured dependent sustains accidental bodily injuries that result in one of the following losses **within one year** of a covered accident, the following benefits apply:

Loss*	Benefit
Life	Full amount
Speech and hearing	Full amount (two times the full amount for child)
Quadriplegia, Paraplegia, Hemiplegia	Full amount – spouse only (two times the full amount for child)
Vision in both eyes	Full amount (two times the full amount for child)
Two or more members**	Full amount (two times the full amount for child)
One member**	One-half the full amount (full amount for child)
Vision in one eye	One-half the full amount (full amount for child)
Speech	One-half the full amount (full amount for child)
Hearing in both ears	One-half the full amount (full amount for child)
Thumb and index finger of the same hand	One-quarter the full amount (one-half the full amount for child)
Burn Benefit	Percentage of the Full Amount equal to the percentage of the body surface suffering third-degree burns
Monoplegia	One-half the full amount - spouse only (two times the full amount for child)

* "Loss," used in reference to hand or foot, means the complete severance through or above the wrist or ankle joint; as used with reference to eye, means entire and irrecoverable loss of sight; as used with reference to speech and hearing, means the entire and irrecoverable loss of speech or hearing; as used in reference to thumb and index finger, means the severance of two or more phalanges of both the thumb and the index finger of the same hand.
** "Member," as used in the above schedule, means hand, foot, sight of eye, speech or hearing in both ears.

Special Benefits

Comatose Benefit

If you have personal or family coverage and if you, your insured spouse, or insured dependent child becomes comatose within 365 days of the accident, a monthly benefit equal to 1% of the amount of coverage in force will be paid starting on the 32nd day of the coma and will continue to be paid until the earlier of 100 months or death.

Common Disaster

If family coverage has been elected and if you and your insured spouse suffer a loss of life in the same accident or separate accidents that occur within 48 hours of each other, the amount payable by reason of the spouse's death will be the same as the amount payable due to your death. The maximum benefit payable for you and your spouse will not exceed $1,000,000.

Special Child Care Center

If family coverage has been elected and if you or your insured spouse suffer an accidental loss of life, a special child care center benefit is provided in the amount equal to 5% of your full benefit or the actual amount of child care costs incurred, whichever is less, but not to exceed $6,000 per year. Benefits will be paid for up to four years for each eligible child under age 13 who is enrolled or enrolls within 90 days of the accident in a qualified child care center. If there is no dependent child who qualifies, an additional benefit of $1,000 will be paid to the beneficiary.

No benefits will be payable after your separation from active service from Aptiv.

Special Education

If family coverage has been elected and if you suffer an accidental loss of life, a special education benefit is provided for each eligible child for tuition expenses in the amount equal to 5% of your full benefit or the actual amount of tuition, whichever is less, but not to exceed $6,000 per year. Benefits will be paid for up to four consecutive years for each child who is enrolled or enrolls within 365 days of your death as a full-time student in an accredited college or university. If there is no dependent child who qualifies, an additional benefit of $1,000 will be paid to the beneficiary.

No benefits will be payable after your separation

from active service from Aptiv.

Spousal Occupational Training
If family coverage has been elected and if you suffer an accidental loss of life, a spousal occupational training benefit is provided for your spouse to attend a formal occupational training program to qualify for active employment in an occupation for which your spouse would not otherwise qualify. Benefits are provided for expenses incurred within three years of the accident and will be paid in an amount equal to 5% of your full amount or the actual amount of expenses incurred, whichever is less, but not to exceed $6,000 per year.

No benefits will be payable after your separation from active service from Aptiv.

Seat Belt and Air Bag Benefit
If you, your covered spouse or your covered child suffers a loss of life as a result of a covered accident in a private passenger car and the covered person's seat belt was properly used, an additional benefit of ten percent (10%) of the covered person's full amount (subject to a maximum of $25,000) will be paid. An additional benefit of ten percent (10%) of the covered person's full amount (subject to a maximum of $25,000) will also be payable if an air bag is deployed for the seat that such person occupied and while properly using a seat belt.

Brain Damage Benefit
The full amount of Personal Accident Insurance in force will be payable on behalf of you, your covered spouse or covered child who suffers brain damage as a direct result of a covered accident. Brain damage is defined as permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such benefit will be payable if the covered person has been hospitalized for five days or more, the damage manifests itself within 30 days of the injury, and the damage persists for 12 consecutive months thereafter.

COBRA Continuation Benefit
A benefit may be payable if you die as a result of a covered accident while you are an active employee and MetLife receives proof that your dependents have elected to continue health care coverage under COBRA. The benefit amount will be equal to 3% of your full benefit or the actual amount of COBRA costs, whichever is less, subject to a maximum of $3,000 per year. Benefits are paid on a quarterly basis for up to three consecutive years and will be paid to your spouse. If there is no spouse, benefits will be paid to the person who incurs medical expenses.

No benefits will be payable after your separation from Aptiv.

Hospital Confinement Benefit
A benefit may be payable if you or a covered dependent is hospitalized as a result of a covered accident. The benefit amount will be equal to 1% of the covered person's full amount, subject to a maximum of $2,000. Benefits are payable starting the fifth day of hospitalization and continue to be paid each month thereafter for a maximum of 12 months of continuous confinement. For any partial month of confinement, the benefit will be paid on a pro-rata basis for any month of partial hospitalization.

If the covered person is hospitalized for more than one continuous period due to the same covered accident, only the first period of confinement will qualify for benefits.

Parental Care Benefit
A benefit may be payable if you or your covered spouse dies as a result of a covered accident while you are an active employee and MetLife receives proof that the deceased insured is survived by a parent, grandparent, parent-in-law or grandparent-in-law, and such person is dependent upon you or your covered spouse for more than 50% of the cost for a licensed nursing care facility, home health care, day care program or if the dependent parent is living with the covered person. The benefit amount will be 10% of the insured's full benefit, subject to a maximum of $10,000 per surviving dependent parent. If both you and your covered spouse die in the same accident, only one additional parental care benefit will be paid for each qualified dependent, based on your full amount.

If there is no eligible dependent parent, an additional benefit of $1,000 is paid to the beneficiary.

No benefits will be payable after your separation from Aptiv.

Rehabilitative Physical Therapy
A benefit may be payable if you or a covered dependent is prescribed rehabilitative physical therapy within 90 days of the date of a covered loss and the prescribed physical therapy is provided within one year of the loss. The benefit

amount will be equal to 10% of the insured's full benefit, subject to a maximum of $10,000 and will be paid on a quarterly basis.

Therapeutic Counseling
A benefit may be payable for you or your covered dependents if a benefit is paid for a loss resulting from a covered accident, MetLife receives proof that therapeutic counseling has been prescribed for the covered person within 90 days of the date of the covered loss and the prescribed therapeutic counseling is provided within one year of the loss. The benefit amount will be equal to 10% of the insured's full benefit or the actual amount of therapeutic counseling expenses, whichever is less, subject to a maximum of $10,000. Benefits will be paid to you on a quarterly basis.

Exclusions
Benefits will not be paid under this section for any loss caused or contributed to by:

(1) physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;

(2) infection, other than infection occurring in an external accidental wound or from food poisoning;

(3) suicide or attempted suicide;

(4) intentionally self-inflicted injury;

(5) 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 country;

(6) any incident related to:
- travel in an aircraft as a pilot, crewmember, flight student or while acting in any capacity other than as a passenger;
- travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
- parachuting or other existing 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

(7) committing or attempting to commit a felony;

(8) 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; or
  - 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;

(9) war, whether declared or undeclared; or act of war, insurrection, rebellion or active participation in a riot.

Effective Date of Coverage
The date your coverage takes effect depends upon when your election is received by the Fidelity Benefits Center.

When your election is received, insurance takes effect the first day of the month following the date your election is received, if you are actively at work.

If you are not actively at work on the date that coverage would otherwise start, coverage will start on the date you return to active work.

You cannot elect coverage, increase the amount of coverage or add a new dependent after your separation from Aptiv.

Cost of Coverage
You pay the full cost of Personal Accident Insurance. Your monthly contribution is based on the amount of coverage you elect. If you elect family coverage, the cost is based on the amount of coverage you elect, and is the same regardless if you are married or the number of children covered.

The Fidelity Benefits Center can inform you of the current monthly contribution rates. Rates are subject to change by the insurance company.

Beneficiaries
For loss of life, you may name anyone you wish

as your beneficiary(ies), and you may change your beneficiary designation at any time. The beneficiary of Personal Accident Insurance does not have to be the same beneficiary you have named for your Basic Life Insurance. However, if you do not name a beneficiary, the proceeds will be paid to the beneficiary designated for Basic Life Insurance. If circumstances in your life change, you may want to change your beneficiary designation.

You are automatically the beneficiary for any benefits payable as a result of your accidental dismemberment. In addition, you are automatically the beneficiary for any loss suffered by a covered dependent.

Benefits will be paid to you (or to your named beneficiary).

Life Insurance and Personal Accident Insurance Certificates

Detailed provisions of the insured benefit coverages you have under the policies issued to Aptiv by its insurance carriers are available to you by contacting the Fidelity Benefits Center at 1-877-389-2374 or www.netbenefits.com in the Health & Insurance Library.

Application and Claims Review Procedures

Life Insurance and Personal Accident Insurance Claims

After your application is received, your eligibility for benefits will be determined, and you will be advised accordingly.

If your application for benefits is denied in whole or in part, written notice will be made to you as soon as practicable, but generally no later than 90 days after receipt of your application (45 days if relating to a claim for disability benefits). This notice will include specific reasons for the denial and will refer to the plan provisions upon which the denial is based. The notice also will include a description of any additional information that may be needed if the claim is to be resubmitted. An explanation of the procedure by which you may have your denied claim reviewed also will be included in the notice.

You will have at least 180 days but in no event, more than 210 days following the receipt of this formal notification from the carrier advising of the reasons for the denial of the claim, to request in writing to have the claim reviewed. The request for review should be submitted directly to the carrier. As part of the review, you may submit any data or written comments to support the claim. A written decision on your request will be furnished within a reasonable time but not later than 45 days (90 days if special circumstances require an extension of time and written notice of the need of an extension is provided) after the request for review is received.

If you are not satisfied with the decision, an additional level of review is provided as detailed in Steps 1 through 6 below. As a part of the review, you may submit any data or written comments to support the claim. Any decision resulting from this process is intended to be final and binding on the Corporation, the Union, the carrier and the employee or beneficiary.

Step 1: Following receipt of the formal notification letter from the carrier by which the employee (beneficiary, following the death of the employee) is advised of the reasons for the denial of the employee's or beneficiary's claim, the employee or beneficiary may request the representative whom the employee's local union has designated to discuss Life and Disability Benefits Program matters to review the reasons for the denial with the management representative.

Step 2: The management representative will review the employee's case with the local union benefit representative. If needed, more details with respect to the reasons for the denial will be obtained from the carrier by the management representative and, if appropriate, the management representative will advise what, if anything, the employee or beneficiary can do to support the claim for payment of benefits. At this meeting, the local union benefit representative will be furnished with all copies of the material pertinent to the claim, which the carrier has made available for examination.

Step 3: If after the discussion with the management representative, the local union benefit representative contests the position of the carrier as reflected by the management representative, the local union benefit representative may refer the case on an appeal form provided for that purpose to the International Union for review with the Corporation. A copy of such appeal form shall be presented to the management representative.

Step 4: The International Union will notify the Corporation of its intent to review a case on a Step 4 appeal form provided for such a purpose. The Corporation will request a review by the carrier and will attempt to resolve the case with the International Union by providing a written answer with respect to the carrier's determination on such form.

Step 5: If the Corporation and the International Union are unable to resolve their differences, the Corporation upon written request of the International Union, will request a review by the carrier. Such request to the carrier will be in writing and will incorporate the Union's position. The carrier's review of the claim will be conducted by a committee of three employees of Metropolitan Life, at least one of whom shall be an officer of the carrier.

Step 6: The carrier will report to the International Union and to the Corporation its action as the result of such review.

Disability

If you are a regular active (permanent) employee (applicable to employees with a W1, W3, W4, W5 or W6 Benefit Code), you are eligible for disability benefits after satisfying the applicable waiting period.

If you become disabled and are unable to work, you may be approved for a disability leave of absence. To be granted a disability leave, you must furnish medical evidence satisfactory to Aptiv that you are unable to perform your job responsibilities as a result of disability.

If you are disabled and furnish medical evidence satisfactory to Aptiv, you may receive Sickness and Accident Disability Benefits for up to 26 or up to 52 weeks depending on your eligibility. If you are eligible, Extended Disability Benefits (EDB) may be payable thereafter. Social Security Disability Insurance Benefits (SSDIB) also may become payable.

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Sickness and Accident Benefits

Eligibility

If you were at work on or after October 19, 2020, you are eligible for Sickness and Accident Disability Benefits the first day of the month after you attain 1 year of seniority (applicable to W1, W3, W4, W5 and W6 Benefit Codes).

If you are not actively at work on the day your coverage otherwise would start, coverage begins on the day you return to active work.

Benefit Duration

While you are unable to work because of sickness or injury and you are being treated by a physician legally licensed to practice medicine, Sickness and Accident Disability Benefits may be payable:

Employees who have:

- 1 but less than 3 years seniority – may receive up to 26 weeks of Sickness and Accident benefits for any one continuous period of disability, or for successive recurrent periods of disability due to the same related causes.
- 3 or more years seniority – may receive up to 52 weeks of Sickness and Accident benefits for any one continuous period of disability, or for successive recurrent periods due to the same related causes.

