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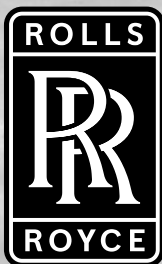
Rolls-Royce Corporation

UAW Benefits Guide

Feb 2020 - Feb 2025 Labor Agreement

For UAW employees hired before Feb 26, 2015



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(For UAW Employees Hired Before February 26, 2015)

October 2020

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Section 1 — Introduction

This Rolls-Royce Corporation UAW Benefits Guide applies to Rolls-Royce employees covered by the UAW collective bargaining agreement and eligible retirees who were hired before February 26, 2015.

The Rolls-Royce Corporation (the "Employer" or "Company") provides various retirement, medical and other benefits to its eligible UAW employees and retirees, their eligible spouses, and eligible dependent child(ren). The purpose of the Benefits Guide is to provide you a summary of these programs. The Guide also serves as the "summary plan description" (SPD) for those plans subject to Employee Retirement Income Security Act of 1974, as amended (ERISA), including the Personal Savings Plan and the Rolls-Royce Corporation Welfare Benefits Plan (the "Welfare Plan"). This and any associated documents are provided to you at no cost.

PLEASE NOTE that it is only a summary and does not describe every feature of each program. Therefore, in the event there is a discrepancy between the Guide and the official program documents, the program documents will govern. Benefits are provided at the discretion of Rolls-Royce and do not create a contract or guarantee of employment. Rolls-Royce reserves the right to modify, suspend, revise and/or terminate any or all of the plans at any time and for any reason.

Section 2 — PERSONAL SAVINGS PLAN

The Rolls-Royce Corporation Personal Savings Plan for Hourly-Rate Employees (the "Personal Savings Plan") is a defined contribution plan designed to provide you with a way to save for retirement on a tax-favored basis.

personal savings plan features

❑ your contributions	You may contribute up to 75% of eligible weekly earnings on a pre-tax or after-tax basis up to the IRS annual limit.
❑ automatic enrollment for new hires	If you are a new UAW employee, you will be automatically enrolled at a pre-tax contribution rate of 3% (unless you make an election not to participate within the 90 day period following the date you are eligible to participate).
❑ company matching contribution	You will receive a Company match of 100% of the first 5% of your eligible earnings that you contribute if you were hired as a UAW employee on or after September 18, 2006.
❑ company nonelective contribution	You may receive a Company contribution of 3% of your eligible earnings if you were hired as a UAW employee on or after September 18, 2006.
❑ rollover contributions	You may rollover a balance from a prior employer's qualified retirement plan or an Individual Retirement Account (IRA).
❑ investing your account	You can invest your account among a number of investment funds.
❑ vesting	Your contributions and matching contributions are 100% vested; company nonelective contributions vest in full after three years.
❑ loans	You may have up to five outstanding loans.
❑ withdrawals	You can withdraw money from your account (within plan limitations).
❑ when your account is paid	Your vested account balance is paid upon your request when you leave the Company for any reason.
❑ how your account is paid	Your account is paid in a lump sum or in installments.

eligibility

You are eligible to participate in the Personal Savings Plan as of the first full pay period that begins after you have acquired seniority. You attain seniority after working at least 90 days within a six-month period. You may discontinue participation in the Personal Savings Plan at any time.

To be considered an eligible employee, you must be a regular hourly employee of Rolls-Royce Corporation (the "Company") who is employed in the United States and is covered by the collective bargaining agreement between Rolls-Royce Corporation and the UAW. Both full-time and part-time employees are eligible for the Personal Savings Plan.

The following employees are not eligible under the Personal Savings Plan:

- ❑ leased employees;
- ❑ hourly-rate employees who are not covered by the UAW collective bargaining agreement (CBA); and
- ❑ salaried employees.

Once you acquire seniority, you are eligible to participate. You acquire seniority after completing 90 days of employment.

enrollment

automatic enrollment

Once you have obtained seniority (90 days), you will be automatically enrolled in the Personal Savings Plan within one to two pay periods. You will be automatically enrolled at a contribution rate of 3% of your pre-tax eligible earnings. You may also elect to contribute at a higher or lower amount.

If you do not wish to contribute or opt out of the automatic enrollment feature — or contribute an amount different than 3% — you must change your contribution rate within 90 days of your hire date.

You will receive information about enrollment on or about the time you obtain seniority.

making changes

To change the your contribution percentage, elect what type of contribution you would like to make (pre-tax or after-tax) or stop participating, you must contact Fidelity Investments ("Fidelity") — the recordkeeper for the Personal Savings Plan.

You must contact Fidelity through the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) or online at Fidelity NetBenefits® at **netbenefits.com** to change, elect or stop your contribution rate. Refer to the *using the Fidelity system— NetBenefits®* section for registration details.

You will need to verify some personal information when you call or log on. Then, you will need to:

- ❑ indicate the whole percentage of eligible earnings (from 1% to 75%) that you want to save. An election of 0% ceases your contribution to the Personal Savings Plan. See the *contributions* section for information.
- ❑ indicate how you want to invest your savings. See the *investing your account* section for details.
- ❑ complete an online beneficiary designation indicating whom you want to receive your vested account balance if you should die before receiving a distribution of your entire benefit interest from the Personal Savings Plan. See the *naming your beneficiary* section for details.

If you are new to the Company, and you have assets in another employer's plan, you may be able to transfer your assets to the Personal Savings Plan. See the *rollover contributions* section for information about transferring funds.

when participation begins

Your participation should begin no later than the first day of the second pay period following the date you elect to enroll or are enrolled automatically.

Once you enroll — or are automatically enrolled — an account will be established for you at Fidelity for the Personal Savings Plan. If you didn't already complete the new user registration process on NetBenefits, you will need to verify your identify, set up your username and create a password on NetBenefits to access your account online or Fidelity's voice response system. See the *using the Fidelity system— NetBenefits®*using the Fidelity system— NetBenefits® section for more information.

when participation ends

Your ability to make contributions into the Personal Savings Plan ends when you are no longer eligible due to termination, retirement, death, transfer, a change in your employment status or extended disability without wage continuation.

contributions

You decide how much of your eligible earnings to contribute to the Personal Savings Plan. You may elect to contribute between 1% and 75% of your eligible earnings, in whole percentages. Your contributions can be made on a pre-tax or an after-tax basis (or any combination of the two). However, your total contributions to the Personal Savings Plan cannot be more than 75% of your eligible weekly earnings.

> *For example*, if you're contributing 10% of your eligible earnings on a pre-tax basis, you cannot contribute more than 65% on an after-tax basis. See the *limits on contribution* section for more information on how much you may contribute each year.

pre-tax contributions

When you set aside part of your paycheck on a pre-tax basis, you put money into the Personal Savings Plan before federal, and in most cases, state and local income taxes (if applicable) are calculated. As a result, your taxable income — and therefore the taxes you owe — are lower. However, your contributions are subject to Social Security taxes.

The investment earnings on your pre-tax contributions are also tax-deferred. This means you don't pay taxes on your investment earnings until you actually receive them.

after-tax contributions

You also have the option of contributing to the Personal Savings Plan on an after-tax basis. This means your contributions will come out of your eligible earnings after income taxes are calculated. While after-tax contributions do not offer the same tax advantages as pre-tax contributions, they offer the convenience of regularly saving for retirement; and, since you already paid taxes on the contributions, they will not be taxed when you withdraw the funds.

The investment earnings on after-tax contributions accumulate on a tax-deferred basis, so you don't pay taxes on the earnings until they are paid to you.

Remember: Contributions can be made on a pre-tax or an after-tax basis or a combination of both.

catch-up contributions

You are eligible to also make catch-up contributions if you are age 50 or older (or turning age 50 by the last day of the calendar year). This election must be made in whole percentages, and may be between 1-50% of your eligible earnings and may not exceed more than 75% of your eligible earnings when combined with regular pre-tax deferrals. Catch-up contributions are treated as deferred savings for investments, vesting, matching contributions, withdrawals and distributions under the Personal Savings Plan. The IRS places an annual limit on catch-up contributions. For 2020, the limit is $6,500. This limit is indexed for inflation and may increase in the future.

If you are age 50 or older (or turning age 50 by the last day of the calendar year) and wish to elect catch-up contributions, contact Fidelity through the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) or online at Fidelity NetBenefits® at **netbenefits.com**. If you call, the interactive voice response system will ask you to enter or say your username or Social Security number, followed by the pound (#) sign. Follow the prompts to speak with a customer service representative.

defining your eligible earnings

Your eligible earnings refer to your weekly base pay, plus any shift premium or cost of living allowances, certain performance bonus payments (including facility bonus or a bonus payable under the All Employee Bonus Scheme), EPO/PPO transition payments (for purposes of employee contributions only), and differential wage payments. Eligible earnings also include overtime for purposes of employee contributions and Company matching contributions, but not for company nonelective contributions.

Your eligible earnings do not include fees, allowances, short- or long-term disability payments, or special payments.

company matching contributions

The Company will match 100% of the first 5% of your eligible earnings that you contribute each pay period, including pre– and after–tax contributions and catch-up contributions. The matching contributions go into your account on a tax-deferred basis. That means you don't pay any taxes on them (or on any investment earnings) until you actually receive them. You are always 100% vested in the matching contributions. See *vesting* section for more information.

If you change your contribution amount, the matching contributions may change accordingly. *For example*, if you contribute 7% in pre- and/or after-tax contributions, you will receive 5% company matching contributions. If you change your deferral election to 3% in pre- and/or after-tax contributions, you will receive 3% company matching contributions. If you stop your contributions, the matching contributions also stop. If you begin contributing again, you will begin receiving company matching contributions equal to 100% of the first 5% of your eligible earnings.

The Company does not match any rollovers or funds transferred from other plans.

company nonelective contributions

The Company may make company nonelective contributions equal to 3% of your eligible weekly earnings for the Plan Year for Employees who:

- were hired as a UAW employee on or after September 18, 2006 (which includes "tier 2" employees); and
- are eligible participants in the Personal Savings Plan and who are employed by the Company on the last day of the Plan Year (December 31).

You will also share in the company nonelective contribution for a Plan Year if your employment with the Company terminated during the Plan Year as a result of your death, disability or retirement.

Company nonelective contributions shall be paid to the Trustee no later than the date prescribed by law for filing the Company's federal income tax return, including extensions. In general, the company nonelective contribution will be deposited into your account by the end of March following the end of the Plan Year for which the company nonelective contribution is made. For example, the company nonelective contribution for 2020 is deposited to the trust by the end of March 2021.

Company nonelective contributions are subject to a three-year vesting schedule. See *vesting* section for more information.

rollover contributions

When you join the Personal Savings Plan, you may have an account balance in another employer's tax-qualified savings plan or in a "conduit" individual retirement account ("IRA").

The Personal Savings Plan will accept the payout of your prior employer's pre-tax account balance as a "rollover". This is a way for you transfer that plan's distribution to the Plan even if you are not currently contributing. When you make a pre-tax rollover, you continue to defer federal, state and local income taxes (if applicable) on your money. It allows you to consolidate your accounts while continuing to defer taxation.

Generally, you can elect a rollover of all, or a portion, of an eligible distribution from your previous employer's tax-qualified savings plan or a conduit IRA. However, the Personal Savings Plan does not accept the following as part of a rollover:

- after-tax contributions;
- hardship withdrawals;
- any portion of your account that the prior plan may have as a required minimum payment. See *when you reach age 72* section for more information; or
- a payment if it is a part of a series of equal (or almost equal) payments that are made at least once a year and that will last for:
  - your lifetime (or your life expectancy);
  - your lifetime and your beneficiary's lifetime (or life expectancies); or
  - a period of ten years or more.