Sickness and Accident Disability Benefits also may be payable if you are disabled from surgery for sterilization, or hospitalized for testing to determine your suitability to be a donor for an organ or tissue transplant.

Benefit Requirements

To receive Sickness and Accident benefits, you must be wholly and continuously disabled as a result of any injury or sickness so as to be prevented thereby from performing any and every duty of your occupation. Generally, Sickness and Accident benefits begin after you have been disabled for seven calendar days if you have been treated by a physician legally licensed to practice medicine or the plant medical department during that period. The requirement that you be under treatment by a physician legally licensed to practice medicine shall be deemed to have been met if you are under the treatment of a physician assistant and the treatment provided is within the scope of his or her license. If a physician assistant provides treatment, certification of disability must be provided by a legally licensed physician. If you have not been treated within the first seven calendar days of disability, Sickness and Accident benefits will be payable as of your first date of treatment.

Notification Requirements

You must give written notice of any sickness or injury to the designated administrator, Sedgwick, **within 7 days after the initial onset of the sickness or the accident causing your injury**. Also, you must provide proof of your injury or sickness to the administrator within 20 days after the start of your disability leave. **Failure to meet these notification requirements will result in a denial of disability benefits for the entire period of disability**.

Benefit Amount and Commencement

Sickness and Accident Disability Benefit amounts are determined by your Base Hourly Rate (see the chart on the next page). Base Hourly Rate, for purposes of Sickness and Accident benefits, includes the premium for necessary continuous seven-day operations, but does not include overtime, night-shift premium or any other payments.

Schedule of Sickness and Accident Benefits for Employees at Work On or After October 19, 2020 (In states with no Disability Benefit Laws)

Base Hourly Rate		Weekly Sickness and Accident Benefit
From $	To $	
12.55	12.89	305
12.90	13.24	315
13.25	13.59	320
13.60	13.94	330
13.95	14.29	340
14.30	14.64	345
14.65	14.99	355
15.00	15.34	365
15.35	15.69	375
15.70	16.04	380
16.05	16.39	390
16.40	16.74	400
16.75	17.09	405
17.10	17.44	415
17.45	17.79	425
17.80	18.14	430
18.15	18.49	440
18.50	18.84	450
18.85	19.19	455
19.20	19.54	465
19.55	19.89	475
19.90	20.24	480
20.25	20.59	490
20.60	20.94	500
20.95	21.29	505
21.30	21.64	515
21.65	21.99	525
22.00	22.34	530
22.35	22.69	540
22.70	23.04	550
23.05	23.39	555
23.40	23.74	565
23.75	24.09	575

Base Hourly Rate		Weekly Sickness and Accident Benefit
From $	To $	
24.10	24.44	585
24.45	24.79	590
24.80	25.14	600
25.15	25.49	610
25.50	25.84	615
25.85	26.19	625
26.20	26.54	635
26.55	26.89	640
26.90	27.24	650
27.25	27.59	660
27.60	27.94	665
27.95	28.29	675
28.30	28.64	685
28.65	28.99	690
29.00	29.34	700
29.35	29.69	710
29.70	30.04	715
30.05	30.39	725
30.40	30.74	735
30.75	31.09	740
31.10	31.44	750
31.45	31.79	760
31.80	32.14	765
32.15	32.49	775
32.50	32.84	785
32.85	33.19	795
33.20	33.54	800
33.55	33.89	810
33.90	34.24	820
34.25	34.59	825
34.60	34.94	835
34.95	35.29	845
35.30	& Over	850

Sickness and Accident benefits may begin immediately in case of an accident if you are: (1) hospitalized as inpatient, or (2) treated by a physician legally licensed to practice medicine or the plant medical department during the first 7 days of disability. In case of sickness, benefits begin the earlier of: (1) after a period of 7 days, (2) when you are hospitalized as inpatient, (3) when confined in an approved substance abuse treatment facility. Benefits can begin the day after surgery in case of outpatient surgery where a surgical benefit of $25 or more is payable under the Health Care Program.

Recurrent Disability

If you return to work before the end of the maximum period for which you are eligible to receive Sickness and Accident benefits and you are absent again within three months because of the same or a related disability, benefits resume where they left off. For example, if you were disabled and received Sickness and Accident Disability Benefits for three weeks, returned to work and then became disabled again two months later from the same or a related condition, you would be eligible for Sickness and Accident benefits, without a new waiting period. When a second claim is recurrent to the first claim, both periods of disability are added together toward the maximum duration for Sickness and Accident benefits (either 26 or 52 weeks, depending on your eligibility).

If your second period of disability results from a different cause, the first absence does not affect the waiting period for the second absence.

Benefit Reductions

Sickness & Accident benefits are reduced by:

- primary Social Security Disability Insurance Benefits (SSDIB) or unreduced Social Security Retirement Benefits (including retroactive amounts paid for the same period of disability),
- certain workers' compensation payments,
- any unemployment compensation payments to which you are entitled for the same period you receive Sickness and Accident benefits, and
- benefits under any state or federal law providing for working time lost because of disability for the same period you receive Sickness and Accident Disability Benefits.

You may be required to apply for SSDIB if your disability is expected to continue for 6 months or longer.

Medical Examination

You may be required to be examined by an impartial doctor, clinic or other medical authority for the purpose of verifying disability at any time you may be eligible to receive Sickness and Accident benefits. Generally, if you are found able to work, your benefits will be discontinued.

Failure to report for the examination may affect any eligibility you may have for benefits.

You will be reimbursed, upon request, for travel to and from the examination if your residence is more than 40 miles (one-way) from the examiner's office. The reimbursement will be calculated using the IRS optional business standard mileage rate.

To apply for **Sickness and Accident Disability Benefits**, you must complete a claim form provided by Sedgwick.

If you become disabled, you should contact Sedgwick at **1-877-933-5744** (or 1-866-665-1287 for the hearing or speech impaired) within 7 working days after the date you became disabled.

Extended Disability Benefits

Eligibility

If you were at work on or after October 19, 2020, you are eligible for Extended Disability Benefits on the first day after you attain 60 months of seniority (applicable to W3, W4, W5 and W6 Benefit Codes).

If you are not actively at work on the day your coverage otherwise would start, coverage begins on the day you return to active work. Furthermore, if your employment ends while receiving Sickness and Accident benefits, your Extended Disability Benefits coverage ends and is not payable.

You are eligible to receive Extended Disability Benefits if, at the date of expiration of the maximum number of weeks of Sickness and Accident benefits, you are totally disabled due to due to sickness or accidental injury, and wholly prevented from engaging in regular employment with the Corporation at the plant(s) where you have seniority.

Benefit Amount

Your monthly EDB amount is determined by your Base Hourly Rate (see the chart on the next page). Base Hourly Rate, for purposes of EDB includes the premium for necessary continuous seven-day operations, but does not include overtime, night-shift premium or any other payments.

Benefit Duration

Under no circumstances will Extended Disability Benefits be payable beyond the date you no longer satisfy the disability requirements of your date of death.

Otherwise, the duration of your Extended Disability Benefits is based on your seniority as of the date of your disability and may be impacted by your Years of Participation* and age.

- **If you have more than 5 years of seniority,** Extended Disability Benefits are payable until recovery, or if less, for a period equal to your Years of Participation* at the commencement of disability (less the period during which Sickness and Accident benefits were received), but generally not beyond the end of the month in which you attain age 65.

If you become disabled at or after age 63 and later become eligible for Extended Disability Benefits, such benefits will be payable in accordance with the following chart:

Age When Disability Begins (Age and Months)		Maximum Duration of Extended Disability Benefits
At least	**But Less Than**	
63 and 0 mos.	68 and 1 mo.	12 months
68 and 1 mo.	68 and 2 mos.	11 months
68 and 2 mos.	68 and 3 mos.	10 months
68 and 3 mos.	68 and 4 mos.	9 months
68 and 4 mos.	68 and 5 mos.	8 months
68 and 5 mos.	68 and 6 mos.	7 months
> 68 and 6 mos.		6 months

* For more information on Years of Participation under the Life and Disability Benefits Program, see page 46.

Schedule of Extended Disability Benefits (EDB) for Employees at Work On or After October 19, 2020 (In states with no Disability Benefit Laws)

Base Hourly Rate		Monthly EDB Amount
From $	To $	
12.90	13.24	1,020
13.25	13.59	1,045
13.60	13.94	1,075
13.95	14.29	1,100
14.30	14.64	1,130
14.65	14.99	1,145
15.00	15.34	1,180
15.35	15.69	1,210
15.70	16.04	1,235
16.05	16.39	1,265
16.40	16.74	1,290
16.75	17.09	1,320
17.10	17.44	1,345
17.45	17.79	1,375
17.80	18.14	1,400
18.15	18.49	1,430
18.50	18.84	1,455
18.85	19.19	1,480
19.20	19.54	1,510
19.55	19.89	1,535
19.90	20.24	1,565
20.25	20.59	1,590
20.60	20.94	1,620
20.95	21.29	1,645
21.30	21.64	1,675
21.65	21.99	1,700
22.00	22.34	1,730
22.35	22.69	1,755
22.70	23.04	1,780
23.05	23.39	1,810
23.40	23.74	1,835
23.75	24.09	1,865
24.10	24.44	1,890

Base Hourly Rate		Monthly EDB Amount
From $	From $	
24.45	24.79	1,920
24.80	25.14	1,945
25.15	25.49	1,975
25.50	25.84	2,000
25.85	26.19	2,030
26.20	26.54	2,055
26.55	26.89	2,085
26.90	27.24	2,110
27.25	27.59	2,135
27.60	27.94	2,165
27.95	28.29	2,195
28.30	28.64	2,220
28.65	28.99	2,245
29.00	29.34	2,275
29.35	29.69	2,300
29.70	30.04	2,330
30.05	30.39	2,355
30.40	30.74	2,380
30.75	31.09	2,410
31.10	31.44	2,435
31.45	31.79	2,465
31.80	32.14	2,490
32.15	32.49	2,520
32.50	32.84	2,545
32.85	33.19	2,575
33.20	33.54	2,600
33.55	33.89	2,630
33.90	34.24	2,655
34.25	34.59	2,685
34.60	34.94	2,710
34.95	35.29	2,725
35.30	& Over	2,765

Benefit Reductions

Extended Disability Benefits are reduced by:

- primary Social Security Disability Insurance Benefits (SSDIB) or unreduced Social Security Retirement Benefits (including retroactive amounts paid for the same period of disability),
- income received for disability under workers' compensation or other occupational Laws or Acts,
- any federal or state lost-time disability benefits.

Increases in any of these benefits payable after Extended Disability Benefits begin will not be deducted, unless the increase represents an adjustment in the original determination of the amount of such benefit. **A retroactive award of any of these benefits, such as Social Security Disability Insurance Benefits (SSDIB), will create an overpayment of Extended Disability Benefits that were paid for the same period of disability.** (See page 75 for Recovery of Benefit Overpayments.)

For Extended Disability Benefits, you must apply for Social Security Disability Insurance Benefits (SSDIB) under a special procedure designed to handle the offset of SSDIB against Extended Disability Benefits. You also must repay any overpayment incurred due to receipt of an SSDIB award.

Social Security Disability Insurance Benefits

If you become disabled before age 65, you may be eligible for disability insurance benefits from Social Security. Your nearest Social Security office can tell you if you qualify. Benefits may be payable after you have been disabled for five full calendar months.

If there is a reasonable basis for you to apply for disability benefits under the Federal Social Security Act, you are required to do so. To apply for Social Security benefits means to pursue such benefits until you receive approval from the Social Security Administration, or a notice of denial of benefits from an administrative law judge.

It is important for you to apply for Social Security Disability Insurance Benefits (SSDIB) because:

- Failure to obtain an SSDIB award may result in a smaller Social Security Retirement Benefit.
- Your dependents also may qualify for Social Security benefits.
- Your Social Security benefits may be increased annually to reflect cost-of-living increases.
- You become eligible for Medicare after receiving 24 months of SSDIB.
- If you are receiving SSDIB and return to work, you may be eligible to continue these benefits in addition to your salary up to 12 months. You should contact your nearest Social Security office for additional information.
- SSDIB awards are given favorable federal tax treatment under current tax laws.

You will be advised by Sedgwick at the time you are required to apply for SSDIB.

If you need assistance with the Social Security Disability Insurance Benefits application process, contact Sedgwick at 1-877-933-5744 or 1-866-665-1287 for the hearing or speech impaired.

To apply for **Extended Disability Benefits**, you must complete a claim form provided by Sedgwick.

You may contact Sedgwick at **1-877-933-5744** (or 1-866-665-1287 for the hearing or speech impaired).

Application and Claims Review Procedures

Disability Benefit Claims

To receive a benefit under the Plan you will need to complete and file the claim form for disability benefits. The appropriate claim forms are available by contacting the carrier, Sedgwick. Written notice of injury or sickness must be given to the carrier (Sedgwick) within 7 days after: (1) the initial onset of the sickness, or (2) the accident causing the injury. Proof of such injury or sickness must be furnished to the carrier within 20 working days after the start of the leave. Failure to meet these requirements will result in a denial of benefits for the entire period of the leave.

If you disagree with the administrator concerning your benefit claim, have a question regarding lack of coverage, or are concerned about an anticipated claim, you may request the

assistance of one of the local union benefit representatives or contact the carrier, Sedgwick.