You can process a rollover online by going to your account on **netbenefits.com**. Before you get started, it is helpful to have an old statement available. There are two ways to process a rollover into your Fidelity account.

In general, you make a rollover in one of two ways – either directly or within 60 days of receiving an eligible distribution. A direct rollover is a plan-to-plan transfer. In most cases, this type of rollover is the easiest way to roll over the full amount of your distribution and avoid taxes and penalties. A 60-day rollover is when your prior employer's plan makes a distribution to you which you, in turn, transfer to the Personal Savings Plan. Once you receive the distribution from your prior employer, you must complete the rollover to Fidelity within 60 days in order to avoid income taxes. A 60-day rollover is subject to 20% mandatory federal income tax withholding. Therefore, you must make up this 20% with other funds if you wish to rollover 100% of your old plan's account balance.

You can begin the rollover process online by going to your account on **netbenefits.com** and then the "Rollover" page. Once online, you will need to:

1. confirm you contact information so Fidelity can keep you updated.
2. provide plan details to make sure your money can be moved to the Personal Savings Plan.
3. request a check, unless you already have the check or will process a direct rollover.
4. provide contribution information about the amount and tax breakdown of the rollover amount
5. send your documents to Fidelity with the NetBenefits app (1-2 business days to process) or mail them to Fidelity (1-2 weeks to process)

To transfer money into Rolls-Royce Corporation's plan, you will need:

- the appropriate rollover form for the Personal Savings Plan (which can be obtained from Fidelity);
- documentation, such as a distribution statement, showing the money is from a qualified plan;
- documentation showing no after-tax money is included in the rollover amount; and
- if rollover is from a conduit IRA, documentation from previous employer's plan and IRA must be provided.

vesting

Vesting means gaining a nonforfeitable right to the funds in your Personal Savings Plan account. You are always 100% vested in your pre-tax contributions, catch-up contributions, after-tax contributions, rollover contributions and company matching contributions (as adjusted for any earnings or losses). However, you vest in your company nonelective contributions (and the associated earnings or losses) under the following vesting schedule:

Company Nonelective Contribution Vesting Schedule	
Years of Service	**Vested Interest**
0-2 years	0%
3+ years	100%

Once you are 100% vested, your nonelective contribution balance is yours to keep. If you leave before you are vested, your nonelective contribution balance will be forfeited as of the earlier of the date you take distribution of your entire vested account balance or have five consecutive annual breaks in service. However, if you subsequently return to Company employment and resume participation beforehand, your forfeited account balance will be restored to you.

Your company nonelective contribution balance will automatically vest if:

- you reach age 55 while employed by the Company;
- you become disabled and are eligible for Social Security disability benefits while employed by the Company (including disability while on Military Leave);
- you die while employed by the Company (including death while on Military Leave);
- the Personal Savings Plan is completely or partially terminated; or
- the Company completely discontinues making Company contributions.

limits on contributions

Your total pre-tax deferrals in any taxable year may not exceed the dollar limit set by the Internal Revenue Service (IRS). The annual deferral limit for plan year 2020 is $19,500. This limit is $26,000 if you are age 50 or older and making catch-up contributions. See *catch-up contributions* section for details.

The Company will automatically stop your pre-tax or catch-up contributions once you reach the IRS limit in any year. However, you may continue to make after-tax contributions. See *making changes or using the Fidelity system— NetBenefits®*using the Fidelity system— NetBenefits® section for information on accessing **netbenefits.com** to elect or change your percentage for after-tax contributions.

There are also IRS limits on the total annual amount of all contributions (pre-tax, after-tax, company contributions) made in a year to the Personal Savings Plan. The maximum annual contribution limit for plan year 2020 is $57,000. This limit is $63,500 if are age 50 or older and making catch-up contributions. Human Resources will contact you if these limits ever affect your Personal Savings Plan account.

In addition, the Personal Savings Plan may only consider your eligible earnings in any year up to Internal Revenue Code compensation limits for the year ($285,000 in 2020). This limit is indexed periodically.

The IRS also has specific non-discrimination rules to make sure the Personal Savings Plan does not favor highly compensated employees. Therefore, if the IRS considers you a "highly-compensated employee," your elective contributions may be subject to additional limitations. If you are a highly compensated employee, Human Resources will notify you if your contribution is affected by these IRS limits. If your contributions exceed the limit, the amount over the limit will be refunded to you, and you will owe taxes on the taxable portion of your refund. These refunds are issued no later than December 31 of the following year. The refund is taxable in the year in which the contribution was made.

naming your beneficiary

When you enroll in the Personal Savings Plan, you must name a beneficiary– the person(s) who will receive any vested benefits you may have under the Personal Savings Plan when you die. If you are married, your spouse is automatically your beneficiary. You must have your spouse's signed, notarized consent to designate another beneficiary. If your spouse dies before you and you have not named a new beneficiary, your vested account will be paid in accordance with the beneficiary designation rules for your basic life insurance under the Rolls-Royce Corporation Welfare Benefits Plan (or, if you have no such coverage, to your estate).

If you are not married, and you have not otherwise named a beneficiary, your vested account will be paid in accordance with the beneficiary designation provision for your basic life insurance under the Welfare Benefits Plan (or, if you have no such coverage, to your estate).

You may change your beneficiary at any time by contacting Fidelity through the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) or online at Fidelity NetBenefits® at **netbenefits.com**. If you call, the interactive voice response system will ask you to enter or say your username or Social Security number, followed by the pound (#) sign. Follow the prompts to speak with a customer service representative.

using the Fidelity system— NetBenefits®

To enroll in the Personal Savings Plan — or access your account after you enroll — you need to register on Fidelity NetBenefits® website. To get started, go to **netbenefits.com** and click *Register Now*. Follow the instructions to set up your username and password. After that, simply log on to see all the features and information on your NetBenefits home page. You may use the same username – or your Social Security number – when you call the Fidelity voice response system. You can call Fidelity or visit NetBenefits when you want to:

- inquire about the current value of your account;
- verify your current contribution amount;
- inquire about investment funds, including your current investment mix, rates of return and share or unit price;
- "model" a loan and request the paperwork;
- determine how much you can withdraw and request the paperwork;
- make changes to your contribution amount or investment mix;
- talk to a customer service representative about any aspect of the Personal Savings Plan; and
- Fidelity also offers information on certain plan provisions.
- plus much more!

To access Fidelity's customer service, call the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) or online at **netbenefits.com**, or download their app from the App Store. If you call, the interactive voice response system will

ask you to enter or say your username or Social Security number, followed by the pound (#) sign. Follow the prompts to speak with a customer service representative.

Whenever you make a change using Fidelity, the system generates a confirmation statement, which is mailed or emailed to you. The confirmation statement verifies that the change was made correctly. If there is an error on your confirmation statement, you should contact Fidelity through the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) as soon as possible.

Then you will decide how you'd like to invest your contributions among the available investment options. The Company offers a diversified selection of investment choices from conservative stable value funds to riskier international and small company mutual funds. An independent investment firm monitors the performance of the Personal Savings Plan's options, and changes are made as necessary.

You can change the percentage of your pre-tax and after-tax contributions at any time. You can also increase, decrease or stop your contributions at any time. Any request to change or stop your contributions will become effective within two pay periods of the processing date. If you stop your contributions, you can begin contributing again. Contact Fidelity by calling Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) from any telephone or visit their website at **netbenefits.com** to make any change in your contribution amount.

special rights upon return from military service

If you return to work for Rolls-Royce after a qualifying military leave, you can "make up" the pre-tax and/or after- tax contributions that you could have made if you had not gone on military leave. Your right to "make up" contributions lasts for a specific time. By law, that period is three times your military leave period (but not more than five years). For example, if you had been on active duty for 12 months, you would have the right to make up any missed elective contributions for a period of three years following your return.

The Personal Savings Plan rules and federal tax limits in effect during your military leave will limit your "make up" contributions. Rolls-Royce will match your "make up" contributions based on the matching formula in effect for the year involved. The Company also will make up any company nonelective contributions for that period. For further information, contact Fidelity through the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)). The interactive voice response system will ask for your NetBenefits username or Social Security number. Follow the prompts to speak with a customer service representative.

investing your account

your investment choices

Your contributions and the Company's contributions can be put into any of the investment funds available under the Personal Savings Plan, in increments of 1%. For example, you can invest 100% of your contributions in a single fund, or 20% in each of five funds, or any other combination that meets your investment objectives.

Each fund has a different investment objective, so the returns on each (and the accompanying risk) will vary. Before you make your investment choices, you should consider the investment goals of each fund, as well as your own investment goals and your tolerance for risk. Certain funds have prospectuses, which provide additional information about the fund options. Contact Fidelity through the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) for more information.

Each fund has a prospectus and summary description which provides information on the funds:

- specific investment objectives;
- risk/return characteristics;
- type of investments; and
- investment diversification.

Each fund also issues annual and other periodic reports that discuss the fund's investment performance and list the fund's current investments. You can get the prospectus, summary description and recent reports for any investment fund by contacting Fidelity through the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) or online at **netbenefits.com**.

If you call, the interactive voice response system will ask you to enter or say your username or Social Security number, followed by the pound (#) sign. Follow the prompts to speak with a customer service representative.

All of the Personal Savings Plan's investment funds are either mutual funds or commingled investment funds. Each investment fund offered under the Personal Savings Plan charges investment management fees (which are normally based on a specified percentage of fund assets) and may have other operating expenses that affect the fund's investment return. In addition, the funds may impose deferred sales charges, sales loads and redemption or exchange fees. Current information on a fund's operating expenses, fees and charges can be found in the most recent prospectus and summary description for the fund.

The Plan Administrator has the right to change the investment funds offered under the Personal Savings Plan at any time.

default investment fund

If you do not specify how you want to invest your account balance or your future contributions, such amounts will be invested in the applicable target date lifecycle fund, based on your date of birth (and assuming you will retire at age 65). However, you are encouraged to take an active role in the Personal Savings Plan and choose a contribution or investment option that is right for you.

changing your investment choices

You can make changes in your investment choices — either in the investment mix or in the funds you invest in — at any time. To make a change, simply contact the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) or online at Fidelity NetBenefits® at **netbenefits.com**.

Any change request made up to 4:00 pm Eastern Time will be made the same day. Changes requested after 4:00 pm Eastern Time will be effective the next business day. You will receive a confirmation statement or email showing your requested investment changes.

investment earnings, losses and gains

Your account balance can change over time because the value of your investments change, and the investments earn dividends and/or interest. Any dividends and/or interest your investments earn will be automatically reinvested in that fund. When a fund shows earnings, gains and/or losses, your account balance will reflect the change on a daily basis.

investment restrictions

A number of funds have begun to impose trading restrictions that are intended to curb short -term and other trading abuses. For example, many funds are restricting excessive short-term trading practices by sending a written warning to any person who has engaged in such trading and temporarily suspending or limiting the trading of anyone who continues to do so after receiving a warning. Trading restrictions may be imposed by the Personal Savings Plan's current investment funds. To find out if there are any restrictions under a fund, you should read the current prospectus and other available information for that fund or contact Fidelity through the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)).

voting and similar rights

All voting, tender and similar rights for any investment funds in which you invest your Personal Savings Plan account are passed through to, and may only be exercised by, you. The proxy statement and accompanying materials will be sent to you with instructions on how to vote or otherwise exercise your rights.

compliance with 404(c) regulations

A federal statute, ERISA Section 404(c), generally addresses how participant-directed investment under the Personal Savings Plan can be handled and provides instructions as to:

- the investment options offered, and
- providing investment information to employees participating in certain kinds of employer-sponsored retirement savings plans.