Initial Determination
After your application is receive, your eligibility will be determined, and you will be advised accordingly.

If your application for benefits is denied in whole or in part, written notice will be made to you as soon as practicable, but generally no later than 90 days after receipt of your application (45 days if relating to a claim for disability benefits). This notice will include specific reasons for the denial and will refer to the plan provisions upon which the denial is based. The notice also will include a description of any additional information that may be needed if the claim is to be resubmitted.

Appealing the Initial Determination
If you wish to appeal an adverse claim determination, you must submit your request for review in writing within 180 days following receipt of the formal notification letter from the carrier that a disability claim has been denied in whole or in part. The request for review should be submitted in writing to the administrator and must include at least the following information:

- Name of employee
- Name of plan
- Reference to the initial decision
- An explanation of why you are appealing the initial determination

As a part of the review, you may submit any data or written comment to support the claim. A written decision will be furnished within a reasonable time, but not later than 45 days (90 days if special circumstances require an extension of time) after the request for review is received. The written decision will include specific reasons for the decision and will set forth specific reference to plan provisions upon which the decision is based.

Once you have completed the appeal process, you may bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 or you may request a review under the voluntary collectively bargained Procedure for Reviewed of Denied Claims.

Collectively Bargained Appeal Process
If you are not satisfied with the decision of the carrier, the Corporation provides for an additional voluntary level of review.

Step 1: Following receipt of the formal notification letter from the carrier by which the employee (beneficiary, following the death of the employee) is advised of the reasons for the denial of the employee's or beneficiary's claim, the employee or beneficiary may request the representative whom the employee's local union has designated to discuss Life and Disability Benefits Program matters to review the reasons for the denial with the management representative.

Step 2: The management representative will review the employee's case with the local union benefit representative. If needed, more details with respect to the reasons for the denial will be obtained from the carrier by the management representative and, if appropriate, the management representative will advise what, if anything, the employee or beneficiary can do to support the claim for payment of benefits. At this meeting, the local union benefit representative will be furnished with all copies of the material pertinent to the claim, which the carrier has made available for examination.

Step 3: If after the discussion with the management representative, the local union benefit representative contests the position of the carrier as reflected by the management representative, the local union benefit representative may refer the case on an appeal form provided for that purpose to the International Union for review with the Corporation. A copy of such appeal form shall be presented to the management representative.

Step 4: The International Union will notify the Corporation of its intent to review a case on a Step 4 appeal form provided for such a purpose. The Corporation will request a review by the carrier and will attempt to resolve the case with the International Union by providing a written answer with respect to the carrier's determination on such form.

Step 5: If the Corporation and the International Union are unable to resolve their differences, the Corporation, upon written request of the International Union, will request a review by the carrier. Such request to the carrier will be in writing and will incorporate the Union's position. The carrier's review of the claim will be conducted by a committee of three employees of Metropolitan, at least one of whom shall be an officer of the carrier.

Step 6: The carrier will report to the International Union and to the Corporation its action as the result of such review.

Other Benefit Program Coverages While on Disability Leave

Health Care Coverages

In most cases, Aptiv will continue contributions toward your health care coverages while you remain totally and continuously disabled and you remain on an approved disability leave.

If your disability leave ends because the period of disability equaled your length of service, health care coverages will continue for any month you receive Sickness and Accident or Extended Disability Benefits provided that you make any required contributions; otherwise, health care coverages will be cancelled at the end of the month in which your approved disability leave ends.

If disability benefits end, health care coverages cease at the end of month in which disability benefits end after a minimum of 36 months of continuation, provided you remain on an approved disability leave.

Life and Disability Benefits Coverages

Basic Life Insurance, Extra Accident, Sickness and Accident, and Extended Disability Benefits (if applicable) coverages will be continued:

- for any period you are entitled to receive Sickness and Accident benefits while you are totally disabled; and
- thereafter, while you are totally and continuously disabled and remain on an approved disability leave, but not to exceed the period equal to your Years of Participation under the Life and Disability Benefits Program as of the first day of disability. Also, such coverages may be continued while you are entitled to receive monthly Extended Disability Benefits after cancellation of your disability leave because the period of the leave equaled your seniority.
- If your disability leave ends because the period of disability equaled your length of service, Basic Life Insurance and Extra Accident will continue for any month you receive Sickness and Accident or Extended Disability Benefits; otherwise, these coverages will be cancelled at the end of the month in which your approved disability leave ends.
- If your disability leave is cancelled because you recovered and you again become totally disabled within three working days of the date your leave was cancelled, Life and Disability Benefit coverages to which you were entitled will be continued under these circumstances. If you are returned to an approved disability leave, Aptiv will make contributions for these coverages while you remain totally disabled. However, coverage cannot continue beyond the period equal to your Years of Participation as of your first day of disability.

While you remain on an approved disability leave as a regular active employee, Basic Life Insurance and Extra Accident will continue for the duration of the disability leave or while you are receiving disability benefits. If disability benefits end, Basic Life and Extra Accident cease at the end of month in which disability benefits end after a minimum of 36 months of continuation, provided you remain on an approved disability leave.

If eligible, you must pay the required monthly contributions to continue Optional Life, Dependent Life and Personal Accident Insurance while your Basic Life Insurance remains in force.

Accelerated Benefits Option

If you are diagnosed as having a terminal illness with a life expectancy of 12 months or less, you may be eligible to receive an Accelerated Benefits Option payment of up to 50%, but not less than $1,000, of your Basic Life Insurance. See page 46 for more information.

Personal Accident Insurance

Personal Accident Insurance also may provide payment for dismemberment and/or loss of hearing, speech or eyesight as a result of an accident. A paralysis benefit also is available if your spouse or dependent child(ren) is injured as the result of an accident.

Additional information is contained in the “Life Insurance” section on page 50.

Supplemental Unemployment Benefits

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Supplemental Unemployment Benefit (SUB) Plan

In the event of layoff, the SUB Plan provides a level of income security to supplement any state unemployment compensation you receive, if eligible. Under the SUB Plan eligible employees may receive the following benefits:

- **Regular SUBenefit** for a full week of layoff from Aptiv;
- **Short Week Benefit** when you are laid off from Aptiv for part of a week; and
- **Separation Payment** upon termination of employment because of layoff.

When you are eligible for SUB

All employees who work on or after October 19, 2020 are eligible for SUB using the following chart:

Seniority / Employment	SUB Eligibility & Duration
0 < 1 year	Not eligible
1 < 5 years	Eligible for 26 weeks
>5 years	Eligible for 156 weeks

Regular SUBenefit — For a Full Week of Layoff

Benefit Eligibility

You may be eligible for a regular SUBenefit for a full week of layoff if you have one or more years of seniority under the SUB Plan and are laid off due to:

- reduction in force;
- discontinuance of a plant or operation;
- temporary layoff; or
- being unable to do work offered by the plant but able to do other available work in the plant if you had more seniority.

To be eligible, you must receive a state system benefit such as state unemployment compensation (UC) or unemployment insurance (UI), or be denied such a benefit only for an acceptable reason under the SUB Plan.

You will not be eligible for a regular SUBenefit if your layoff was for disciplinary reasons or was a consequence of:

- any strike, slowdown, work stoppage, picketing or concerted action, at a Company plant or plants, or any dispute of any kind involving, generally, employees covered by this Plan;
- any fault attributable to you, the employee;
- sabotage (including arson) or insurrection; or
- any act of God, after the first two consecutive full weeks of layoff resulting from such cause for which regular SUBenefits are payable.

Generally, if you refuse an Aptiv employment interview or job offer after your fourth full week of layoff, SUBenefit eligibility will be terminated until you return to work for Aptiv. Refusal of such a job offer during the first four full weeks of layoff generally will disqualify you for SUB for one week. However, if such refusal results in denial of state unemployment compensation (UC) benefits for one or more weeks of layoff thereafter, you will either: (1) be denied SUB for such weeks, or (2) have your payment limited to the maximum amount of $190 per week.

Duration of Benefits

If you are laid off with at least one year of seniority as of your last day worked prior to a qualifying layoff, and are otherwise eligible:

- 1 but less than 5 years seniority – may receive 26 weeks of SUBenefits for the duration of the contract.
- 5 or more years seniority – may receive 156 weeks of SUBenefits for the duration of the contract.

Application Requirements

To receive any Regular SUBenefit, you must file an application covering each week of layoff within 60 days after the end of the week, or within 60 days of a state UC redetermination or adjustment, which provides a basis for eligibility for a SUBenefit. The application must be filed with the Aptiv SUB Administration Center. You will need your state UC monetary determination at the beginning of each UC benefit year, and your UC benefit proof of payment for each week, to process your SUBenefit application. SUB applications are available from your location or from your local union. The telephone number for assistance with SUBenefits is 1-248-813-1782, option #2.

For each week of layoff for which you apply, you must have reported to the state employment office (as required by the state) and provide to the Aptiv SUB Administration Center satisfactory evidence that you have received a state UC

benefit, or be ineligible for a state UC benefit only for an acceptable reason under the SUB Plan.

Amount of Regular SUBenefit

For full weeks of layoff, your regular SUBenefit is calculated on the basis of your weekly after-tax, or "take-home" pay, from Aptiv when working full time. Your highest base hourly rate in the 13 weeks prior to layoff (52 weeks in a defined "plant closing" situation) will be used in this calculation. This "take-home" pay would be 40 hours' gross pay, less all federal, state, and local taxes as of your last week worked. If your marital status or dependent income tax withholding exemptions change during a period of layoff, promptly report this fact to the Aptiv SUB Administration Center. An adjustment will be made in your future regular SUBenefit payment amount.

The amount of your regular SUBenefit is an amount which, when added to the following, will equal 95% of your weekly after-tax pay, minus $15.00 for work-related expenses not incurred:

- the amount of any state system benefit (UC, UI, TRA, EUC, etc.) received or receivable, plus,
- any Aptiv pay (excluding call-in pay and Sunday earnings), plus
- any earnings from another employer, or from the military, in excess of the greater of $10 or 20% of such earnings.

A maximum regular SUBenefit of $190 will apply to any week for which you refused available Aptiv work and for which you either: (1) had exhausted your state UC benefits, or (2) were denied UC because of such refusal, provided that you refused a job offer you had an option to refuse under your local seniority agreement.

If you are serving a state UC "Waiting Week", if otherwise eligible, you will be paid a regular SUBenefit for such "Waiting Week." The SUBenefit will be unreduced for any estimated state UC benefit amount.

EXAMPLE:
An employee with a spouse and two children last works in April 2021. The employee is laid off, with an hourly rate of **$21.01**.

40 hours' gross pay	$840.40
Less: federal, state, local taxes & FICA	−$151.83*
Weekly after-tax pay	$688.57
95% of after-tax pay	$654.18
Less: Work-related expenses not incurred	−15.00
Total income level for week	$639.19

** Based on the provisions of tax laws as of April 2021 for single with two exemptions. Taxes in this example consist of federal and Ohio taxes, with no local income tax.*

The total income level for the week of **$639.18** is what the SUBenefit would be during a State Waiting Week. If the employee received State UC Benefits, the gross amount of the UC Benefit would be deducted from the gross SUBenefit. The gross SUBenefit amount is subject to federal income tax withholding, as well as state and local withholding taxes. If an individual has outside earnings that would disqualify them from UC Benefits, then the gross SUBenefit would be subject to federal FICA taxes, too. The SUBenefit amount also is subject to deductions of Union dues, court orders, life insurance contributions and by the amount of any outstanding debts owed to Aptiv.

Disability Benefits While Laid Off

If you become disabled while on a layoff, and your Sickness and Accident benefit coverage is no longer in force, your Sickness and Accident benefit coverage may be reinstated.

To qualify for reinstated Sickness and Accident benefits while on layoff, you must:

- submit satisfactory evidence on a claim form provided by Aptiv for that purpose, certifying that you are disabled (call Sedgwick at 1-877-933-5744; *Hearing or speech impaired 1-866-665-1287*)
- be insured for Basic Life Insurance;
- be on a qualifying layoff; and
- be eligible for either a regular SUBenefit, or a Trade Readjustment Allowance benefit, or be employed by another employer immediately prior to becoming disabled.

If eligible for reinstated Sickness and Accident benefits, you may receive up to the maximum duration. If you still are disabled after the period for which you are entitled to receive reinstated Sickness and Accident benefits, you may be eligible for monthly Extended Disability Benefits, as described on page 59.

Short Week Benefit — When Laid Off from Aptiv for Part of a Week

Eligibility

You may be eligible for an automatic short week benefit for a week if:

- you had less than 40 hours of work or pay made available to you by Aptiv;
- you were laid off at any time during the week for a qualifying reason, as described in the information provided under Regular SUBenefits on page 65 or you were ineligible for Aptiv pay for: (1) jury duty, (2) bereavement, or (3) short term National Guard duty, because you would have been on a qualifying layoff;
- you have one or more years of seniority as of the last day of the week (or have broken your seniority during the week only by reason of death); and
- you worked for Aptiv during the week, or received from Aptiv bereavement, jury duty, military or (under certain circumstances) holiday pay, for part of the week.

Overtime hours worked, or made available, during the week will be excluded in the short week benefit calculation for such week, unless (1) such overtime was worked prior to layoff, or (2) notice of intent to work such overtime had been given prior to the layoff. Also excluded from a short week benefit calculation will be any overtime hours available to certain employees medically restricted as to the number of weekly and daily working hours.

Application Requirements
Automatic Short Week Benefits will be paid to you, without application, in your regular paycheck for the week, or shortly thereafter.

If you do not receive an Automatic Short Week Benefit to which you believe you are entitled, you must apply within 60 days after the date you normally would have received the benefit payment.

Amount of Short Week Benefits
Automatic Short Week Benefits are payable at 80% of your straight-time pay for each hour less than 40 for which you (1) were not offered work, or (2) did not receive pay.

EXAMPLE:
An employee earning **$21.89** per hour, worked 23 hours and received holiday pay for 8 additional hours (which were not worked) for a total of 31 hours. The employee is 9 hours short of 40 and was on a qualifying layoff during the week:

Monday	8	hours worked
Tuesday	6	hours worked (laid off for 2 hours, machine breakdown)
Wednesday	9	hours worked
Thursday	0	hours worked (laid off because of part shortage)
Friday	0	hours worked (holiday – no work but received
	8	hours holiday pay)
TOTAL	31	

Therefore, the employee is entitled to an Automatic Short Week Benefit of 80% of 9 hours' pay, or **$157.61** ($21.89 an hour x 9 hours x 80%).

Separation Payment — Upon Termination of Employment Due to Layoff

Eligibility
You may be eligible for a Separation Payment if you have one or more years of seniority on the last day you are on the active employment roll, and are laid off from Aptiv for 12 or more continuous months, provided you have not refused an Aptiv offer of work or broken your seniority within the first 12 months of layoff.

You must not have broken seniority as of the earliest date you may be eligible to apply for a Separation Payment.

Application Requirements
To be eligible, you must apply between 12 and 24 months (36 months if you have 10 or more years of seniority) after the first day of layoff, or at any time up to 24 months (36 months, if applicable) after the date you are determined by Aptiv to be totally and permanently disabled (or, if you then are receiving Extended Disability Benefits under the Life and Disability Benefits Program, within 30 days after the last month for which you are eligible for such benefit).

Cancellation of Seniority
If you receive a Separation Payment, (1) you no longer are an Aptiv employee, and (2) your seniority is canceled at all Aptiv plants.

Amount of Separation Payment
The amount of a Separation Payment is determined by multiplying your base hourly rate by the number of hours of pay, according to your years of seniority, as shown in the following table, less any SUBenefits paid to you for weeks following your last day worked.

The amount of a Separation Payment may be offset by such things as, but not limited to, the amount of any payment received, or receivable,

under any other Aptiv SUB plan, or under any Aptiv plan or program to which Aptiv has contributed, for layoff or separation from Aptiv subsequent to the last day you worked for Aptiv.

Separation Payment Table	
Years of Seniority on Last Day on the Active Employment Roll	**Number of Hours of Pay**
1 but less than 2	50
2 but less than 3	70
3 but less than 4	100
4 but less than 5	135
5 but less than 6	170
6 but less than 7	210
7 but less than 8	255
8 but less than 9	300
9 but less than 10	350
10 but less than 11	400
11 but less than 12	455
12 but less than 13	510
13 but less than 14	570
14 but less than 15	630
15 but less than 16	700
16 but less than 17	770
17 but less than 18	840
18 but less than 19	920
19 but less than 20	1000
20 but less than 21	1085
21 but less than 22	1170
22 but less than 23	1260
23 but less than 24	1355
24 but less than 25	1455
25 but less than 26	1560
26 but less than 27	1665
27 but less than 28	1770
28 but less than 29	1875
29 but less than 30	1980
30 and over	2080

SUB Plan Overpayments

Any SUB Plan overpayment must be repaid unless (1) the cumulative overpayment is $3 or less, or (2) notice of the overpayment was not given to you within 60 days from the date the overpayment was established or created. Notification of overpayment time limits do not apply in any case of fraud or willful misrepresentation in applying for benefits under the Plan.

If you fail to promptly return the amount of the overpayment, a maximum of $100 per week, but not more than 1/2 of your weekly SUBenefit or paycheck, will be deducted from your future SUBenefits or paychecks until the overpayment is recovered in full. No overpayment recovery limits apply in cases of fraud or willful misrepresentation.

Appealing a Dispute

You may request that the SUB Administrator provide information concerning the payment, denial or appeal of a SUBenefit or separation payment through your Local Union Benefit Representative.

If you disagree with an Aptiv determination as to eligibility for, or amount of, benefits, you may appeal to your local Union Benefit Representative within 30 days of determination.

If your local Union Benefit Representative cannot resolve your claim, you may request that he/she refer your claim to the International Union, who will in turn, file the appeal with Aptiv Employee Benefits.

The Aptiv Supplemental Unemployment Benefit Plan is not grievable.

Life and Disability Coverages for Employees on Layoff

Coverages may be continued for the following periods, after the month in which you last worked prior to layoff:

- For the first month, all Basic Life, Extra Accident, Sickness and Accident and Extended Disability Benefits coverages in force, are continued with Aptiv paying the full cost.
- After the first month, Basic Life and Extra Accident coverages are continued at no cost to you, if you are on a qualified layoff, for up to 12 months (24 months, if you have 10 or more years of seniority). The period these coverages will be continued without cost to you is based on your years of seniority, as shown in the table below.

Years of Seniority as of Last Day Worked Prior to Layoff	**Maximum Number of Months of Corporation-Paid Continuation**
Less than 1	0
1 but less than 2	4
2 but less than 3	6
3 but less than 4	8
4 but less than 5	10
5 but less than 10	12
10 and over	24

If you are placed on layoff immediately upon your return to work from a disability leave of absence, the day you return from such leave will be deemed to be the day you last worked prior to layoff. However, only those life and disability coverages in force on your last day at work prior to your disability leave can be continued.

If eligible to continue, you must pay the required monthly contributions to continue any Optional Life and Dependent Life Insurance.

Personal Accident Insurance may be continued during layoff whether or not Basic Life Insurance remains in effect, provided you make the required contributions. The maximum period that coverage may be continued after the month in which you last worked prior to layoff is based on your years of seniority as of your last day worked as shown in the table below.

Years of Seniority as of Last Day Worked Prior to Layoff	Maximum Number of Months for Which Personal Accident Insurance Can Be Continued
Less than 1	0
1 but less than 2	16
2 but less than 3	18
3 but less than 4	20
4 but less than 5	22
5 but less than 10	24
10 and over	36

Health Care Continuation for Laid Off Employees

If you are laid off, your coverage as an active employee ceases at the end of the month in which you last are in active service, as defined under the Health Care Program.

Thereafter, generally you are entitled to a number of months of Corporation contributions for Health Care, based upon your seniority at the time of layoff, as shown in the chart below.

Years of Seniority as of Last Day Worked Prior to Layoff	Maximum Number of Months of Corporation Contributions for Health Care
Less than 1	1
1 but less than 2	4
2 but less than 3	6
3 but less than 4	8
4 but less than 5	10
5 but less than 10	13
10 and over	25

After the period of Corporation contributions shown on the chart, you will be provided information concerning your health care continuation under COBRA.

If you are placed on layoff from disability leave of absence or military leave of absence, the date you report for return from such leave and are placed on layoff will be deemed to be the last day worked prior to layoff, for the purposes of determining continuation. However, only those Health Care coverages, which were in force as of your actual last day worked can be continued.

Survivor Benefits

Your survivors may be eligible for benefits under both the Aptiv Life and Disability Benefits and Health Care Program for Hourly Employees.

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Life and Disability Benefits for Beneficiaries

Your Basic Life Insurance

If you die from any cause while coverage is in force, your beneficiary will receive a benefit equal to the amount of your Basic Life Insurance in effect, less any Accelerated Benefits Option payment you may have received (see page 46).

Metropolitan Life Insurance Company (MetLife) will pay the benefit in one sum in one of the following forms:

- 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.

Other modes of payment may be available upon request.

If you do not have a beneficiary when you die, your benefit will be paid to your estate. However, MetLife may instead, at its discretion, pay all or part of that amount, generally in the following order, to one or more of the following persons who are related to you and who survive you:

- Spouse
- Child
- Parent
- Estate

Any payment will discharge MetLife's liability for the amount so paid.

Your Extra Accident Insurance

An additional benefit, called Extra Accident Insurance may be payable to your beneficiary if you die. Extra Accident coverage is equal to one-half of your Basic Life Insurance amount in effect.

For the Extra Accident benefit to be payable, your death must occur within one year after the covered accident and cannot be caused wholly or partly, directly or indirectly by any of the exclusions listed on page 52.

If your death results from an accidental bodily injury caused solely by employment with Aptiv, three times the scheduled benefit amount of Extra Accident Insurance may be payable. To apply for Basic Life and Extra Accident Insurance benefits, a beneficiary must complete a claim form provided by MetLife. You may contact the Fidelity Benefits Center at 1-877-389-2374 to initiate the claim process.

Your Optional Life Insurance

If you die from any cause while coverage is in force, your beneficiary will receive a benefit equal to the amount of your Optional Life Insurance in effect. However, if you do not name a beneficiary, the proceeds will be paid in accordance with the information provided in the preceding Basic Life Insurance section. Proceeds will be paid in one sum and under one of the options described in the Basic Life Insurance section above.

Your Dependent Life Insurance

If an eligible dependent dies from any cause, benefits will automatically be paid to you since you are always the beneficiary for Dependent Life Insurance (or to the surviving spouse if they continued coverage after your death) under the one of the options described in the Basic Life Insurance section above.

If you die while Dependent Life Insurance is in effect, your surviving spouse may continue this coverage until the earliest of:

- remarriage; or
- death.

Your Personal Accident Insurance

If you die as a result of a covered accident while insured for Personal Accident Insurance, your beneficiary(ies) will receive a benefit equal to the amount of your Personal Accident Insurance in effect. However, if you do not name a beneficiary, the proceeds will be paid in accordance with the information provided in the preceding Basic Life Insurance section. If circumstances in your life change, you may want to change your beneficiary designation.

You are automatically the beneficiary for any benefits payable as a result of your accidental

dismemberment. In addition, you are automatically the beneficiary for any loss suffered by a covered dependent.

Benefits will be paid to you (or to your named beneficiary) under one of the options described in the preceding Basic Life Insurance section.

Other benefits also may be payable as the result of a covered accident. Refer to the Personal Accident Insurance section beginning on page 49.

How to File a Claim

To apply for Basic Life, Extra Accident, Optional Life, Dependent Life, or Personal Accident Insurance benefits, you or your beneficiary(ies) must complete a claim form provided by MetLife. You may contact the Fidelity Benefits Center at 1-877-389-2374 to initiate the claim process.

Health Care Coverage for Survivors

Surviving spouses and dependent children of active employees who die may be eligible to continue Aptiv health care coverage as explained below.

- **If you die <u>prior</u> to becoming eligible for health care**:
  - Your surviving spouse may continue medical coverage on a self-paid basis for 24 months, provided your surviving spouse was married to you (the deceased employee) for at least one full year immediately preceding the date of death. Your surviving spouse may elect COBRA continuation or conversion in lieu of Aptiv continuation.

- **If you die <u>after</u> becoming eligible for health care**:
  - Surviving Spouse
    - If your surviving spouse is age 45 or more, or if your surviving spouse's age plus your service equals 55 or more, your surviving spouse is eligible to continue medical coverage with Aptiv contributions for a maximum of 12 months, provided your surviving spouse was married to you (the deceased employee) for at least one full year immediately preceding the date of death. Afterwards, your surviving spouse can continue medical coverage on a self-paid basis until the earlier of the date when your spouse: (1) dies, (2) remarries or (3) becomes age 62. Your surviving spouse may elect COBRA continuation or conversion in lieu of Aptiv continuation.
  - Dependent Children
    - Coverage for your dependent children will cease at the end of the month in which you die. Any surviving dependent children are eligible for COBRA continuation or conversion only.

- **If you die as a result of an accidental bodily injury caused solely by employment with Aptiv**:
  - Health care coverages that were available to you will be provided for your surviving spouse until the earlier of the date when your spouse: (1) dies or (2) remarries.
  - Eligible dependent children may be included as indicated earlier.

- **If none of the above apply to you**, your surviving spouse and eligible dependent children will not be eligible for Aptiv contributions for the continuation of health care. However, they would be eligible for COBRA continuation or conversion.

If your surviving spouse is eligible to continue coverage, he/she may continue coverage until such time the surviving spouse becomes eligible for Medicare in the normal course (i.e., age 65).

If your surviving spouse is eligible to continue coverage, he/she may continue coverage for dependent child(ren) who were enrolled prior to your death, provided they continue to meet the eligibility criteria applicable to dependent child(ren).

General Information

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Aptiv Contributions

Aptiv pays the full cost for Basic Life Insurance, Extra Accident, Sickness and Accident, Extended Disability Benefits and SUB after you become eligible (if applicable) and while you are in active service. Aptiv also pays the full cost for certain Health Care coverages after you become eligible (if applicable) and while you are in active service, with the exception of contributions that may be required for the Basic Plan, self-paid continuation, or for deductibles, coinsurance, copayments required under the rules of the Health Care Program for Hourly Employees.

The contribution amounts under the Life and Disability Benefits Program are determined by the carrier based on claim experience. The contribution amounts for any self-paid continuation for the self-insured Health Care Program for Hourly Employees are based on claim experience.

Optional Life Insurance, Dependent Life Insurance and Personal Accident Insurance are made available by Aptiv, but the full costs are borne by employees.