The guidelines provide that employees be given at least three different investment choices, with varying risk and return characteristics, and be allowed to change the investment mix at least quarterly. A package of financial information and a description of the investment funds offered through this Personal Savings Plan are available from the benefits department.

The Personal Savings Plan is intended to comply with ERISA Section 404(c). To the extent that your Personal Savings Plan account balance is invested as you have directed, the Personal Savings Plan's fiduciaries are not responsible for losses that may result from following your investment choices.

access to your savings while employed

Though the Personal Savings Plan is intended to provide savings for your retirement, you can, under certain conditions, receive a portion of your account balance while still employed by the Company by:

- borrowing from your account; or
- making an in-service withdrawal.

When you take a loan, you are borrowing money from your account and agreeing to pay it back over a certain period, including principal and interest. When you take a withdrawal, you remove the money from your account and don't pay it back.

borrowing from your account

Once a year, you may borrow money from your plan account for any reason. The maximum amount you can borrow is the lesser of:

- 50% of the current vested value of your account; or
- $50,000, minus your highest outstanding loan balance during the last 12 months.

The minimum loan is $1,000. Your loan is considered "effective" on the date the loan is initiated with Fidelity. Funds for your loan come from the following sources, in this order:

- your pre-tax savings, including the investment earnings;
- any rollover or transfer from a previous plan, including the investment earnings;
- your after-tax savings, including the investment earnings;
- your company match assets, including the investment earnings; and
- your company nonelective assets, including the investment earnings.

You may have no more than five loans outstanding at any one time, and the total of all outstanding loans cannot be more than the maximum amount permitted for a single loan.

In general, the interest rate on a plan loan will be the prevailing Prime Rate published in the Wall Street Journal on the first business day of the month you apply for the loan. For example, if you apply for a loan on August 10, you will pay the prime rate published in the Wall Street Journal on the first business day in August.

While you have an outstanding loan balance, you don't receive investment earnings (if applicable) on that amount. However, when you make loan payments, you pay the interest to yourself, which could help restore the balance in your account. You may take up to five years to repay the loan; the minimum repayment period is six months. If you borrowed the money to buy or build your primary home, you may take up to ten years to repay the loan.

The cost to initiate a loan is $35.00, and there is a $3.75 quarterly maintenance fee. The loan initiation fee and maintenance fees will be deducted from your individual plan account.

how to apply for a loan

If you are considering requesting a loan, you may call Fidelity or visit their **netbenefits.com** to "model" a loan – that is, you can see how taking a loan will affect your account balance, find out what your payments will be, or get information about the interest rate you may be paying.

If you want to borrow from your account, contact Fidelity through the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) or online at **netbenefits.com** model a loan, if acceptable, the following will be mailed to you:

- loan check, with a promissory note activated upon signing the check;
- truth in lending disclosure;
- authorization for payroll deductions to repay the loan; and
- loan amortization.

repaying the loan

You will make loan payments through payroll deductions after federal and state taxes (if applicable) have been taken out. Fidelity will apply those payments to both principal and interest according to the loan amortization schedule. The minimum payment is $10 per pay period on an after-tax basis. The amount of your repayment (both principal and interest) goes directly into your Personal Savings Plan account and will be reinvested in the fund options in effect at the time of repayment.

You can also repay all or part of the remaining loan balance at any time with no penalty. If you are interested in these special payment provisions, contact Fidelity through the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)). The interactive voice response system will ask you to enter your NetBenefits® username or Social Security number, followed by the pound (#) sign. Follow the prompts to speak with a customer service representative.

Your outstanding loan principal, plus any accrued interest, will be immediately due and payable if any of the following events occurs:

- you retire or terminate your employment with the Company;
- you become eligible for a distribution because you have a Disability, or
- you die.

If you default on the loan, meaning you don't pay back the full amount on a timely basis, the unpaid balance will be treated as a plan distribution, subject to applicable taxes and the early withdrawal penalty. If you leave Rolls-Royce Corporation for any reason before repaying the loan, you have the option to continue making payments by mailing a check or through ACH directly to Fidelity. If you fail to make timely payments, your outstanding loan amount will be in default and will be treated as a distribution, meaning you or your beneficiary will have to pay any taxes or penalties owing on the unpaid balance of the loan.

if you have a loan and you are placed on disability leave or go on military leave

If you are placed on disability leave you will be sent a loan coupon book by Fidelity so that you can make payments directly to Fidelity. Payments can be remitted by mailing a check or through ACH. Failure to make payments while on a leave of absence, will result in the default of your loan. Personal Savings Plan loan payments are not deducted from disability pay. You may be able to suspend loan payments for up to 12 months while on an unpaid leave of absence, if the suspension does not extend beyond the maximum loan term.

In addition, if you are absent on a qualifying military leave, you can suspend your loan payments for the duration of that leave. Plus, by law, the maximum interest rate that can be charged on your loan during your military leave is 6%.

withdrawals from your after-tax and rollover assets

You may withdraw your after-tax and rollover contribution balances for any reason at any time. While after-tax contributions are not taxable, the withdrawal will include a pro-rata share of earnings, which are such income tax. On the other hand, a withdrawal of rollover contribution monies will be taxable. After making a withdrawal of after-tax assets, you will be suspended from making any contributions to the Plan for a period of six months. Also, if you withdraw your after-tax and/or rollover assets before age 59 ½, you may be liable for an additional 10% "early withdrawal" penalty tax. This penalty is not withheld when you take the withdrawal, but you will owe it when you file your federal tax return.

withdrawals at age 59½ or older

If you are age 59½ or older, you may request a withdrawal of all or a part of your vested account balance. However, you must withdraw your entire after-tax contribution balance prior to receiving a withdrawal of pre-tax and/or Company contribution balances. There's no penalty for withdrawing your money after age 59½, but you'll pay ordinary income tax on the taxable amount of the distribution.

hardship withdrawal

If you experience a financial hardship, you may request a "hardship" withdrawal when other financial resources are not available to you (with the exception of a Personal Savings Plan loan). The Personal Savings Plan defines a hardship as:

- costs directly related to the purchase of your principal residence (excluding mortgage payments);
- payment of expenses to prevent foreclosure on, or eviction from, your principal residence;
- payment of tuition for the next 12 months of post-secondary education for you or your dependents (or beneficiary);
- medical expenses for you or your dependents (or beneficiary) not covered by insurance;
- funeral expenses for your deceased parents, spouse, children, dependents or beneficiary;
- certain expenses for the repair of damage to your principle residence that would qualify for casualty deduction under Internal Revenue Code Section 165; or
- expenses and losses (including loss of income) related to a disaster declared by the Federal Emergency Management Agency (FEMA), provided that your principal residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance for the disaster.

Any withdrawal from the Personal Savings Plan for hardship will be limited to the lesser of (a) the amount of your pre-tax savings, including company match and any amounts rolled over, or (b) the amount required to meet the hardship, plus taxes required due to early withdrawal. You may include in the hardship withdrawal request an amount necessary to pay the taxes and penalties resulting from this withdrawal. In addition, before you may withdraw assets for a hardship, you must take all available asset distributions and withdrawals under all plans maintained by the Company (and its affiliates) in which you participate.

tracking your savings

You may elect to receive a quarterly statement of your Personal Savings Plan account balance by mail or you may choose to view your statement online at Fidelity's website. Log onto your account on **netbenefits.com**, then go to Profile > Preferences to set how you would like to receive communications and other important account information.

Your quarterly statement for the Personal Savings Plan reflects your account summary, personal rate of return for the quarter, asset allocation, market value of your account, change you made to prior investment elections (if applicable), investment elections for future contributions, contribution summary, account and loan activity (if applicable). You can use the information to keep track of your savings.

If you want information about your account balance on a day-to-day basis, you can call Fidelity through the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) or online at Fidelity NetBenefits® at **netbenefits.com**.

You should contact a financial advisor if you would like to change how you invest your current account balance or future contributions.

receiving your benefit

In most cases, you will be entitled to receive your vested account balance in either a lump sum or installments when you retire or otherwise leave the Company. However, your distribution options ultimately depend on your vested account balance. In the event of your death, your beneficiary receives your vested account balance.

Your company nonelective contributions that are not vested when your employment ends will be forfeited as provided under the terms of the Personal Savings Plan. If you are later rehired, any forfeited amounts may be restored depending on your break in service. Refer to the *vesting* section above for more information on this subject.

Refer to sections titled *if you leave the company*, *if you become disabled*, *when you die*, and *when you reach age 72* below for more information on receiving your benefits.

if you leave the company

If you leave the Company, you have several options for withdrawing your vested assets in the plan. You can:

- transfer your money to the qualified plan of another employer or an Individual Retirement Plan ("IRA");
- take a cash payment of the full vested amount, which will be subject to income tax and possibly the 10% early withdrawal penalty tax;
- have it paid out in installments if your vested account balance is more than $5,000; or
- leave it in the Personal Savings Plan until you reach age 72 (age 70½ for participants born prior to July 1, 1949), with the option to withdraw it at any earlier time. You can leave your account balance in the Personal Savings Plan only if your vested account balance is greater than $5,000.

Your funds in the Personal Savings Plan may be transferred, or "rolled over" to another employer's plan if that employer's plan:

- is a "tax-qualified" plan under the Internal Revenue Code, and
- accepts such transfers.

You can also transfer your assets to an IRA offered by a bank or other financial institution. In either case, any taxes you owe are deferred until you receive the money. If you intend to transfer your funds to another tax-qualified plan, be sure to read the important information included in the section on rollovers below. You can also opt for a cash distribution of the total assets in your account. If you choose this type of payment, you may be subject to penalty taxes, in addition to a 20% federal income tax withholding.

when you reach age 72

The Personal Savings Plan is required to begin paying your vested account balance to you when you reach age 72 if you are no longer employed by the Company (age 70½ if you were born prior to July 1, 1949). You will receive the minimum required distribution of your account balance by April 1 of the year following the year in which you reach that age or retire, whichever is later. Each year thereafter, you will receive an additional amount no later than December 31.

If you are still employed by the Company at that age, you are not required to begin payout until you retire.

if your account balance is $5,000 or less

If your entire vested account balance (including any rollovers you have made to the Personal Savings Plan) is $5,000 or less, you (or your beneficiary) will automatically receive a cash payment of your entire account after you retire, die or otherwise leave the Company. However, you may elect to do a direct rollover of this payout. Under certain conditions, your account automatically will be rolled over to an IRA.

Your vested account balance will be rolled over to an IRA set up by the Plan Administrator in your name if:

- Your vested account balance is more than $1,000 but not more than $5,000; and
- You do not make a choice about the method of distribution (either a direct rollover or a lump sum payment directly to you).

You will receive a notice from the Plan Administrator describing your rights as owner of this IRA.

outstanding loans

If you have any outstanding loans when you elect to withdraw or transfer your Plan account, the unpaid balance of those loans will be treated as a distribution from the Personal Savings Plan at that time (unless you choose to repay them in full).

if you become disabled

If you become disabled and under age 65, you may choose to have your account balance paid to you in a lump sum payment. Under the Personal Savings Plan, disabled mean:

- you are not engaged in regular employment or occupation for pay or profit; and,
- you are found to be wholly and permanently prevented from engaging in regular employment or occupation with the Company at the plant or plants where you have Seniority on the basis of medical evidence satisfactory to the Company as a result of bodily injury or disease, either occupational or non-occupational in cause.

However, an Employee shall not be deemed to be totally and permanently disabled if the disability resulted from service in the armed forces of any country, unless the Employee becomes totally and permanently disabled after accumulating at least five years of Seniority following separation from service in the armed forces.

when you die

Your beneficiary will receive the vested assets left in your account when you die. If you have more than one beneficiary, your assets will be divided among them equally, unless you have specified otherwise. Your beneficiary will receive a lump sum payment.

The Personal Savings Plan is required to distribute your account balance to a non-spouse beneficiary within ten years after your death. This requirement does not apply to the following designated beneficiaries:

- surviving spouses;
- minor children; and
- disabled and chronically ill beneficiaries.

Surviving spouses can still elect to delay distributions until the end of the year that you turn age 72.

If there is a question about who is the beneficiary of your Plan account, the Plan Administrator has the authority to withhold payment in the event of a dispute until finally resolved. For more information about beneficiaries, refer to the *naming your beneficiary* section above.

applying for benefits

If you leave the Company for any reason, you or your beneficiary are responsible for applying for a distribution from the Personal Savings Plan unless one of the following circumstances apply:

- your entire vested account balance (including any rollovers you have made to the Personal Savings Plan) is $5,000 or less; or
- you are age 72 and do not want to receive benefits until April 1 of the year following the year in which you reach that age.

Please contact the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) for more information. If your claim for benefits is denied for any reason, refer to the *Section 12 — Claims Procedures* for more information.

payment directly to you

If you choose to have your benefits paid directly to you in either one lump sum or in installments payable over a period of less than ten years (and the taxable portion of the payment you receive is more than $200), the following rules apply:

- you receive only 80% of the taxable portion of your account balance, because the IRS requires the plan to withhold 20% to be credited against your taxes. For example, if the taxable portion of your eligible distribution is $10,000, you will receive only $8,000 because the plan must withhold $2,000 as income tax. However, when you prepare your

income tax return for the year, you will report the full $10,000 as a taxable payment from the plan and the $2,000 as tax withheld. The withholding will be credited against any income tax you owe for the year.

- the amount of your taxable distribution and corresponding tax withholding will be based on the amount of any outstanding loans, even though you will not actually receive any cash for the loan amount.
- your payment is taxed in the current year. You may be able to use special tax rules that could reduce the tax you owe. However, if you receive the payment before you reach age 59½, you may have to pay the 10% early withdrawal penalty taxes as well.
- when you receive a payment in your own name (not in the name of the trustee/custodian/employer plan in a direct rollover), the 20% automatic withholding will apply. You can, however, roll over the taxable portion of your plan payout by depositing it into an IRA or to another employer plan within 60 days of receiving the payment. In that case, the amount rolled over will not be taxed until you take it out of the IRA or employer plan. If you choose to roll over 100% of your account balance to an IRA or an employer plan, you must find other money to replace the 20% that was withheld. If you roll over only the 80% that you received, you will be taxed on the 20% that was withheld and not rolled over. Refer to section titled *rollover into another employer's qualified plan or IRA* below.

rollover into another employer's qualified plan or IRA

A distribution from your account under the Personal Savings Plan may also be eligible for direct rollover to your own IRA or to another employer plan. Make sure the new employer's plan or IRA accepts rollovers.

If you wish to rollover your Plan payment to another employer's plan or an IRA, you may start the process by contacting Fidelity through the Rolls-Royce Benefits Center at (844) 625-5900 (select option 5 for 401(k)) or online at **netbenefits.com**.

If your plan payment is eligible for rollover, you can receive all or any portion of your payment in one of two ways:

- direct rollover for a plan-to-plan transfer; or
- 60-day rollover – you receive a plan distribution and transfer the money to the other plan.

This choice will affect the tax you owe. You will continue to defer taxes and will not pay any penalty with a direct rollover.

rollovers by surviving spouses or alternate payees

Your surviving spouse, or your spouse or former spouse who is an alternate payee under a qualified domestic relations order (see section titled *assigning your account*) and who is entitled to receive a benefit payment from the Plan also may make a direct rollover to a traditional IRA or another employer's plan.

rollovers by non-spouse beneficiaries

If you die and your beneficiary is not your spouse, your non-spouse beneficiary also may make a direct rollover to a traditional IRA if that IRA is treated as an "inherited" IRA. Your beneficiary should talk with a tax professional about the effect of making a rollover to an inherited IRA before making an election to do so.

voluntary withholding

For any taxable Plan payments that are not subject to automatic withholding, you may elect to have taxes withheld if you wish. For more information about the taxes you may owe on your benefits, please contact your tax advisor.

things that can affect your benefit

Benefits may be denied, lost or stopped, or you may not be eligible for benefits, under the following circumstances:

- you are not eligible to participate in the Personal Savings Plan;

- if the Personal Savings Plan cannot make a payment because you or your beneficiary cannot be found, the benefit may be forfeited. If the person entitled to the payment is located at a later date, benefits which were due but could not be paid shall be paid in a single sum;
- if you receive a benefit payment that is larger than it should be, you must repay the excess to the Personal Savings Plan;
- some Plan fees may be charged directly to your account. See *expenses* section for more information on the payment of these fees; and
- if the Company is not allowed to take a tax deduction for a company contribution, the company contribution can be returned to the Company. This action may reduce your account balance.

assigning your account

Your creditors cannot take your Personal Savings Plan account balance to pay your debts. But a court can order all or some of your account be paid to an "alternate payee" (like a former spouse or minor child) under a Qualified Domestic Relations Order ("QDRO").

The Plan Administrator has rules for deciding if a domestic relations order is qualified. For information about a specific order, you should contact the Rolls-Royce Benefits Center at (844) 625-5900 (select option 6) or by email at *QOCenter@alight.com*. You must include the following information:

- your name;
- employer's name (include in the subject line and body of the email);
- plan name; and
- last four digits of your Social Security number.

For your own security, don't include personal and confidential information (such as a full Social Security number or your order) in the email. If the former spouse is submitting the QDRO, the email should include the former spouse's name, the employee's name and the employee's Social Security number.

In general, if you get divorced, any prior beneficiary designation of your former spouse will automatically become invalid as of the date the divorce is finalized. You should file a new beneficiary designation following a divorce.

expenses

In general, all expenses of the Personal Savings Plan are paid by Rolls-Royce (which can, under Plan terms, use contribution forfeitures for this purpose). However, if you take a loan from the Plan, your account will be charged a loan origination fee and a quarterly loan maintenance fee.

benefit guarantees

The Pension Benefit Guaranty Corporation ("PBGC") does not insure benefits provided under the Personal Savings Plan because the insurance provisions of ERISA are not applicable to this type of plan. Neither the Company, its affiliates nor the Trustee guarantees any benefits that may be provided under the Personal Savings Plan

The information contained in this guide is a brief summary of the benefits under the Rolls-Royce Corporation Personal Savings Plan for Hourly-Rate Employees. It is not intended to describe the plan terms fully or to serve as a guarantee of plan benefits. The official plan documents and contracts govern in case of a dispute over plan provisions.

Section 3 — AEBS/Facility Bonus Program

This purpose of the AEBS/Facility Bonus Program (the "Bonus Program"), as outlined in the collective bargaining agreement, is to provide you with a distribution in Rolls-Royce Corporation financial performance from operations. This program is not subject to ERISA.

eligibility

You are eligible for the Bonus Program if you are a seniority hourly-rate, full-time employee, or an hourly-rate, part-time employee working on a regular and continuing basis. Part-time is defined as working at least half of a regular workweek. This Bonus Program is not available to leased employees or employees represented by a labor organization that has not agreed to offer it to its members.

If you are eligible, it is effective on your date of hire. In addition to active employees, employees who worked for Rolls-Royce Corporation during the year but retired, died, or were placed on layoff or leave of absence before the end of the year may receive a share of the Rolls-Royce Corporation bonus distribution.

how the bonus program works

The Bonus Program is made up of two components: 1) Rolls-Royce plc All Employee Bonus Scheme ("AEBS") and 2) Facility Bonus. Both bonuses will be paid out 2 ½ months from the end of the year.

Bonus Potential - All Hourly Employees	
AEBS	5% of eligible earnings
Facility Bonus: Productivity	$1,333
Facility Bonus: Scrap	$1,333
Facility Bonus: Schedule Adherence	$1,333
Productivity Target: 4% above baseline	$4,000
Total Eligible Bonus	**$8,000 + 5% AEBS**

AEBS (All Employee Bonus Scheme)

At the start of each year, the targets for AEBS portion of the Bonus Program are set and documented in writing by a committee which consists entirely of non-executive directors of the Company. The targets are commercially sensitive and cannot be published. Normally it is not possible to achieve the targets simply by meeting the previous year's level of performance; the targets do usually require profits to grow. Employees who participate in an alternative annual bonus or sales incentive plan are not eligible to participate in the AEBS.

For any bonus to be payable, cash performance needs to achieve the target set at the start of the year. If this cash "hurdle" is achieved, then a bonus can be paid to the extent that Company profit targets are met.

1. Minimum profit target, which generates 50% of the maximum AEBS Bonus Pool; i.e., 2.5% of Total Eligible Earnings.
2. Maximum profit target, which generates 100% of the maximum AEBS Bonus Pool; i.e., 5% of Total Eligible Earnings.
3. A profit level between minimum and maximum targets results in a bonus pool between 2.5% and 5%.
4. 80% of the AEBS Bonus Pool is generated by Company performance regardless of the performance of individual businesses. The remaining 20% of the AEBS Bonus Pool will be allocated to individual businesses and functions by the Office of the Chief Executive, who will consider:
    a. Outstanding financial performance of a particular business;

b. Significant strategic successes and missed opportunities which may not affect the financial performance within the bonus year but will have an impact in the longer term; and

c. Appropriate relativities which recognize the levels of performance of businesses and functions.

facility bonus calculation

At the beginning of each Plan Year, facility targets will be published. Targets will be set during the plan quarter preceding the Plan Year. It is expected that the target for any Plan Year will reflect an improvement in performance over the previous year. The facility bonus will be earned quarterly, but paid annually.

The 2020 – 2025 facility bonus has two thresholds:

1. The first threshold facility bonus will pay $4,000 per year ($1,333 per quarter) for achieving the agreed baseline performance targets for productivity, quality and delivery.

2. The second threshold facility bonus will pay $1,000 for each 1% of productivity above the established targets, up to an additional $4,000, as illustrated in the table below.

- ❑ The payout under this plan is not cumulative and the loss of the bonus in an earlier plan quarter cannot be made up in a following plan quarter. However, exceeding the target in one plan quarter can be applied to the following plan quarter.