Recovery of Benefit Overpayments

If any benefit paid to you should not have been paid or should have been paid in a lesser amount, your prompt voluntary repayment will be requested. If necessary, to the extent allowed by applicable law, overpayments or an overpayment may be recovered from any monies then payable, or which may become payable, to you in the form of wages or benefits payable under an Aptiv benefit plan. Health Care Program overpayments may be recovered from wages or benefit plans or programs, as appropriate; but overpayments under other plans or programs will not be offset against health care benefits.

When Coverages End and Leave Continuation

Quit or Discharge

Health Care: Health care coverages cease at the end of the month in which you quit or are discharged.

Life and Disability Benefits: Aptiv contributions for Basic Life Insurance, Extra Accident and Disability Benefits cease on the day you quit or are discharged.

Disability Leaves

If you are granted a disability leave of absence, you will be setup for direct bill and will receive an invoice (if applicable) from WageWorks / HealthEquity (Fidelity's direct bill administrator for Aptiv) indicating any monthly contributions owed to continue coverage. Payment to continue coverage during an approved leave is due the first of each month.

Health Care: While you are on an approved disability leave, health care coverages will continue for the duration of the disability leave or while you are receiving disability benefits, provided you pay any required contributions. If disability benefits end, health care coverages cease at the end of month in which disability benefits end after a minimum of 36 months, provided you remain on an approved disability leave.

If your disability leave ends because the period of disability equaled your length of service, health care coverages will continue for any month you receive Sickness and Accident or Extended Disability Benefits; otherwise, health care coverages will be cancelled at the end of the month in which your approved disability leave ends.

If health care benefits are terminated, COBRA continuation will be offered. COBRA and conversion privileges are described on page 77.

Life and Disability Benefits: While you are on an approved disability leave as a regular active employee, Basic Life Insurance and Extra Accident will continue for the duration of the disability leave or while you are receiving disability benefits. If disability benefits end, Basic Life and Extra Accident cease at the end of month in which disability benefits end after a minimum of 36 months, provided you remain on an approved disability leave.

If your disability leave ends because the period of disability equaled your length of service, Basic Life Insurance and Extra Accident will continue for any month you receive Sickness and Accident or Extended Disability Benefits; otherwise, these coverages will be cancelled at the end of the month in which your approved disability leave ends.

If your disability leave ends because the period of the leave equaled your length of service, Disability Benefits coverages will continue for

any month you receive Sickness and Accident or Extended Disability Benefits payments; otherwise, Disability Benefits will be cancelled at the end of the month in which your approved disability leave ends.

Optional and Dependent Life Insurance cease on the earlier of the following dates: (1) on the date that your Basic Life Insurance ceases, or (2) on the last day of the calendar month preceding the month for which a required contribution was due, but not paid. Dependent Life Insurance also ceases when you no longer have an eligible dependent.

Personal Accident Insurance ceases on the earlier of the following dates: (1) on the date your Basic Life Insurance ceases, except when your Basic Life Insurance ceases during periods of layoff, or (2) on the last day of the calendar month preceding the month for which a required contribution was due but not paid. Personal Accident Insurance for a dependent ceases for any person when that person no longer is an eligible dependent.

Conversion privileges are described on page 78.

Non-Disability Leaves

If you are granted a non-disability leave of absence, you will be setup for direct bill and will receive an invoice (if applicable) from WageWorks / HealthEquity (Fidelity's direct bill administrator for Aptiv) indicating any monthly contributions owed to continue coverage. Payment to continue coverage during an approved leave is due the first of each month.

Health Care: Your health care coverage as an active employee (if applicable) will cease at the end of the month in which you are last in active service.

You may continue coverages on a self-paid basis at the same cost as an active employee for either up to 12 months or the duration of the leave, depending on the type of leave, while your seniority remains unbroken:

- Up to 12 months for an educational leave, government service leave, long-term military leave, personal leave, relocated spouse leave or unpaid layoff

  If you wish to continue coverages beyond this time, you may continue coverage under the applicable provisions of federal law (see COBRA on page 87).

  If you are granted a non-disability leave of absence in anticipation of a later disability, and if you continue your coverages on a self-paid basis, you will be eligible for reinstatement of Corporation contributions for coverages, and for continuation of such coverages during the period you are disabled.

- For the duration of the leave while on active duty from reserve leave, short-term military leave or a special annual military training leave

If you do not pay the required monthly contributions (if applicable) to continue health care coverages, coverage will be termed due to non-payment.

Life and Disability Benefits:
Your life and disability benefits as an active employee (if applicable) will cease at the end of the month in which you are last in active service. Coverage may be continued after the month in which you last worked prior to an approved non-disability leave of absence as specified below.

For the first month, Sickness and Accident and Extended Disability Benefit coverages (if applicable) in force are continued at no cost to you.

Basic Life and Extra Accident coverages in force are continued at no cost to you for either up to 12 months or the duration of the leave, depending on the type of leave, while your seniority remains unbroken. Optional Life, Dependent Life and Personal Accident coverages may be continued on a self-paid basis at the same cost as an active employee for either up to 12 months or the duration of the leave, depending on the type of leave, while your seniority remains unbroken:

- Up to 12 months for an educational leave, government service leave, long-term military leave, personal leave, relocated spouse leave or unpaid layoff

  If you are granted a non-disability leave of absence because of a medical condition that may be expected to result in total disability in the future (e.g., anticipated surgery or termination of pregnancy), Sickness and Accident and Extended Disability Benefits coverages (if applicable), which are discontinued at the end of the month in which you last worked, may be reinstated. For disability coverages to be reinstated,

you must present medical evidence satisfactory to Aptiv that you are totally disabled. Reinstatement will be made effective as of the date you present satisfactory medical certification of your disability. Aptiv will contribute the full cost of your Disability coverages and such contributions will start the first of the month in which you present evidence satisfactory to Aptiv of your total disability.

- For the duration of the leave while on active duty from reserve, short-term military leave or a special annual military training leave

If you do not pay the required monthly contributions to continue Optional Life, Dependent Life and Personal Accident Insurance, coverage will be termed due to non-payment.

Family and Medical Leave

Under the Family and Medical Leave Act of 1993 (FMLA), you may be eligible to receive health care, life and disability coverages on the same basis as an active employee for up to 12 weeks in a year, if such leave is related to any of the following:

- The birth of a child or the placement of a child by adoption or foster care
- The need to provide care for a family member (child(ren), spouse, parent) with a serious health condition
- A serious health condition that makes you unable to do your job
- A "qualifying exigency" resulting from a family member's military service
- The need to provide care for a covered family member seriously injured in the line of duty (up to 26 weeks of leave available)

Note: If your own serious health condition qualifies you for disability leave, it generally will be in your interest to apply for such leave. The benefit treatment is generally more favorable. Periods of disability leave will apply towards any FMLA entitlement you may have.

If you are granted FMLA you will be setup for direct bill and will receive an invoice (if applicable) from WageWorks / HealthEquity (Fidelity's direct bill administrator for Aptiv) indicating any monthly contributions owed to continue coverage. Payment to continue coverage during an approved leave is due the first of each month.

If you do not return to work immediately following an FMLA leave, your eligibility and the basis for continuation of health care, life and disability coverages, if any, will be governed by the Program provisions applicable to your status as of and following the date you do not return to work. If appropriate, Aptiv can recover the cost for the continuation of coverages during the FMLA leave unless your continued absence is caused by a serious health condition or another reason beyond your control.

Benefit Program Coverages When Returning from Permanent Layoff

Continuation of Health Care, Life and Disability coverages during layoff are described on pages 68 and 69.

Health Care

Upon return to active work from permanent layoff, any health care coverages discontinued (except coverage you voluntarily cancel) while on layoff with seniority will be reinstated the day you return to active work. Corporation contributions also will resume at that time.

Life and Disability Benefits

If you return to active work from permanent layoff, you will be eligible for Sickness & Accident and Extended Disability Benefit coverage on the first day you are at work.

If You Leave Aptiv

If you leave Aptiv, you will have certain rights and be required to make certain decisions relative to your benefit program coverages, as described below.

Health Care

If you leave Aptiv, you may be eligible to continue your health care coverage through COBRA Continuation or Conversion.

- **COBRA Continuation:** If your health care coverage is cancelled due to termination of employment, you will have 60 days to elect COBRA Continuation. WageWorks / HealthEquity (Fidelity's COBRA administrator) will mail information to you about COBRA Continuation after your separation. Please see the Consolidated Omnibus Budget Reconciliation Act (COBRA) section on page 87 for more information.

- **Conversion:** During the 31 days following cancellation of your health care coverages, you may convert, at your expense, to whatever "direct pay" individual contract for basic health care that is available through the carrier. (Corporation contributions for health care coverage cease at the end of the month you are last in active service.)

Another option is to purchase health insurance through the Marketplace (HeatlhCare.gov).

Life Insurance

If you leave Aptiv for any reason, your Basic Life Insurance (including Extra Accident), Optional Life Insurance, Dependent Life Insurance and Personal Accident will not continue after you leave Aptiv. However, you may be eligible to continue your Life Insurance coverages through conversion as explained below.

Basic Life Insurance

You may convert, at your expense, all or part of your Basic Life Insurance to a personal policy of insurance without proof of good health if you apply in writing to the insurance company within 31 days from the date your coverage ends.

Optional Life Insurance

You may convert your Optional Life Insurance to a personal policy of insurance without proof of good health, as long as the insurance ceases for reasons other than failure to pay the required contributions and you apply in writing to MetLife within 31 days from the date your coverage ends.

Dependent Life Insurance

Your dependents may convert Dependent Life Insurance to a personal policy of insurance without proof of good health, provided the insurance ceases for reasons other than failure to pay the required contributions and they apply in writing to MetLife within 31 days from the date the coverage ends.

Personal Accident Insurance

Personal Accident Insurance cannot be converted to an individual policy.

Life Insurance Conversion

If you experience a life event that makes you eligible for conversion, MetLife will provide the information you need to begin the conversion process.

If you or your dependents wish to exercise the conversion privilege for Basic, Optional or Dependent Life Insurance coverages, you should contact MetLife at 1-877-ASK-MET7 (1-877-275-6387) or via email at solutions@metlife.com. MetLife will arrange for a financial services representative to follow up with you and help you and/or your dependents with your application.

The new individual policy will be upon one of the forms then customarily issued by the carrier, except term insurance, and will be without disability or accidental means death benefits. The cost will depend on the amount and type of policy and your class of risk and age at that time. The individual policy will not become effective until the end of the 31-day waiting period. However, if you, or in the case of Dependent Life Insurance coverage, your spouse, or eligible child die during this 31-day period, the amount of life insurance that ceased under the Aptiv Life and Disability Benefits Program for Hourly Employees will be paid whether or not you applied for an individual policy.

Legally Required Information

With the exception of the right to amend, modify, suspend or terminate, or unless otherwise noted, this section applies only to benefit plans governed by the Employee Retirement Income Security Act of 1974 (ERISA).

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Plan Sponsor

The plans described in this booklet are sponsored by Aptiv Corporation, 5725 Innovation Drive, Troy, MI 48098, 248-813-2000.

Plan Administration Summary

Common Name of Plan	Plan Type	Plan ID Number	Plan Trustee (T), Insurer (I) or Administrator (A)
Health Care Program for Hourly Employees	Welfare benefit plan providing insured and/or self-insured benefits to employees and their eligible dependents	501	Blue Cross Blue Shield of Michigan (A) — **Medical** Cigna Dental (A) — **Dental** Davis Vision (A), (I) — **Vision** Fidelity H&W Benefits Administration (A)
Life Insurance	Welfare benefit plan providing life insurance coverage to employees and their eligible dependents	501	Metropolitan Life Insurance Company (I), Fidelity H&W Benefits Administration (A)
Personal Accident Insurance	Welfare benefit plan providing accident death and dismemberment insurance coverage to employees and their eligible dependents	501	Metropolitan Life Insurance Company (I), Fidelity H&W Benefits Administration (A)
Sickness and Accident Disability Benefits	Welfare benefit plan providing short-term disability benefit coverage to employees	501	Sedgwick CMS (A)
Extended Disability Benefits (EDB)	Welfare benefit plan providing long-term disability coverage to employees	501	Sedgwick CMS (A)
Supplemental Unemployment Benefits*	Welfare benefit plan providing benefits while employees are absent from work due to layoff.	501	Aptiv SUB Administration Center (A)

* Plan is not subject to ERISA

Plan Year

December 31 is the end of the Plan Year for all plans and programs. Records of these plans are kept on a calendar-year basis.

Named Fiduciary

Except as described below, the Board of Directors of Aptiv Corporation is the Named Fiduciary of the benefit plans described in this booklet that are governed by ERISA. The Board of Directors may delegate authority to carry out such responsibilities as it deems proper, to the extent permitted by ERISA.

Plan Administration and Funding

The Aptiv benefit plans are administered and funded in different ways. All plans described in this Summary Plan Description booklet are funded with participant and/or Company contributions as described in the separate benefit sections.

Aptiv Corporation is the sponsoring employer and administrator of the Aptiv employee benefit plans described in this booklet that are governed by ERISA. The administrator's address is Aptiv Corporation, 5725 Innovation Drive, Troy, MI 48098-2815.

For some of the plans, Aptiv has delegated authority to an insurance company to administer benefit claims. The claims administrators are listed on page 80 of this section. Subject to Aptiv's overall authority as plan administrator, the claims administrator has discretionary authority to interpret plan provisions and determine benefit claims.

Cost of Administering the Plans

Aptiv intends to pay certain expenses of administering the Health and Welfare plans.

Contributions to the Plans

Aptiv's health and welfare plans are either fully insured or self-insured. Under self-insured plans, such as the Medical, Dental, Sickness and Accident and Extended Disability Benefits (EDB), Aptiv pays benefits out of its own funds. An insurance company or other third party, however, is retained to administer claims for benefits under the Plans.

Life insurance and Vision are fully insured. For these benefits, the insurance company provides the benefit and dictates the premiums to be paid. Premiums are based on administrative costs, claims experience, expected future losses and the number of employees covered.

Aptiv pays the full cost of Sickness & Accident, Extended Disability Benefits and Basic Life Insurance coverage for eligible, active employees and during the applicable continuation period for certain non-disability leaves, a disability leave of absence or layoff.

The name of each insurance company or administrator appears on page 80.

Limitations on Rights

Participation in a plan does not give you the right to remain employed by the Company. Also, you cannot sell, transfer or assign, either voluntarily or involuntarily, the value of your benefit under a plan unless specifically stated in the appropriate section of this guide. Participation in the plan also is not a guarantee that plan benefit levels will remain unchanged in future years.

Qualified Medical Child Support Orders (QMCSOs)

Federal law requires group health plans to honor Qualified Medical Child Support Orders (QMCSOs). In general, QMCSOs are orders from a state court or state administrative agency requiring a parent to provide medical support to a child, for example, in cases of legal separation or divorce.

A QMCSO may require the plan to make coverage available for your child even though, for income tax or plan purposes, the child is not your dependent due to divorce or legal separation. In order to qualify as a QMCSO, the medical support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which does the following:

- Specifies your last known name and address and the child's name and last known address
- Provides a reasonable description of the type of coverage to be provided by the plan, or the manner in which the type of coverage is to be determined
- States the period to which it applies
- Specifies each plan to which it applies

The QMCSO may not require the plan to provide coverage for any type or form of benefit or any option not otherwise provided under the terms of the plan. Upon approval of a QMCSO, the plan is required to pay benefits directly to the child, or to the child's custodial parent or legal guardian, pursuant to the terms of the order to the extent it is consistent with the terms of the plan.

Information about Aptiv's QMCSO procedures is available from the Fidelity Benefits Center.

Employer Identification Number

The Internal Revenue Service has assigned the employer identification number **27-0791190** to Aptiv Corporation. If you need to correspond with a government agency about a benefit plan, use this number along with the plan name and the company's name.

Legal Process

Service of legal process on Aptiv Corporation may be made at any office of the CT Corporation. CT Corporation, which maintains offices in all 50 states, is the statutory agent for services of legal process on Aptiv. The procedure for making such service generally is known to practicing attorneys. Service of legal process also may be made upon Aptiv at the Service of Process Office, Aptiv Legal Staff, 5725 Innovation Drive, Troy, MI 48098.

As to all other matters, service for legal process with respect to the Plan should be directed to the Plan Administrator named above.

Your Rights Under ERISA

As a participant in the Aptiv benefit plans, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office all documents governing the plan, including insurance contracts and collective bargaining agreements, and 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.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- 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.

Continue Group Health Plan Coverage

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

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases if you request it before losing coverage or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and Beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in

whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy 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 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 suite 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.

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 (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA publications hotline at 1-800-998-7542.

Right to Amend, Modify, Suspend or Terminate

Aptiv reserves the right to amend, modify, suspend, increase, decrease or terminate any of its employee benefit plans or programs by action of its Board of Directors (Board) or other committee or individual expressly authorized by the Board to take such action.

The benefits to which an employee is entitled are determined solely by the provisions of the applicable Aptiv benefit plan or program, as amended. No changes may be made to the "Contract Settlement Agreement" until expiration, except as permitted by law or mutually agreed to between Aptiv Corporation and the IUE-CWA, Local 717.

Absent an express delegation of authority from the Board of Directors, no one has the authority to commit the Corporation to any benefit or benefit provisions not provided for under the applicable benefit plan or program, or to change the eligibility criteria or any other provisions of such plan or program.

Aptiv's right to amend or terminate the plan includes, but is not limited to, changes in the eligibility requirements, premiums or other employee payments charged, benefits provided and termination of all or a portion of the coverage provided under the plan. If the plan is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination, altered or increased accordingly, as of the effective date of the amendment or termination. You do not have ongoing rights to any plan benefit, other than payment of any covered expenses you incurred prior to the plan amendment or termination.

Life and Disability Benefits Program and Health Care Program

Upon termination or partial termination of either welfare program, coverage will cease as of the effective date of termination or partial termination.

Supplemental Unemployment Benefits (SUB)

Upon termination, or partial termination, of SUB, eligibility and payments will cease as of the effective date of termination or partial termination.

Collective Bargaining Agreement

The Health Care Program, Life and Disability Benefits Program, and Supplemental Unemployment Benefit Plan, each as described in this booklet, are maintained pursuant to collective bargaining agreements with the International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers, AFL-CIO. A copy of the agreements may be obtained upon your written request to the Plan Administrator.

Application and Claims Review Procedures

To receive benefits under any of these employee benefit plans, generally you will need to file an application. Appropriate forms, if applicable, are available by contacting the appropriate servicing center, whose phone numbers are listed on page 1.

For claims appeals information:

- **Health Care:** see page 40.
- **Life Insurance and Personal Accident Insurance:** see page 53.
- **Disability:** see page 61.
- **Supplemental Unemployment Benefits (SUB):** see page 68.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully.

Federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), limit the use and disclosure of protected health information ("PHI") by the Aptiv Corporation Salaried Health Care Program, The Aptiv Corporation Health Care Program for Hourly Employees, and the Aptiv Health Care Reimbursement Plan for Salaried Employees (collectively the "Programs"). PHI is individually identifiable health information created for or received by the Programs that relates to (i) the past, present, or future physical or mental health or condition of an individual, (ii) provision of health care to a covered individual, or (iii) payment for health care received by an individual. This Notice is being provided in accordance with HIPAA. It applies to covered dependents as well as primary enrollees.

Permitted Uses

With some exceptions, described below, the law generally permits the Programs to use and disclose PHI without an individual's authorization only for medical treatment, to pay health care claims, and for health care operations. The Programs sometimes contract with third-party business associates for services. The Programs may disclose PHI to business associates so that they can perform the job the Programs have asked them to do. To protect an individual's PHI, the Programs require their business associates to appropriately safeguard PHI. Business associates who provide these types of services to the Programs (e.g., Fidelity H&W Benefits Administration, Blue Cross Blue Shield, Express Scripts, Cigna, etc.) may also use or disclose PHI to their subcontractors subject to their agreement with the Business Associates to keep PHI confidential.

Treatment: The Programs may use or disclose PHI for medical treatment. Although the Programs do not directly engage in treatment, they may use or disclose PHI to assess medical necessity and medical appropriateness of a particular treatment. For example, PHI may be used when recommending a treatment, providing treatment alternatives, or describing health-related benefits and services to an individual.

Payment: The Programs may use or disclose PHI to pay claims for health care benefits. Payment includes, but is not limited to, determining eligibility, processing claims, making pre-certification or pre- authorization decisions, medical review, utilization review, billing, coordinating benefits, and exercising the Programs' subrogation rights. For example, PHI may be used to pay a doctor's bill for covered services or to reimburse an individual from his or her health care spending account.

Health Care Operations: The Programs may use or disclose PHI to operate. This includes, but is not limited to, business management, customer service, enrollment, care management, case management, audit and actuarial functions, fraud and abuse detection, due diligence, and quality assurance. For example, the Programs may review PHI to respond to an appeal from a denial of benefits or to audit the accuracy of a health care

carrier's claims processing.

Required Uses and Disclosures
The Programs are required to disclose PHI without an individual's authorization to the Secretary of the U.S. Department of Health and Human Services ("HHS") to enable the Secretary to investigate and determine the Programs' compliance with HIPAA. The Programs will also disclose your PHI when required to do so by other federal, state, or local law, including those laws that require the reporting of certain types of wounds, illnesses, or physical injuries. Upon request, the Programs are required to give you access to certain portions of your PHI for inspection and copying.

Other Permitted Uses and Disclosures:
The Programs may disclose PHI without an individual's authorization to avert a serious health or safety threat, in a report regarding victims of abuse, neglect, or domestic violence, for public health activities, to help law enforcement officials perform their duties, for post-mortem identification, for tissue donation, in a judicial or administrative proceeding, pursuant to a subpoena, to comply with Workers Compensation laws, for reasons of national security, for disaster relief, to researchers under limited circumstances, to a health oversight agency (such as Medicare or Medicaid), or when legally required.

The Programs may disclose PHI to Aptiv for purposes related to Aptiv's sponsorship and administration of the Programs. These purposes include, but are not limited to, recording annual health care elections and verifying dependent status.

The Programs may use PHI in order to communicate with individuals via newsletters, mailings or other means regarding treatment options, health-related information, disease management programs, wellness programs or other community-based initiatives in which the Programs are participating. In most circumstances, the Programs are required by law to receive an individual's written authorization before the Programs can use or disclosure PHI for marketing purpose. Under no circumstances will the Programs sell information to a third party without an individual's written authorization.

The Programs will not use or disclose any genetic information that is PHI for underwriting purposes.

In general, other uses and disclosures of PHI will be made only with an individual's prior written authorization. This means that other persons (e.g., spouses, representatives) may not act on an individual's behalf without a signed authorization.

An authorization may be revoked prior to the Programs' use or disclosure of PHI in reliance on the authorization.

Individual Rights

Individuals have the right to receive a copy of the Programs' Notice of Privacy Practices at any time.

Individuals may ask the Programs to further restrict the use or disclosure of PHI for payment or health care operations, or for disclosures to family members, relatives, or personal representatives involved in the individual's care or about the individual's location, general condition, or death. The Programs may elect to decline this request. For example, an individual may ask the Programs to send written communications to a different address than that of the primary enrollee. Such requests must be made in writing and sent to the appropriate health care carrier(s). The Programs are not obligated to accommodate all such requests, but will respond as appropriate.

Individuals may request that the Programs use alternative means of communicating PHI to the individual, and the Programs must accommodate such a request if reasonable. The request must be made in writing, sent to the Privacy Official for the Programs, state that disclosure otherwise may endanger the individual, and specify the desired alternative means of communication.

Individuals have the right to inspect and copy their own PHI maintained in a designated record set within thirty days of a written request. A single, thirty-day extension is allowed if the Programs are unable to comply by the initial deadline. To the extent your PHI is maintained electronically in a designated record set by the Programs, you also have the right to request a copy of the PHI in a specified electronic form and format. If the requested form and format is not readily producible, the Programs will provide the copy in a readable electronic form and format that is agreed to by you and the Programs. You may request that the paper or electronic copy of your PHI be sent to another entity or person, provided that the request is made in writing, signed by you, and clearly

identifies the entity or person and where to send the copy of the PHI. The Programs may deny an individual's request to inspect and obtain a copy of PHI in certain limited circumstances. Some, but not all, denials are subject to review. For denials that are subject to review, the review will be conducted by a licensed health care professional who was not directly involved in the original denial. The Programs will comply with the outcome of the review. The Programs may charge a reasonable, cost-based fee for the cost of copying and/or mailing copies of your PHI (including the cost of any required supplies).

Individuals have the right to request that PHI be changed (e.g., due to inaccuracy or incompleteness). If the Programs deny the request, the individual may submit a written statement of disagreement with the applicable Program's denial. Such a statement will be kept on file with the disputed record.

Individuals have the right to receive a free annual accounting of disclosures for reasons other than treatment, payment, or health care operations (and certain other permitted purposes in accordance with the regulations) during the six-year period immediately prior to a request. All such requests should be directed to the appropriate health care carrier(s).

The Programs are required to notify an individual of any breaches of unsecured PHI as soon as possible, but in any event, no later than sixty days following the discovery of the breach. Unsecured PHI is information that is not secured through the use of a technology or methodology identified by the Secretary of HHS to render PHI unusable, unreadable, and undecipherable to unauthorized users.

You may have additional privacy rights under state laws, including rights in connection with mental health and psychotherapy reports, pregnancy, HIV/AIDS-related illnesses, and the health treatment of minors.

If an individual believes his or her privacy rights have been violated, he or she may file a complaint with the Programs by contacting the Fidelity Benefits Center at the contact information provided below, or by writing to the Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F HHH Bldg., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. The complaint should generally be filed within 180 days of when the act or omission complained of occurred. You will not be penalized or retaliated against for filing a complaint.

Please note that these rights relate only to PHI maintained by the Programs. The regulations do not apply to medical information used for purposes of determining work restrictions, workers compensation or disability, pension, or life insurance benefits.

Policies and Procedures

The Programs have adopted privacy policies and procedures to ensure that only authorized persons who administer the Programs have access to PHI. When required or permitted to do so, the Programs will use or disclose only the minimum necessary PHI permitted or required. The Programs' use and disclosure of PHI will be limited to the limited data set (i.e., a data set that excludes direct identifiers of an individual), or, if needed, to the minimum PHI necessary to accomplish the intended purpose of the use or disclosure, pending further guidance from the Secretary of HHS.