- ❑ The maximum payout under the facility bonus will be as follows:

  - Plan year 2020: $8,000, up to $2,000 per plan quarter
  - Plan year 2021: $8,000, up to $2,000 per plan quarter
  - Plan year 2022: $8,000, up to $2,000 per plan quarter
  - Plan year 2023: $8,000, up to $2,000 per plan quarter
  - Plan year 2024: $8,000, up to $2,000 per plan quarter

Your share of any profit sharing distribution is based on your eligible compensated hours, up to a maximum of 1,850 hours per year for the Facility Bonus and a maximum of 2,080 hours per year for AEBS. Those hours generally include any time for which you receive pay, including your straight-time hours, for such things as:

- ❑ bereavement pay;
- ❑ call-in pay;
- ❑ holiday pay;
- ❑ jury duty;
- ❑ overtime (with each hour paid at premium rates to be counted as one hour);
- ❑ short-term military duty; and
- ❑ vacation pay.

the amount of your distribution

The amount of

1. part one (to determine the distribution rate per hour):

   total distribution amount for eligible employees / total eligible compensated hours = distribution per hour

2. part two (to calculate your distribution):

distribution per hour x your eligible compensated hours = your distribution

The amount of your Facility Bonus distribution is determined by a simple two-part formula, as follows:

1. part one (to determine the target performance):

   percentage of achieving each of three targets (productivity, quality and delivery – each 33%)

2. part two (to calculate your distribution):

   percentage of hours compensated up 463 maximum hours in each quarter x percentage of achieving target $1,000 per quarter

bonus payment options

cash payment

You may choose to take your bonus distribution as a cash payment. If you elect cash, you will receive your bonus distribution no later than March of the year after the year in which a distribution is generated. If you elect this option, your cash payment is subject to all payroll taxes, including local, state, federal, and Social Security taxes.

deposit to Personal Savings Plan

As an alternative, you may direct the Company to place up to 100% of your distribution in 1% increments, into the Rolls-Royce Corporation Personal Savings Plan and/or Health Savings Account ("HSA"), subject to any applicable legal limits.

If you elect to place your bonus program distribution amount in the Rolls-Royce Corporation Personal Savings Plan, it will be subject to Social Security taxes. Federal income taxes – and in most cases, state and local taxes – will be delayed until you withdraw your money at a later date.

If you elect to place your bonus program distribution amount in the HSA, it will be subject to Social Security taxes, but not federal income taxes. Contributions made to the HSA are made on a pre-tax basis and are not subject to federal tax if used for an eligible health care expense.

Both components, AEBS and Facility Bonus, are paid annually.

Section 4 — Health Care and Other Benefits Overview

The Rolls-Royce Corporation Welfare Benefits Plan (the "Welfare Plan") is designed to provide quality medical and other benefits for you and (where applicable) your eligible dependents. While this document contains different plans and plan designs, as reflected in the upcoming sections, your individual circumstances determine what options are available to you.

While coverage provided under the Welfare Plan is very broad and comprehensive, this Plan does not provide all health care and other under all circumstances. Descriptive materials concerning benefits provided under each option are available from your Union Benefits Representative. This document provides a general description only and the applicable provisions of the Welfare Plan control your eligibility for coverage and specific benefits.

eligibility

eligible employees

Generally, you are an eligible to participate in the health care and other benefits described in this guide if you are:

- a Rolls-Royce Corporation employee who was hired before February 26, 2015;
- scheduled to work at least 30 hours per week; and
- covered by the UAW collective bargaining agreement.

The following are not considered eligible employees for this purpose:

- employees hired on or after February 26, 2015;
- independent contractors (even if later determined to be a Company employee);
- consultant;
- leased or contract employee (even if they are later reclassified as employees); and
- nonresident aliens.

eligible dependents

Some benefit plans allow you to enroll or cover eligible dependents. When you enroll in one of these benefit plans or corresponding benefit options, you can also enroll or cover your eligible dependents:

- legal spouse;
- children up to age 26 — including stepchildren and adopted children;
- unmarried children of any age (up to age 65) who become physically or mentally disabled before age 26, incapable of self-support, totally dependent on you for support and can be claimed as a dependent on your U.S. federal income tax return; and
- children who are entitled to benefits required through a Qualified Medical Child Support Order ("QMSCO") or other court or administrative order, as described in the *medical child support orders* section.

Note: Your Dependents may not enroll in certain plans unless you are also enrolled. A child cannot be the dependent of more than one employee nor can a child be covered as both an employee and a dependent.

Some benefits and programs have specific eligibility criteria. Refer to the applicable section for those benefit plans and options.

eligible retirees

If you retire, you may be eligible to continue certain welfare benefits if your date of hire is before February 26, 2015.

Refer to *Section 11 — Retiree Welfare Benefits* for eligibility criteria.

enrollment

If you are eligible, you can enroll at any of the following times:

initial eligibility period

If you are a newly eligible employee, you must complete the enrollment process within 60 days of the start of your employment. Coverage will be effective retroactive to your date of employment. Your UAW representative will assist you in completing this process.

If you do not enroll within 60 days from your hire date, you will receive default coverage in Company-provided benefits such as basic life insurance, basic accidental death and dismember insurance and short- and long-term disability. You will not be enrolled in any of Rolls-Royce's health care or ancillary programs. Your next opportunity to enroll in optional benefits will be during the next benefits annual enrollment period unless you experience a qualifying event. See the *notice of special enrollment rights* section for more information.

If you wish to enroll a newly-eligible dependent (for example, as a result of your marriage or the birth or adoption of a child), you must do so within 31 days of the change in family circumstances. Please contact your UAW representative for further information regarding this process.

- coverage for new dependent(s) acquired as a result of marriage will become effective on the date of the event.
- coverage for new dependent(s) acquired as a result of birth, adoption or placement for adoption will become effective on the date of the child's birth, adoption or placement for adoption, as applicable.
- coverage required by a court order for a spouse or child will become effective on the date of the order.

You may enroll by calling the Rolls-Royce Benefits Center at (844) 625-5900 (select option 4) from 8:00 a.m. to 8:00 p.m. Eastern Time, Monday through Friday.

late enrollees

A "late enrollee" is an individual (including yourself) for whom you do not elect coverage during your initial eligibility period (within 60 days for newly hired employees).

If you do not enroll yourself or your eligible dependents when you (or they) are first eligible for coverage, you may not elect coverage until the next open enrollment period, unless:

- you experience a change in family circumstances; or
- you lose other coverage you had when you previously declined coverage.

See the *notice of special enrollment rights* section for more information.

annual enrollment

Each year, usually late October, the Company holds an open enrollment period. During Annual Enrollment, you decide whether to enroll (or continue enrollment) in the Program, and the type of coverage you wish to receive under the Program for the following year. Your election will then become effective beginning January 1 of the following year.

cost of coverage

Rolls-Royce Corporation pays the total premium cost for the following:

- medical, dental and vision insurance;
- basic life insurance;
- basic accidental death and dismemberment insurance (AD&D); and
- disability insurance.

You are required to pay the premiums for the following:

- optional life insurance for you or your dependents; and
- optional accidental death and dismemberment (AD&D) insurance for you or your dependents.

Your contributions for optional life and/or AD&D are deducted from your weekly paychecks on an after-tax basis.

when participation begins

In general, your health and other benefits are effective the first day of the month following the month in which you acquire seniority (90 days of employment). If you are not actively-at-work on this date, your coverage will become effective upon your return to work. If applicable, you have 60 days from your effective date to enroll in the plan. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a spouse or dependent children that you acquire via marriage becomes effective upon providing notice, as long as you notify the Company within 31 days of your marriage. Coverage for dependent children acquired through birth, adoption, or placement for adoption is effective as of the date of the applicable event, provided you enroll the dependent within 31 days of the birth, adoption, or placement. Please refer to the *notice of special enrollment rights*notice of special enrollment rights section for more information.

when coverage ends

In general, your entitlement to benefits automatically ends on the date that coverage ends. Your coverage under the Plan will end on the earliest of:

- the end of the month in which you are last in active service;
- the date the plan ends;
- the last day of the month you stop making the required contributions, if applicable;
- the last day of the month in which you are no longer eligible;
- the last day of the month in which the Claims Administrator receives written notice from the Company to end your coverage, or the date requested in the notice, if later;
- when you allow a person other than your spouse or covered dependent to use your insurance card or otherwise commit fraud in obtaining plan benefits; or
- the last day of the month in which you retire, unless specific coverage is available for retired persons and you are eligible for that coverage.

You may be entitled to continued coverage if you leave active service because of disability, layoff or retirement. In the event you cease to qualify for coverage because employment ceases or you are no longer in an eligible class because of a reduction in your hours of employment, you may eligible to elect to continue coverage for up to 18 months at your own expense.

In general, your coverage cannot be retroactively terminated, except in the case of fraud, an intentional misrepresentation of a material fact, failure to pay the required employee cost timely or your election to terminate coverage.

termination of dependent coverage

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required contributions, if applicable;
- the last day of the month in which your dependent child reaches the limiting age shown in the *eligible dependents* section; or

- ❑ the last day of the pay period in which your dependents no longer qualify as dependents under this Plan for any other reason.

In the event a dependent ceases to qualify for Plan benefits, your dependent may be eligible to elect to continue coverage for up to 36 months at your own expense. It is your responsibility to notify the Rolls-Royce Benefits Center at (844) 625-5900 (select option 4) of any change in your dependents' eligibility status. The Benefits Center automatically processes coverage changes for dependents who cease to be eligible due to age.

changing your coverage

You may make coverage changes during the year only if you experience a qualified life event. The change in coverage must be consistent with the life event (e.g., you cover your spouse following your marriage, your child following an adoption, etc.). You must submit your election changes within 31 days of the qualified life event. Otherwise, you will need to wait until the next Annual Enrollment. Please refer to the *notice of special enrollment rights*notice of special enrollment rights section for more information.

coordinating with Medicare

You become eligible for Medicare at age 65, whether or not you choose to continue working. You may be automatically enrolled in Medicare Parts A and B if you are receiving Social Security benefits when you become eligible. Otherwise, you must enroll yourself. Whichever medical plan is designated as the primary plan pays first on your claims. If a balance is still due after the primary plan's payment, the Claim should be sent to the secondary plan for consideration.

Medicare basics

Your first chance to sign up for Medicare is called your Initial Enrollment Period ("IEP"). It happens around your 65th birthday and lasts a total of seven months. It includes your 65th birthday month plus the three months before and the three months after. 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 you begin the process three months prior to attaining age 65 to allow sufficient time to process your application so you will not miss your initial opportunity for enrollment. This is true not only because of penalties which may be incurred in Medicare premiums**.** Moreover, eligibility for Company-paid coverage may depend on Medicare enrollment. For example, in the event of your death, your surviving spouse will not be eligible for Corporation contributions for any Rolls-Royce Corporation health care coverage if your spouse is eligible for, but is not enrolled in, Medicare Part B at or after age 65.

If you or one of your dependents have a severe long-term disability, end-stage renal disease, or undergo a kidney transplant, you may be eligible for Medicare coverage prior to age 65. If you or one of your dependents fit one of these categories, you should contact your nearest Social Security Administration office to have your case evaluated. You can also obtain more information by contacting your Union Benefits Representative.

active employees

Generally, you or your dependents may want to enroll for Medicare when you first are eligible. You may want to enroll in just Part A during your IEP if you work past age 65 and have coverage under the Rolls-Royce's Welfare Plan. No premium is required if you have enough work credits under Social Security; and Part A may supplement the Rolls-Royce medical plan. If you're an active employee, and you or an enrolled dependent enroll in Medicare due to age, the Rolls-Royce Plan is generally the primary payer and Medicare is the secondary payer.

If you choose not to enroll in Medicare during your Initial Eligibility Period, You may qualify for a Special Enrollment Period (SEP) to enroll in Part A, Part B or both without penalty for up to 8 months after the month your (or your spouse's) employment or employer coverage ends, whichever comes first.

effect of Medicare on your company health care plan

If you are working, and you (1) are over age 65, or (2) have a dependent who is eligible for Medicare, you may elect to have coverage under both the Rolls-Royce Corporation Welfare Benefits Plan and Medicare. Generally, if you do so, the Rolls-Royce plan will be the primary source of benefits (the first to pay for any covered services). **Eligibility for Company-paid coverage may depend on Medicare enrollment.** For example, in the event of your death, your surviving spouse will not be eligible for Corporation contributions for any Rolls-Royce Corporation health care coverage if your spouse is eligible for, but is not enrolled in, Medicare Part B at or after age 65.

If you retire and are enrolled in Medicare, Medicare will be the primary source of benefits for you and your dependents who also are enrolled for Medicare. Refer to *Section 11 — Retiree Welfare Benefits* for more information.

effect of Medicare on a health savings account (HSA)

If you have an HSA and you will soon be eligible for Medicare, it is important to plan ahead and understand how enrolling in Medicare will affect your HSA. By law, if you are enrolled in Medicare, you are not eligible to either receive or make HSA contributions. This is because you cannot have any health coverage other than a High Deductible Health Plan ("HDHP") to be eligible to contribute to an HSA. Medicare is considered other health coverage. However, you may withdraw money from your HSA after you enroll in Medicare to help pay for eligible medical expenses (e.g., deductibles, premiums, copays or coinsurances).

Whether you should delay enrollment in Medicare so you and the Company can continue contributing to your HSA depends on your circumstances. Please consult with your financial advisor or the Social Security Administration to determine what would be best for you.

retirees eligible for the retiree welfare program

When you retire, you may be eligible for the Company's retiree welfare benefits. For retiree eligibility criteria, refer to *Section 11 — Retiree Welfare Benefits*.

coordination of benefits

This coordination of benefits ("COB") provision applies to this *Plan* when you or your *dependent* has health coverage under more than one group health plan. The purpose of this provision is to avoid duplicate payment of benefits in the event an individual is covered by more than one group health care plan. For example, if expenses are incurred by your spouse who is covered by another plan, the other plan may have the primary responsibility of payment. If so, your overall coverage may be enhanced and the cost to the Rolls-Royce Corporation Welfare Benefits Plan will be reduced.

If COB is done properly, you and your dependents will receive no fewer benefits than you would have received under the Rolls-Royce Corporation Welfare Benefits Plan alone and you may receive more or enhanced benefits.

When the Rolls-Royce Corporation Welfare Benefits Plan is secondary, the following provisions apply:

- Certain requirements under the Rolls-Royce plan, such as precertification of hospital admissions, are waived; and
- Only those services covered under the Rolls-Royce plan will be considered for additional benefit payment.

The Rolls-Royce Corporation carrier should be notified of other plans or programs which may cover you or your dependents. No notice is required for insurance policies issued in your name, or a dependent's name, for which you pay more than half the cost. In some cases, you may be required to provide the carriers with additional information.

Once you have identified whether other coverage is involved, you should determine which plan is primary for the individual having a claim. If another plan or program is primary, the claim should be filed first with the primary plan or carrier. If the primary plan does not cover the health care expenses in full, the unpaid balance can be considered under the Rolls-Royce Corporation Welfare Benefits Plan. You should provide your Rolls-Royce Corporation carrier with information on the payments made by the other plan or authorize the other carrier to do so. From that point, COB is handled between the carriers. If the remaining balance is for services covered under the Rolls-Royce Corporation Welfare Benefits Plan, the Plan will pay the balance, up to the maximum permitted under the Rolls-Royce Welfare Benefits Plan.

subrogation and reimbursement for third party liability

If the Welfare Plan pays medical expenses for you or your covered dependent for an injury or illness that appears to be the fault of someone else or for which you have other coverage (for example, car insurance), you agree to:

- repay the Welfare Plan for such medical expenses from any compensation you receive from, or on behalf of, the person who caused the injury or illness, or your insurance carrier;
- not settle, without the prior consent of the Welfare Plan, any claim that you or your covered dependent may have against any legally responsible party or insurance carrier;

- give the Welfare Plan a lien on any such compensation and hold that compensation in trust for the Welfare Plan;
- promptly reimburse the Welfare Plan when you receive a recovery through settlement, judgment, award or other payment; and
- cooperate fully and sign any documents needed to protect the Welfare Plan's rights to reimbursement and subrogation, including entering into a subrogation agreement.

Failure to comply with any of these requirements may result in the Welfare Plan withholding or reducing payment for further medical, dental or disability benefits.

The Welfare Plan has the right to be reimbursed for the full amount of the medical expenses it paid, even if that amount is greater than the settlement you received from, or on behalf of, the person who caused the injury or illness or your insurance carrier. In addition, the Welfare Plan is not responsible for any portion of attorney fees or other expenses you are required to pay, and is entitled to reimbursement before any other party that may have a claim on any amounts you recover.

> *For example:* You were injured in a car accident that was caused by another driver. The Welfare Plan pays $25,000 in medical expenses resulting from the accident. If you sue the other driver, the Welfare Plan has a right to be reimbursed from any settlement you receive. If you receive a settlement of $25,000 or less, the Welfare Plan will receive the entire amount, even if you owe a percentage of that amount to your attorney. If you receive a settlement of more than $25,000, the Welfare Plan is only entitled to the $25,000 it paid for your medical expenses.

"Subrogation" means that the Welfare Plan stands in your place in connection with any settlement or insurance payment you receive. By allowing the Welfare Plan to pay for your medical treatment, you agree to protect the Welfare Plan's rights in the same way you protect your own rights. The Welfare Plan's rights of subrogation and reimbursement apply whether you agree to them in writing or not.

If the Welfare Plan has to sue you to receive reimbursement from a settlement or insurance payment you receive you will be responsible for paying the Welfare Plan's collection expenses (including attorneys' fees).

This is a very general "plain English" explanation of the Welfare Plan's reimbursement and subrogation rights. Contact the Plan administrator for a copy of the Welfare Plan document and the detailed explanation of the plan's rights if you think this section may apply to you.

This provision does not limit any other legal remedies the Welfare Plan may have. The Welfare Plan's rights of subrogation and reimbursement apply regardless of the location of the event that led to or caused the applicable sickness, injury, disease or disability.

the health insurance portability and accountability act of 1996 (HIPAA)

A federal law called the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires group health plans to take certain precautions in using and disclosing specified information about your health and the health of your dependents. HIPAA also places limitations on the disclosure of such information to the Company and third parties. Generally, your personal health information may be used only for treatment, payment, health care operations and certain other specified purposes such as under a court order. When using or disclosing protected health information, the Plan Administrator will make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose. You also have the right to file a complaint with the Company or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

You can obtain more information from the HIPAA Privacy Notice that is mailed out annually, or from the HIPAA Privacy Officer (identified in the HIPAA Privacy Notice). You may request a copy of the Privacy Notice from the Benefits Department.

More information on your privacy rights is contained in the privacy notice that has been provided to you, or from the privacy officer (identified in the privacy notice). You may request a copy of the privacy notice from a UAW Benefits Representative during normal business hours.

medical child support orders

The Plan Administrator is required to comply with qualified medical child support orders. A qualified medical child support order (“QMCSO”) is a judgment, decree, order or approval of a property settlement agreement by a court that creates or recognizes the existence of a dependent’s right, or assigns to a dependent the right to receive benefits to which a participant or beneficiary is eligible under a group health plan. The Plan Administrator determines whether a medical child support order is qualified and whether it must be honored by the Plan.

In addition, a properly completed national medical support notice (“NMSN”) issued by a state child support enforcement agency must be treated as a QMCSO. The plan administrator is required by law to honor a QMCSO or a NMSN. You may request and receive, without charge, a copy of the program’s procedures for evaluating such orders or notices. You will be notified if the plan receives a medical child support order or notice in your name. If you are in the process of getting a divorce and have questions about QMCSOs or NMSNs, please contact a UAW Benefits Representative.

maximum allowed amount for health benefits

Payment of health benefits for services rendered by in-network and out-of-network providers is based on this Welfare Plan’s maximum allowed amount for the covered service that you receive.

The maximum allowed amount is the maximum amount the Claims Administrator will pay for covered health services and supplies:

- to the extent such services and supplies are covered under the Welfare Plan and are not excluded;
- that are medically necessary; and
- that are provided in accordance with all applicable precertification, case management or other requirements set forth in the Welfare Plan.

You will be required to pay a portion of the maximum allowed amount to the extent you have not met the deductible or have a copayment or coinsurance. In addition, when you receive covered services from an out-of-network provider, you may be responsible for paying any difference between the maximum allowed amount and the provider’s actual charges. This amount can be significant.

When multiple procedures are performed on the same day by the same physician or other health care professional, the Welfare Plan may reduce the maximum allowed amounts for those secondary and subsequent procedures because reimbursement at 100% of the maximum allowed amount for those procedures would represent duplicate payment for portions of the primary procedure.

provider network status

The maximum allowed amount may vary depending upon whether the provider is an in-network provider or an out-of-network provider.

An in-network provider is a provider who is in the managed network or in a special Center of Excellence, or who has a participation contract with the Claims Administrator. The maximum allowed amount for services provided in-network is the rate the provider has agreed with the Claims Administrator to accept as payment for the covered services. Because in-network providers have agreed to accept the maximum allowed amount as payment in full for those covered services, they should not send you a bill or collect for amounts above the maximum allowed amount. However, you may receive a bill or be asked to pay all or a portion of the maximum allowed amount to the extent you have not met your deductible or have a copayment or coinsurance. Please call Anthem Customer Service for help in finding an in-network provider or visit **anthem.com**.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator’s networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims. Providers who are in-network for some services may be out-of-network for other services.

For covered services you receive from an out-of-network provider, the maximum allowed amount for this Welfare Plan will be one of the following as determined by the Claims Administrator:

- an amount based on the Claims Administrator's out-of-network provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time;
- an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS");
- an amount based on information provided by a third party vendor;
- an amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider; or
- an amount based on or derived from the total charges billed by the out-of-network provider.

Unlike in-network providers, out-of-network providers may send you a bill and collect for the amount of the provider's charge that exceeds the Welfare Plan's maximum allowed amount. You are responsible for paying the difference between the maximum allowed amount and the amount the provider charges. This amount can be significant and will not apply toward your deductible or out-of-pocket maximum. Choosing an in-network provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a network provider or visit the Claims Administrator's website at **anthem.com**.

Customer Service can assist you in determining the Welfare Plan's maximum allowed amount for a particular service from an out-of-network provider. In order for the Claims Administrator to assist you, you will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this pre-service information, the final maximum allowed amount for your claim will be based on the actual claim submitted by the provider.

Emergency health services are always paid as in-network services.

member cost share for covered health services

For certain covered services, you may be required to pay a part of the maximum allowed amount as your cost share amount (for example, deductible, copayment, and/or coinsurance).

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from a network or out-of-network provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using out-of-network providers.

The Welfare Plan will not pay for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by an in-network or out-of-network provider. Non-covered services include services specifically excluded from coverage by the terms of your Welfare Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower in-network cost sharing amount when you use an out-of-network provider. For example, if you go to an in-network hospital or provider facility and receive covered services from an out-of-network provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an in-network hospital or facility, you will pay the in-network cost share amounts for those covered services. However, you also may have to pay the difference between the maximum allowed amount and the out-of-network provider's charge.

authorized services

In some cases, such as where there is no in-network provider able to provide the required service, the Welfare Plan may authorize the in-network cost share amounts (deductible, copayment, and/or coinsurance) to apply to a claim for a covered service you receive from an out-of-network provider. In such circumstance, you must contact the Claims Administrator in advance of obtaining the covered service. Note, though, that emergency health services are always paid as in-network services. Contact Customer Service for authorized services information or to request authorization.

health care exclusions and limitations

The Plan does not pay benefits for certain health care services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition. In addition, the Plan will not pay benefits for covered services or supplies during times you or your covered dependents were not covered under the Plan.