The Programs have appointed a Privacy Official to develop and implement their policies and procedures. The Programs reserve the right to change their policies and procedures at any time at the discretion of the Privacy Official or his delegate. In the event such changes are made, the change to the Notice(s) of Privacy Practices or the revised Notice(s) of Privacy Practices will be posted on the Fidelity Benefits Center website by the effective date of the revision(s). The revised Notice(s) of Privacy Practices or information about the change(s) to the Notice(s) of Privacy Practices and how to obtain the revised Notice(s) of Privacy Practices will be sent to you in the Programs' next annual mailing to participants. The revised Notice(s) of Privacy Practices will be sent electronically if you have consented in advance to receive the Notice(s) of Privacy Practices electronically.

The Programs are obligated to abide by the terms of this Notice, which will be posted at www.netbenefits.com, and to protect the privacy of your PHI.

Contact Information

For further information or to request a paper copy of this Notice, please contact the Fidelity Benefits Center at 1-877-389-2374 or www.netbenefits.com. Written submissions (e.g., inquiries, complaints) should be sent to the appropriate health care carrier(s).

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The notice on the pages that follow is required under COBRA when you become eligible for Corporation contributions for health care coverage.

COBRA requires most employers sponsoring group health plans to offer employees and their families the opportunity to buy a temporary extension of health coverage (called "COBRA Continuation Coverage") at a contribution rate slightly above group rates, in certain instances where coverage under the employer's plan is lost. For COBRA purposes, a "loss of coverage" means any change in the terms or conditions of your coverage. This notice is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. Both you and your spouse, if applicable, should take the time to carefully read this notice.

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When COBRA Applies

COBRA applies to you if you have coverage as an active employee, as an employee on disability leave, or as a dependent of one of the above.

Employee Information

As an employee, you have a right to elect COBRA Continuation Coverage if you "lose" your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

In some situations, you may "lose coverage" but have a limited opportunity to continue some alternate coverage under the Health Care Program for Hourly Employees (Program Continuation). In such cases, the options available to you will be explained. You must choose between COBRA and continuation under the Program Continuation.

Dependent Information

If you are the spouse or dependent child of a covered employee, you may have the right to elect COBRA Continuation if you lose group health coverage. See the chart below for more information.

General Information

If you and/or any of your covered dependents lose your health care coverage as the result of a "qualifying event" as described in the following chart, you and/or your covered dependents may be eligible to continue medical, dental and vision coverages at your cost for a limited period of time, in accordance with COBRA. The events and the maximum period for which you may continue coverage include:

Qualifying Event	Who May Continue Coverage	Maximum Period of Coverage
Termination of employment (unless for gross misconduct) or reduction in hours	Employee, spouse and dependent children	18 months
Divorce	Spouse, former spouse and/or dependent children	36 months
Death of employee	Surviving spouse and/or dependent children	36 months
Dependent child loses eligibility	Dependent child	36 months

Electing Continuation Coverage

If the qualifying event is divorce or your dependent child ceasing to be eligible for coverage (other than due to age), you or your dependents must inform WageWorks / HealthEquity at 1-888-678-4881 within 60 days of the date of the event to request notice of your COBRA continuation rights. If notice is not provided within 60 days of the qualifying event, you may not elect continuation coverage.

In all other cases, you and your covered dependents will be notified automatically of your rights to continue coverage and provided with the necessary information to complete an election. You and your covered dependents will have 60 days from the later of the date coverage is lost or the date the notice of the right to continuation coverage is received to complete an election of continuation coverage. If the election is not completed within the 60-day period, you will not have continuation coverage and will have no further rights to elect such coverage.

If you do not elect COBRA and do not have alternative continuation rights under the Program, your group health coverage will end in accordance with the Program provisions. You may be eligible for a "conversion contract" from the carrier administering your coverage when eligibility ceases. A conversion policy offers

limited coverages and is a private contract between you and the carrier.

The law also provides that at the end of the 18-month or 36-month continuation period, you must be offered an individual conversion policy if that option is provided under the Program.

Coverage During the Election Period

As of the date coverage is terminated, you and your covered dependents will not have any coverage until continuation coverage is properly elected and the required premiums have been paid. This means no claims will be paid during the election period. In order to receive uninterrupted coverage, you should elect continuation coverage and make the required premium payments as soon as possible after receiving your notice of continuation coverage (see "Cost of Continuation Coverage" below). If a completed election form is received and all required premiums are paid in a timely fashion, coverage becomes retroactive to the date coverage was terminated. This means that a claim for covered expenses that may have been denied during the grace period will be paid once timely payment of the premium is received. For the initially denied claim to be paid, you or your dependent must call the carrier to ask that the claim be reconsidered.

Second Qualifying Events

The maximum period for which you may elect continuation coverage is shown in the chart on page 88. In some cases, however, your dependent may elect a longer period of coverage, based on the occurrence of a second qualifying event during the initial period of coverage. For example, if your dependent child has coverage because your employment terminates, and during the first 18 months of coverage ceases to be eligible because he or she turns age 26, then he or she may be eligible for an additional 18 months of coverage, for a total of 36 months of continuation coverage. WageWorks / HealthEquity is monitoring this second qualifying event, and they will extend the additional continuation coverage if appropriate. If you have questions about second qualifying events, call WageWorks / HealthEquity COBRA Administration at 1-888-678-4881. Other events that may permit an extension of coverage are described in the next few paragraphs.

Medicare

If you become entitled to Medicare and after that you lose coverage under the Plan due to your termination of employment or reduction in hours of employment, your covered dependents will be entitled for continuation coverage until the later of the date which is 36 months from the date you became entitled to Medicare or 18 months from the date of your termination of employment or reduction in hours in employment.

Disability

If you or any of your covered dependents are found to be disabled for purposes of Social Security at the time of or within 60 days of your termination of employment/reduction in hours of employment, then you and your covered dependents are eligible to elect an additional 11 months of continuation coverage.

To purchase the additional 11 months of continuation coverage, you or your dependent must contact WageWorks / HealthEquity 60 days of the date the determination of disability was made by the Social Security Administration and within the first 18 months of continuation coverage and provide proof of the Social Security Administration's determination of disability.

If the Social Security Administration determines that the disabled person is no longer disabled, you or your dependent must contact WageWorks / HealthEquity within 30 days of the date of the determination. Continuation coverage will stop on the first day of the month that is at least 30 days after the person is determined not to be disabled.

Cost of Continuation Coverage; Payment

Your or your dependent's cost for continuation coverage is 102% of Aptiv's cost for providing coverage to a similarly situated active employee. If you or your dependent is entitled to elect the additional 11 months of continuation coverage in the case of disability, the premium will be 150% of the cost of providing coverage to a similarly situated active employee if the disabled person elects the extension. (If the disabled person does not elect the extension but other family members do, the applicable premium will remain at the 102% rate.)

You and your covered dependents will receive written notice of the cost of continuation coverage at the time of eligibility. The cost will be adjusted from time to time, as costs for active employees are adjusted. You may request written verification of the cost of continuation

coverage at any time during the continuation coverage period.

If you or your covered dependents elect COBRA, you will receive a bill that shows you the required contribution amount for the coverages you elected. That payment will cover the entire period from the time your active coverage would otherwise have terminated—you cannot elect to waive coverage for that period just because you didn't need it. You will have 45 days from the date you receive your first bill to pay the contribution amount for the first payment due. All continuation coverage payments will be made on an after-tax basis. After the initial bill, payment is due on or before the first day of each month for which coverage is continued. You will have a 30-day grace period to make each monthly payment. Failure to pay the contribution amount by the end of the grace period for the month for which coverage is to be continued will result in loss of coverage retroactive to the last day of the prior month. Once you lose this COBRA Continuation Coverage, you will NOT be able to have it reinstated. Even if continuation coverage is elected, benefits for any period will not be paid until payment for that period has been made.

Trade Adjustment Assistance Reauthorization Act of 2015 (TAARA 2015)

The TAARA provides a Health Coverage Tax Credit (HCTC), which is a tax credit that pays 72.5 percent of qualified health insurance premiums for eligible individuals and their families. The HCTC acts as partial reimbursement for premiums paid for qualified health insurance coverage through 2019.

Aptiv COBRA coverage is qualified health insurance coverage.

You may be eligible to elect the HCTC only if you are one of the following:

- An eligible trade adjustment assistance recipient, alternative TAA recipient or reemployment TAA recipient,
- An eligible Pension Benefit Guaranty Corporation payee, or
- The family member of an eligible TAA, ATAA, or RTAA recipient or PBGC payee who is deceased or who finalized a divorce with you.

If you purchase Aptiv COBRA coverage, you can claim your HCTC when you file your federal income tax return. This will increase your refund or lower the amount of tax that you would otherwise owe.

For more details about the HCTC, please visit www.irs.gov.

Changing Coverage; Adding Dependents

You may change your coverage elections and/or add dependents if you experience a life event as long as you notify WageWorks / HealthEquity within 31 days of the event. You also may change your coverage elections each year during open enrollment. If the addition of a dependent will result in a higher applicable premium, your premium rates will be adjusted.

You may remove dependents from your COBRA coverage at any time.

Be sure to notify WageWorks / HealthEquity if your address changes during your period of continuation coverage.

If you have any questions, or if you have changed marital status, please call WageWorks / HealthEquity at 1-888-678-4881 or online at https://mybenefits.wageworks.com/.

Termination before the End of Maximum Coverage Period

Normally, your continuation coverage may be continued for the maximum period stated in the chart at the beginning of this section, as long as you or your covered dependents make timely payment of premiums. In some cases, however, continuation coverage may end before the maximum coverage period ends. Continuation coverage will terminate immediately if:

- Aptiv no longer provides group health coverage to any of its employees;
- You or your covered dependents fail to pay the premium for the continuation coverage elected within 30 days of the first day of the month;
- After continuation coverage is elected, you or your covered dependents become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation that affects coverage of a covered individual's pre-existing

condition; or
- You or your covered dependents become eligible for Medicare.

In addition, the 11-month extension of continuation coverage due to disability will terminate as of the first day of the month beginning 30 days after the Social Security Administration determines that the covered dependent whose disability permitted the extension is no longer disabled. You must notify Aptiv within 30 days of such a determination.

Glossary of Key Terms

Sometimes, in order to accurately describe a benefit plan, it is necessary to use technical terms. To help you better understand them, the following are brief definitions of some of the most commonly used terms. They are not meant to be all-inclusive as each plan or program may have specific uses, which may vary.

Programs for Aptiv hourly employees referenced here are as follows:

- Health Care Program for Hourly Employees (Program)
- Life and Disability Benefits Program

Actively at Work – You are considered actively at work whenever you are performing the regular duties of your assignment, as determined by the Corporation, on a scheduled work day at one of the Corporation's places of business or at any other location to which the Corporation's business may require you to travel. Assignment includes both your regular assignment, as well as any given on a temporary basis. If you are on an approved vacation as determined by the Corporation, or excused with pay, you shall be considered "actively at work" while on such approved vacation.

Ambulance Services – Medically necessary transportation and life support services furnished within the Program provisions to sick, injured or incapacitated patients by a licensed ambulance provider meeting program standards, utilizing ambulance vehicles and personnel recognized as qualified to perform such services at the time and place where rendered.

Beneficiary – The person, persons or entity named by you, a plan participant, to receive the plan's benefits when you die—or if you die before receiving a benefit due you.

Benefit Period – A period of time during which an enrollee is entitled to receive certain covered services that are subject to Health Care Program maximums. A Benefit Period may cross calendar years. Once meeting these maximums, a new benefit period begins only when the enrollee has been out of care for 60 consecutive days.

For inpatient benefits subject to Benefit Period maximums, coverage is not provided for any days by which an inpatient stay exceeds the established benefit period maximum under the plan. Subsequent inpatient days are only covered if the enrollee has met the requirement of being out of care for 60 consecutive days even if such subsequent inpatient days occur in the next calendar year.

To be eligible for further benefits there must be a separation of 60 days between periods of hospitalization for any reason. For example, if an enrollee's initial inpatient admission for one condition exhausts the maximum and is separated by 60 days from a second admission for that same condition, but the person had been hospitalized for other reasons during the intervening period, the second admission would not be covered.

A new benefit period begins only when the enrollee has been out of care for a continuous period of 60 days. Accordingly, there must be a lapse of at least 60 consecutive days between the date of the enrollee's last discharge from any hospital, skilled nursing facility, residential substance abuse treatment facility, or any other facility to which the 60-day benefit renewal period applies and the date of the next admission, irrespective of the reason for the last admission and irrespective of whether or not benefits were paid as a consequence of such admission. Further, if subsequent to such discharge, the enrollee is a patient in a psychiatric or substance abuse program, a hospice program or is receiving home health care services, the 60-day renewal period is broken, whether or not benefits were paid as a consequence of receipt of such services.

Brand Name Drug – A drug that is covered by a patent and for which an equivalent version cannot be manufactured or marketed (single source) or a drug that is no longer covered by a patent and for which

chemically equivalent versions can be manufactured and marketed (multi-source). Brand name drugs may be "preferred" or "non-preferred," as determined by the carrier.

Carrier – Any entity by which any of the various benefit program coverages are administered or benefits paid. The term includes, but is not limited to, the following:

- Aptiv Corporation
- An insurance company
- Non-governmental administrative services organizations

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985 — federal legislation providing continuation rights to certain employees or dependents whose health care coverage under company-sponsored programs is lost due to certain "qualifying events."

Coinsurance – The percentage of the reasonable and customary cost or negotiated fee for medical services that you pay after the deductible is met, or the negotiated fee for prescription drugs that you are required to pay.