The following are examples of excluded services. This list is not all-inclusive. Some covered services may also have coverage limits. Review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits. Please contact your medical carrier at the number on your ID card *before services are rendered*.

- charges above the maximum allowable amount.
- injury or illness covered by workers' compensation.
- injury or illness incurred while in the military service of any country, except as noted in the section titled *health care coverage during uniformed services leave*.
- voluntary sterilization reversal.
- confinement or treatment not recommended and/or approved by a licensed physician.
- custodial care charges.
- **non-licensed Provider –** treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services if the Member is not required to pay for them or they are provided to the Member for free.
- **act of war/military duty –** treatment for any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military facilities as required by law.
- **certain providers -** service you get from providers that are not licensed by law to provide covered services. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- **experimental/investigative/unproven services -** treatments, procedures, equipment, drugs, devices or supplies which the Claims Administrator considers to be experimental or investigative services and unproven services are excluded. The fact that an experimental or investigative services and unproven services, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
- **foot care -** foot care only to improve comfort or appearance, routine care of corns, bunions, calluses, toe nails, flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for medically necessary foot care (including shoe inserts and orthotics) required as part of the treatment of diabetes or for impaired circulation to the lower extremities.
- **government agency/laws/plans**
  - treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
  - services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease ("ESRD"), Medicare shall be treated as the primary payor whether or not the Member has enrolled in Medicare Part B.
  - services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.

- court-ordered services, or those required by court order as a condition of parole or probation unless medically necessary and approved by the Claims Administrator.

❑ **medically unnecessary services or supplies - s**ervices, supplies, or equipment not determined by the Claims Administrator to be medically necessary for the treatment of an injury or illness. This includes, but is not limited to, care which does not meet the applicable medical policy, clinical coverage guidelines, or benefit policy guidelines. Some examples are:

  - vitamins, minerals and food supplements, as well as vitamin injections not determined to be medically necessary in the treatment of a specific illness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary;
  - services for an in-patient hospital stay primarily for diagnostic studies; and
  - cosmetic or plastic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when medically necessary to correct damage caused by an accident, an injury or to correct a congenital defect.

❑ therapy, supplies, or counseling for sexual dysfunctions or inadequacies.

❑ charges for, or related to, services, treatment, education testing or training related to learning disabilities or developmental delays.

❑ miscellaneous exclusions and limitations

Certain covered services have exclusions and limitation. The following is a list of some examples. Refer to *covered services* section for more information. Please call Anthem at (888) 823-8576 to confirm specific exclusions and limitations for any service prior to receiving benefits.

  - convalescent care;
  - dental services - any treatment of teeth, gums or tooth related service except otherwise specified as covered by the plan;
  - medications - drugs, devices, products, or supplies with over-the-counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply;
  - donor search/compatibility Fee (except as otherwise indicated);
  - in-vitro fertilization and artificial insemination is limited to a lifetime maximum;
  - hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth;
  - private duty nursing;
  - services and supplies primarily for educational, vocational or training purposes, except as expressly provided under as a covered service;
  - services and treatment related to religious, marital and sex counseling;
  - christian science practitioner;
  - services provided in a halfway house, except as approved by Beacon Health Options (Anthem Behavioral Health beginning January 1, 2021); and
  - services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products.

Note: log on to (or create) your account at express-scripts.com for your Prescription Drug benefits; and contact the Rolls-Royce Benefits Center at (844) 625-5900 for details on the UBreathe Tobacco Cessation Program through RR Wellbeing.

- **special charges/services**
  - services or supplies provided by a member of your family or household;
  - charges or any portion of a charge in excess of the maximum allowable amount as determined by the Claims Administrator;
  - fees or charges made by an individual, agency or facility operating beyond the scope of its license;
  - services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage;
  - services for any form of telecommunication;
  - administrative charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results; specific medical reports including those not directly related to the treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation;
  - separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available; and
  - personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
- **surgery**
  - charges for or related to cosmetic or not medically necessary services for sex change surgery or to any treatment of gender identity disorders;
  - reversal of vasectomy or tubal ligation; and
  - salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.
- **therapies -** Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy in-home wrap around treatment, wilderness therapy, and boot camp therapy.
- vision care not covered under the medical plan. Refer to *Section 7 — Vision* for coverage through EyeMed. Medical plan exclusions related to vision care include:
  - vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses, sclera shells following intraocular surgery or for soft contact lenses due to a medical condition, i.e., diabetes; and
  - vision surgeries related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

Note that beginning January 1, 2021, vision benefits will be provided through Anthem Blue View Vision.

- **Weight Reduction Programs -** Charges for weight reduction programs, services and supplies, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

This list is not all-inclusive. Please contact Anthem Customer Service at (888) 823-8576 for more information.

using your health benefits

Your plan ID and group number are always needed when you communicate with any of the carriers. If you are a dependent, you will need the plan ID and group number of the employee, retiree, or surviving spouse through whom you have coverage. For more information on claims procedures, refer to *Section 12 — Claims Procedures*.

reduction in benefits

You may not receive all of the benefits to which you think you are entitled under the Welfare Plan, under the following circumstances:

- you do not qualify as an eligible employee under the Welfare Plan;
- you have exceeded the Welfare Plan's limits on services;
- you fail to file a claim for out-of-network benefits in a timely manner;
- you fail to respond within a reasonable period to a request for additional information regarding the processing of a claim;
- you fail to pre-certify a medical service where required;
- payment for your benefits is being coordinated with another group health plan;
- you may be required to repay the Welfare Plan for benefits paid if you recover monetary damages for an illness or injury caused by a third party; or
- the Welfare Plan is amended to eliminate specific benefits (although the Welfare Plan will, in general, provide coverage for any such benefit services received prior to the date of the amendment).

annual required legal notices applicable to health care coverage

notice of special enrollment rights

In general, IRS restrictions prevent you from making changes to your coverage elections during the year. This means that once you make your health care plan elections during benefits enrollment, you may not drop dependents or change your coverage until the next benefits enrollment period. However, you may be able to change your coverage during the year if you experience and report a qualified life event, also known as a life or employment status change. These changes include the following:

- you get married or divorced;
- you acquire a dependent child through birth, adoption, or placement for adoption;
- your spouse or dependent dies;
- your dependent no longer meets the plan's eligibility requirements;
- your spouse terminates employment or begins new employment;
- you or your spouse changes from part-time work to full-time work (or vice versa);
- you or your spouse has a significant change in health care coverage; or

- you are required to provide dependent medical coverage as a result of a valid court decree that meets the requirements of a Qualified Medical Child Support Order ("QMCSO").

Any benefits enrollment change you make must be consistent with your qualified life event. To change your coverage, you must call the plan administrator within 31 days of the date you experience the life event or employment status change. Your new elections will be effective on the date of your life event or employment status change, and retroactive payroll deductions may be withheld. If you do not call within the 31-day period, you must wait until the next benefits enrollment period to change your benefits.

statement of rights under the newborns' and mothers' health protection act (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean 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 insurers may not, under federal law, require that a provider obtain authorization from the Welfare Plan or the insurer for prescribing a stay less than 48 hours (or 96 hours.

notice of women's health and cancer rights act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical plan in which you participate.

explanation of certain terms applicable to health care coverage

approved facility or treatment program

A facility or a treatment program that has met criteria established by the carrier to provide certain services covered by the Welfare Plan. **The following are examples of facilities and treatment programs which must be approved by the applicable carrier for full benefits to be paid:**

- hospitals;
- skilled nursing facilities\outpatient mental health facilities;
- substance abuse treatment facilities;
- outlets for prosthetic or orthotic appliances
- freestanding physical therapy facilities;
- home health care programs;
- hospice programs;

- ❑ freestanding ambulatory surgical centers (“FASC”); and
- ❑ hemodialysis programs.

In addition, certain services are not payable under the Welfare Plan unless rendered by approved facilities or on approved equipment. Some services also must meet certain medical criteria.

If you have any doubts about the approved status of a facility or treatment program, you should contact the appropriate health care carrier before services are rendered.

birthday rule

If your children are covered under two parents’ plans, the plan of the parent whose birthday falls earlier in the calendar year pays benefits first. If both parents have the same birthday, the plan that has covered the family for a longer period of time will pay benefits first.

carrier

Any entity through which Welfare Plan coverage is administered or benefits are paid, including, but not limited to, a commercial insurance company, or a preferred provider organization.

coinsurance

Coinsurance is a percentage of the maximum allowed amount for a covered expense. For example, if the plan covers an in-network expense at 80%, you pay 20% of the maximum allowed amount. If the plan covers an out-of-network expense at 60%, you pay 40% of the maximum allowed amount plus the difference between the maximum allowed amount and the actual amount charged.

coordination of benefits (COB)

Your Anthem coverage may be coordinated with another insurance plan that covers you or your dependents. Anthem will pay benefits so that the total you receive from both plans reimburses you for the maximum allowable expense. The combined benefits will not be more than the total expenses recognized under these plans. If children are covered under both parents’ health plans, the *birthday rule* (see definition) is used to coordinate benefits.

copayment

A specific dollar amount that you pay to receive a covered service.

deductible

The amount that you must pay before the Welfare Plan begins paying for any medical services. There is an in-network deductible, and an out-of-network deductible. The deductibles apply to the out-of-pocket maximums.

eligible dependents

You can enroll eligible dependents in certain plans offered under the Welfare Plan. The following family members qualify as “dependent” under the Program --

- ❑ your legal spouse (of the same or opposite sex);
- ❑ a biological, adopted, step or foster child through the end of the calendar month in which he/she reaches age 26.
- ❑ an unmarried child who becomes handicapped before age 26 and is incapable of self-support if you submit proof of the handicap to Anthem within 31 days of the date when coverage would otherwise stop. Coverage stops if the disability ends or when the child reaches age 65.
- ❑ a child who is entitled to benefits under the Program pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

if you're involved in a qualified medical child support order

Upon receipt of a QMCSO, the plan is required to pay benefits directly to the child, the child's custodial parent or legal guardian, according to the order. You and the affected child will be notified if an order is received and about the procedures used to determine whether the order is qualified. These children must qualify as dependents under the Rolls-Royce Corporation plan.

eligible charges/eligible expenses

Health care expenses that are covered under Anthem's group health plan; Mental Health and Alcohol/Substance Abuse expenses that are administered by Beacon Health Options; and pharmacy expenses that are administered by Express Scripts.