Conversion – An opportunity to obtain other available individual coverage on a self-paid basis, from the carrier with which the employee enrolled at the time eligibility terminated.

Copayments – A fixed amount you pay when you receive covered services or covered prescription drugs (deductible does not apply to a service with a copayment).

Core Coverage – Hospital, surgical, medical, prescription drug, hearing aid, mental health and substance abuse coverage.

Covered Expenses – The reasonable and customary, pre-established or contracted charges incurred for covered materials and services provided or rendered to or for an enrollee for treatment of illness or injury, and performed by a provider or prescribed by a physician in accordance with the provisions of the Health Care Program.

Covered Service – A service that is included within the range of services identified in the Health Care Program and that meets all Program requirements to be eligible for payment of benefits. A service within the range of those identified in the Health Care Program (e.g., a diagnostic radiology service) but which does not meet all the specifications to be eligible for benefit payment (e.g., medically necessary) is considered a non-covered service.

Custodial or Domiciliary Care or Services – The type of care or service which, even if ordered by a physician, is primarily for the purpose of meeting personal needs of the patient or maintaining a level of function (as opposed to specific medical, surgical or psychiatric care, or services designed to reduce the disability to the extent necessary to enable the patient to live without such care or services).

Custodial or domiciliary care generally does not require the continuing attention of medically skilled personnel and usually can be provided by aides or other persons without special skills or training, operating without direct medical supervision. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, toileting, meal preparation and eating, taking of medications, ostomy care, bed baths, hygiene or incontinence care, checking of routine vital signs, routine dressing changes and routine skin care.

The determination as to the nature of the care is not a function of the setting (e.g., hospital, skilled nursing facility, nursing home, another institutional setting or the patient's home) or of the professional status of the person (e.g., physician, nurse, therapist or aide) rendering the service, but of the severity of the patient's illness and the intensity of services being performed. The carriers shall have discretionary authority to interpret, apply and construe this provision of the Program. The carrier's determination as to the nature of the care being provided shall be given full force and effect unless it is determined by the Plan Administrator that the determination was inconsistent with the Program provisions or arbitrary and capricious.

Deductible – The amount you must pay up front each year as you receive services before the plan begins to cover a percentage of the charges.

Durable Medical Equipment – Equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally useful to an enrollee in the absence of illness or injury.

Emergency Room Services – Services in the emergency room of a hospital are covered for the initial examination and treatment of conditions resulting from accidental injury or medical emergencies. A medical emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to the pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

If services are not in an emergency room and the carrier determines the condition is not the result of an accidental injury or was not a medical emergency, the facility charges are not covered even though the professional charges of the physician may be covered (i.e., the charges comparable to an office visit).

Covered facility services and expenses are reimbursed based on charges or consistent with "reasonable and customary" levels and/or the contractual arrangements that may exist between the carrier and the facility. If Blue Cross and Blue Shield (or any other carrier that has participating agreements with hospitals) is your carrier, coverage for services obtained from other facilities may be reduced.

ERISA – The **E**mployee **R**etirement **I**ncome **S**ecurity **A**ct of 1974, as amended.

Fidelity Benefits Center – A service center provided to Aptiv employees that processes various benefit-related transactions, provides general benefit-related information and assists with problem resolution.

Formulary – A list of medications that are covered under the prescription drug plan, as determined by the carrier.

Freestanding Ambulatory Surgical Center – A facility, separate from a hospital, in which outpatient surgical services are provided. Such facilities must meet Program standards and be approved by the local carrier.

Freestanding Outpatient Physical Therapy Facility – A facility, separate from a hospital, that provides outpatient physical therapy services. Such facilities must meet Program standards and be approved by the local carrier.

Generic Drug – A drug not sold under an advertised product name, but that has the same active ingredients (and is often made by the same manufacturer) as the brand-name counterpart. Generic drugs are typically sold at substantial discounts—and, according to the FDA Office of Generic Drugs, they are identical to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.

HIPAA — Health **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996 **–** Federal legislation intended to improve the availability and portability of health care coverage, which requires employers to provide a certificate of prior health care coverage when an enrollee loses coverage.

Home Health Care – Care or services provided in the home for a patient who is essentially homebound, but whose condition does not warrant care in an institutional setting (such as a hospital or skilled nursing facility). The care/service is generally skilled, part time and intermittent in nature.

Hospice Program – Medical and non-medical services provided for terminally ill enrollees and their

families through agencies that administer and coordinate the services. A hospice program must meet Program standards and be approved by the local carrier.

Intermittent Care – Part-time care that is provided on less than a daily basis or up to eight hours per day of skilled nursing and home health aide services combined, delivered on a daily basis, but for a temporary period not to exceed one month.

Non-Core Coverages – Dental and Vision coverage.

Non-Physician Practitioners – Individuals other than physicians who are legally qualified and licensed to perform certain health care services. The following categories of non-physician practitioners may be eligible for reimbursement for services within their area of expertise. To be eligible for reimbursement, they must meet Program standards (including eligibility for reimbursement by Medicare for Medicare-eligible patients) and be approved by the carrier.

- "Advance Practice Nurse Specialties" include, but are not limited to, certified nurse practitioners, clinical nurse specialists, certified nurse mid-wives and certified nurse anesthetists. Covered services for these providers will include all services within their scope of practice as articulated by the respective national societies and endorsed through the state licensing process.
- "Certified Nurse Anesthetists" means a registered nurse trained in the administration of anesthetics.
- "Certified Nurse Mid-Wife" means a registered nurse trained to provide obstetrical services who is legally qualified and registered, certified and/or licensed.
- "Functional Occupational Therapist" means an individual trained in the restoration of a specified level of function of injured or disabled enrollees through non-medical and non-surgical measures.
- "Physical Therapist" means an individual trained in the evaluation and rehabilitation of injured or disabled enrollees through non-medical and non-surgical measures.
- "Physician Assistant" means a nurse licensed to practice medicine with the supervision of a licensed physician. Includes all covered services within their scope of practice as articulated by the respective national societies and endorsed through the state licensing process.
- "Speech Therapist" means an individual trained in the correction of speech and language disorders through non-medical and non-surgical measures.

Non-Preferred Brand Name Drug – A drug sold under an advertised product name that is on the plan's formulary at the highest copayment or coinsurance level (see "preferred brand name drugs," below).

Orthotic Appliance – An external device intended to correct any defect of form or function of the human body.

Out-of-Pocket Maximum – The maximum amount you would have to pay for covered services in a given year under a plan, including your deductible, copayments and coinsurance. (Note: does not include charges for non-covered services or charges for covered services above reasonable and customary charges).

Participating or Approved Provider – Any hospital, skilled nursing facility, outpatient physical therapy facility, home health care agency, physician, dentist or other provider of health care services that, at the time an enrollee receives services included under the Program, meets its standards and has entered into a contract or agreement with a carrier to provide those health care services in accordance with the Program. Such contract or agreement shall include a provision that the provider accepts the amount of covered expenses, as determined by the carrier, as payment in full (unless otherwise provided). Providers who are not participating providers may or may not participate for individual claims and accept the amount determined by the carrier as payment in full.

Part-Time Care – Up to and including 28 hours per week of skilled nursing and home health aide services combined, for less than eight hours per day; or up to 35 hours per week for less than eight hours per day, subject to individual review and approval by the carrier.

Physical Therapy and/or Functional Occupational Therapy – Therapy directed toward improving or restoring the level of musculoskeletal function lost due to illness or injury, the development of new function attainable following surgery, or, if for a chronic or congenital condition, significantly improving

the condition in a reasonable and predictable period of time. Physical therapy generally pertains to large muscle use and functional occupational therapy to fine motor activities.

Physician – A doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine or osteopathic medicine and/or perform surgery at the time and place services are rendered or performed. As used herein, physician shall also include the following categories of limited-practice professionals who are legally qualified and licensed to practice their specialties at the time and place services are performed, and who render specified services they are legally qualified to perform:

- "Dentist" means doctor of dental surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.) whose scope of practice is the diagnosis, prevention and treatment of disease of the teeth and related structures.
- "Podiatrist" means a doctor of podiatric medicine (D.P.M.) or a doctor of surgical chiropody (D.S.C.) whose scope of practice is the diagnosis, prevention and treatment of ailments of the feet. Services of podiatrists, relating to the foot (including the ankle), may be covered under the surgical and medical coverages. A podiatrist also may prescribe medications that may be covered under the prescription drug coverage.
- "Chiropractor" means a doctor of chiropractic (D.C.) whose scope of practice is the diagnosis and treatment of subluxation or misalignments of the spinal column and related bones and tissues that produce nerve interference. Services of chiropractors that may be covered are limited to diagnostic radiological services and emergency first aid (as set forth in an administration manual published by the Control Plan), both pertaining to the spine and related bones and tissues. Under the Program, a chiropractor may not prescribe medications or perform invasive procedures or incisive surgical procedures, provide outpatient physical therapy services, nor perform physical examinations not related to the spine and related bones and tissues.

Plan Year – January 1 through December 31 is the Plan Year for all plans and programs.

Precertification or **Predetermination –** A review process performed by a carrier before treatment to determine if proposed treatments, services or facilities may be appropriate.

Preferred Brand Name Drug – A drug sold under an advertised product name and on the plan's formulary. The formulary provides the list of brand name drugs that the plan has determined are both effective for treating conditions and typically cost less than other brand name drugs. For the NMVP and Basic Plan, contact Express Scripts at 1-800-711-3459 or visit Express-Scripts.com for the formulary list.

Prescription Legend Drug – Any medicinal substance which, under the Federal Food, Drug and Cosmetic Act, is required to be labeled "Caution: Federal law prohibits dispensing without a prescription" or "Rx Only" and includes compounded medications containing at least one prescription legend drug.

Primary Plan – Refers to the health care plan responsible to pay first when the covered person has coverage under more than one plan.

Private Duty Nursing – Care or services provided by a nurse pursuant to a contract with a patient and/or a patient's family/personal representative. The services may be skilled or unskilled, therapeutic or custodial in nature and may be provided in any setting. Generally, the care contracted for is in excess of the care provided by an institution (such as a hospital or skilled nursing facility) or the part-time/intermittent/skilled care provided by a home health care agency.

Prosthetic Appliance – An artificial device that replaces an absent part of the body, or which aids the performance of a natural function of the body without replacing a missing part.

Reasonable and Customary Charge – The actual amount a provider charges the majority of patients for similar services taking into consideration geographic variations, the provider's skill and training and any unusual circumstances or complications. It also includes the negotiated amount a provider had agreed to accept from the health care carrier as full payment for the services rendered. The health care carrier is responsible for determining the appropriate reasonable and customary charge for a given provider, service or material.

Secondary Plan – Refers to the health care plan that has the secondary obligation to pay benefits when more than one health care plan covers an individual.

Skilled Nursing Care – Care or services that are prescribed by a physician and furnished by a licensed registered nurse (RN) or licensed practical nurse (LPN). The services may be provided on a continuous (as in a hospital or skilled nursing facility) or on an intermittent/part-time basis. The patient must be under treatment and/or convalescing from an illness or injury that requires ongoing evaluation and adjustment of care. The nature of the service and skills required for safe and effective delivery, rather than the patient's medical condition, determines whether the service is skilled.

Skilled Nursing Facility (SNF) – A facility providing convalescent and long-term illness care with continuous nursing and other health care services by, or under the supervision of, a physician and a registered nurse. The facility may be operated either independently or as part of an accredited general hospital. A skilled nursing facility must meet Program standards and be approved by the local carrier.

Specialty Drug – A covered medication that typically costs $500 or more per dose, or $6,000 or more a year and has one or more of the following characteristics:

(1) Complex therapy for complex disease
(2) Specialized patient training and coordination of care (services, supplies or devices) required prior to therapy initiation and/or during therapy
(3) Unique patient compliance and safety monitoring requirements
(4) Unique requirements for handling, shipping and storage
(5) Significant potential for waste due to the high cost of the drug

Exceptions to the cost threshold may exist based on certain characteristics of the drug and therapy that will still require the drug to be classified as a specialty drug. In addition, a follow-on biologic/generic product will be considered a specialty drug if the innovator drug is a specialty drug. The carrier is responsible for designating the "specialty drug" status for covered medications.

Therapeutic Care – Specific and definitive surgical, medical, psychiatric or other care provided to a patient whose condition continues to improve due to the treatment being received. It is provided with the expectation that the patient's level of disability will be reduced, within a reasonably predictable period of time, to enable the patient to function without such care. The improvement must be observable and documented by objective measurement. If a patient's condition stabilizes and further improvement is not reasonably predictable, continuing care will be considered maintenance care in nature.

Acronyms

ACA — **A**ffordable **C**are **A**ct
CMS — The **C**enters for **M**edicare and **M**edicaid **S**ervices
COB — **C**oordination **O**f **B**enefits
COBRA — **C**onsolidated **O**mnibus **B**udget **R**econciliation **A**ct of 1985
EOB — **E**xplanation **O**f **B**enefits
ERISA — The **E**mployee **R**etirement **I**ncome **S**ecurity **A**ct of 1974, as amended
FMLA — **F**amily and **M**edical **L**eave **A**ct of 1993
HIPAA — **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996
IRS — **I**nternal **R**evenue **S**ervice
NMVP — **N**ational **M**edical **V**alue **P**lan
SSDIB — **S**ocial **S**ecurity **D**isability **I**nsurance **B**enefits