> Note that beginning January 1, 2021, Mental Health and Alcohol/Substance Abuse coverage will be provided through Anthem Behavioral Health.

explanation of benefits

The forms the Claims Administrator sends you in response to the submittal of health claims for you or your dependents. You should always keep these forms because if you have any questions about how a bill was processed, you can refer to the explanation of benefits ("EOB"). It also serves as a record of charges that have been applied to your deductible.

formulary

This is a list of prescription drugs that have been evaluated and selected by Express Scripts clinical pharmacists for their therapeutic equivalency and efficacy. The formulary includes both brand-name and generic drugs and is periodically reviewed and modified by Express Scripts.

generic drug

This is a prescription drug that is not protected by trademark registration, but is produced and sold under the chemical formulation name.

in-network (or network)

Those physicians, hospitals, and other health care providers who have entered into agreements with the carrier to provide health care to plan participants at negotiated rates.

inpatient

Admission to a hospital or other medical facility for treatment that requires an overnight stay.

maximum allowed amount

An amount determined by the carrier, according to certain standards and considerations or a contracted amount agreed upon as payment in full by the carrier and provider. **The carrier's determination is conclusive.** See more information in the *maximum allowed amount for health benefits* topic.

medically necessary

A service or supply is medically necessary if the Claims Administrator determines that it is appropriate for the diagnosis, care, or treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and

- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.
- the following services or supplies are not considered necessary:
- those that do not require the technical skills of a medical, mental health or dental professional; or
- those provided mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any health care provider or health care facility;
- those provided only because the person is an inpatient on any day when the person's disease or injury could safely and adequately be diagnosed or treated while not confined as an inpatient; or
- those provided only because of the setting, if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

out-of-network (or non-network)

Those physicians, hospitals, and other health care providers of your choice who have not entered into agreements with Anthem or other plan carrier.

out-of-pocket maximum

The maximum amount per calendar year that you would have to pay before the Welfare Plan begins paying at 100% of the **maximum allowed amount** for the rest of the calendar year. Each January 1, you start over with a new out-of-pocket maximum. There are separate out-of-pocket maximums for services provided in-network and services provided out-of-network.

outpatient

Admission to a medical facility for treatment in which the patient is released the same day.

precertification

A requirement for doctors and/or hospitals to obtain prior approval of all non-emergency, non-maternity hospitalizations and certain other services. Enrollees also may request precertification. Precertification of hospital admissions does not apply to Medicare-enrolled individuals where Medicare is primary. For more details, see the *precertification* topic.

Failure to pre-certify an inpatient hospital admission or mental health or substance abuse treatment will result in a reduction in benefits. If you use a network physician, that physician is responsible for the precertification of your admission. However, if you use a non-network provider, pre-certification is your responsibility.

provider

A person (such as a doctor) or a facility (such as a hospital) that provides health care services. Providers are considered to be in-network when they have signed an agreement with the carrier to accept as "payment in full" the amount which the carrier determines to be an appropriate charge for services rendered. **You should use in-network providers, whenever possible for a higher benefit level and to limit the likelihood of having to pay for charges in excess of the carrier's maximum allowed amount.**

You may be uncertain about the participating status, or whether there is any need for participation, by a health care provider in your area. If in doubt, contact the appropriate carrier before services are rendered.

consolidated omnibus budget reconciliation act (COBRA) continuation coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, generally provides certain employees and dependents the opportunity to continue Rolls-Royce Corporation group health care coverage when eligibility otherwise would end because of a qualifying life event under the Rolls- Royce Corporation Welfare Benefits Plan. This is called COBRA Continuation Coverage.

COBRA Continuation Coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under

the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for that coverage. In general, the permitted COBRA rate is 102% of the total premium cost for the elected coverage.

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 read this notice carefully.

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 an active employee or an employee on disability leave.

employee information

As an employee, you have a right to choose COBRA Continuation Coverage if you "lose" your group health coverage because of (1) a reduction in your hours of employment, or (2) 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 alternative coverage under the Welfare Plan. If this is applicable to you, the options available will be explained to you. You will be required to choose between COBRA and the alternative continuation coverage.

retiree information

At the time you retire, if your date of hire is on or before February 25, 2015, you may be eligible to continue health care coverage for you and your eligible dependents under the Rolls-Royce Corporation Welfare Plan. See *Section 11 — Retiree Welfare Benefits* for a description of eligibility criteria. Alternatively, you or your dependents may be eligible to elect to continue coverage for up to 18 months under COBRA.

If you are Medicare-eligible and elect to enroll in COBRA, whether you can have COBRA and Medicare depends on which one you had first. If you have Medicare and then become eligible for COBRA, you may enroll for coverage under COBRA and it will pay secondary to Medicare. If you are not Medicare-eligible and elect COBRA when you retire, your COBRA coverage may end when you become eligible for Medicare. If you have dependents covered under COBRA, you should consider how their coverage will be affected if you lose of drop your COBRA.

spouse information

If you are the spouse of a covered employee, you have the right to choose COBRA Continuation Coverage if you lose group health coverage for any of the following reasons:

- the death of your spouse;
- a termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment sufficient to cause a loss of coverage(s);
- divorce or legal separation from your spouse (in either case, timely notice should be provided to Rolls- Royce Corporation); or
- your spouse becomes entitled to Medicare.

dependent children information

In the case of a dependent child of a covered employee (including a dependent child who is born to or adopted by the covered employee while he or she has COBRA coverage), the child has the right to COBRA Continuation Coverage if the dependent's group health coverage is lost for any of the following reasons:

- the death of the covered employee;
- the termination of the covered employee's employment (for reasons other than gross misconduct) or reduction in the hours of employment sufficient to cause a loss of coverage(s);
- parents' divorce or legal separation (in either case timely notice should be provided to Rolls-Royce Corporation);

- the dependent ceases to be a “dependent child,” under the terms of the Welfare Plan; or
- the covered employee becomes entitled to Medicare.

notifying the union benefits representative of a qualifying event

You (or your qualified beneficiaries) are responsible for notifying the Union Benefits Representative of the following qualifying events:

- you and your spouse become divorced or legally separated; or
- your dependent child loses his or her eligibility for coverage under the Welfare Plan as a dependent child.

In general, you will be required to identify (i) you and your qualified beneficiaries, (ii) the health plan in which you are enrolled, (iii) the event involved and (iv) the date that event took place. The plan administrator also may require that additional information be provided concerning the event. The requested information must be promptly provided to ensure that the notice is effective.

If notice (or any required information) is not provided as explained above, COBRA continuation coverage will not be available.

The Company is responsible for providing notice to the COBRA Administrator for the other qualifying events -- basically, your death, termination of employment, reduction in hours of employment, or entitlement to Medicare benefits.

election of COBRA continuation coverage

Under the law, you or your dependent(s) have 60 days from the later of the date you (1) would lose coverage, or (2) are notified of your rights, to inform the COBRA Administrator that you want COBRA Continuation Coverage.

Each qualified beneficiary may separately elect such coverage. For example, upon your termination of employment, your spouse or dependent child is entitled to elect to continue coverage even if you do not elect to do so.

In addition, you may add a dependent child born to or adopted by you to your COBRA coverage. To do so, you must timely notify the COBRA Administrator.

If you or your qualified beneficiaries elect to continue coverage, coverage begins the day after benefits end under the Welfare Plan, provided that you pay the required premium. Any claims incurred during the election period will not be paid unless or until the continuation coverage is elected and you pay the required premium. The initial premium must be paid on or before the 45th day after the election of continuation coverage. *If continuation coverage is not elected for the Welfare Plan within the required 60-day election period, eligibility for coverage will end.*

COBRA maximum coverage period

COBRA continuation coverage is a temporary continuation of coverage. The maximum period of coverage for each qualifying event is as follows:

When the qualifying event is your death, your becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or your dependent child’s losing eligibility as such, COBRA continuation coverage is generally available for up to 36 months from the date the event occurred.

When the qualifying event is the end of your employment or a reduction in your hours of employment, you and your other qualified beneficiaries are entitled to elect COBRA continuation coverage for up to 18 months from the date the event occurred. This 18-month period may be extended in the following three situations:

*Disability extension***.** If you or any of your dependents who have COBRA coverage is determined by the Social Security Administration (“SSA”) to be disabled, you and your other covered family members may be entitled to elect up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. To be eligible for this extension, SSA must determine that the disabled person became disabled before the 60th day of COBRA continuation coverage. To obtain this extension, you must notify Rolls-Royce Corporation of SSA’s determination (as described above under the section titled *notifying the union benefits representative of a qualifying event*) within 60 days of that determination and before the end of the initial 18-month coverage period. If SSA later determines that you or your dependent is no longer disabled during the 11-month extension period, any COBRA coverage you and your family members have at the time will be terminated. You must notify the Plan administrator (as described above) of such a determination within 30 days.

- *Second qualifying event extension***.** If a covered family member has a second qualifying event during the initial 18-month COBRA coverage period, the family member may be entitled to elect up to an 18 additional months of coverage (for a maximum of 36 months). To obtain this extension, notice of the second qualifying event must be given to Rolls-Royce Corporation (as described above under *notifying the union benefits representative of a qualifying event*). This extension is available for the following qualified events: Your death, your divorce or legal separation, or a dependent child ceases to be eligible as a "dependent" under the Welfare Plan, but *only if* the second qualifying event would have caused the family member involved to lose Welfare Plan coverage had the first qualifying event not happened.

- *Medicare eligibility extension*. If you became entitled to Medicare benefits within 18 months before your termination or reduction in hours, your qualified beneficiaries may be entitled to elect up to 36 months of continuation coverage from the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before the date on which your employment ends, COBRA continuation coverage would be available to your spouse and children for up to 36 months after the date of your Medicare entitlement (or 28 months from the date of your termination).

cost of COBRA coverage

If you elect COBRA coverage, you and each qualified beneficiary will have to pay for the entire cost of coverage, plus a 2% for administration charge (102% of the full premium). If you are entitled to 11-month extension for disability, you will have to pay 150% for any month after the 18th month of continuation coverage. The cost of COBRA coverage will be 102% or 150%, as applicable, of the total monthly premium cost for the coverage that you or your family members elected.

You will also pay any coinsurance, deductibles or sanctions required under the rules of the Rolls-Royce Corporation Welfare Benefit Plan.

when COBRA coverage ends

The right to continue coverage can last no longer than the "maximum coverage period" described above. However, your right to coverage continuation may end earlier on account of any of the following: Rolls-Royce Corporation no longer provides group health coverage to any of its employees;

- the contribution rate for the COBRA Continuation Coverage is not paid;
- the individual becomes covered under another group health plan; or
- the individual becomes eligible for Medicare.

If you have any questions or if you have changed marital status, please contact your Union Benefit Representative as soon as possible.

other coverage options besides COBRA continuation coverage

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

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

switching between the marketplace and COBRA

If you sign up for COBRA continuation coverage, you can switch to a plan through the Marketplace during a Marketplace open enrollment period. You can also stop your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to

wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

health care coverage during uniformed services leave

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you and your covered dependents will be entitled to elect COBRA coverage the same as if you had experienced one of the "qualifying events" as described above.

You are eligible if you are unable to work at least 30 hours per week for more than six months because of duty in the "Uniformed Services". Uniformed Services are the Armed Forces; the Army National Guard and the Air Force National Guard when engaged in active duty training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and other categories of personnel designated by the President of the United States in time of war or emergency.

USERRA coverage for you and your dependents ends on the earliest of the following dates:

- the last day of the 24-month period beginning on the date your absence begins.
- the date your reemployment rights end (i.e., the day after the date on which you fail to apply for a return to a position of employment with the Company).
- the date you fail to make a required USERRA premium payment.

All rights guaranteed by USERRA are dependent on the Uniformed Service ending honorably. In general, the rights guaranteed by USERRA do not apply if the aggregate length of your military leave exceeds five years.

health care coverage during FMLA leave

If you take family or medical leave under the terms of the Family and Medical Leave Act of 1993 ("FMLA"), you may have the option to continue coverage during your absence or suspend coverage while you are on leave. If you choose to continue coverage during your absence, you and your dependents will be covered under the Welfare Plan while you are absent from work provided you continue to pay the required monthly premiums. This coverage will continue as if you were actively working until the earlier of the expiration date of your FMLA leave, the date you discontinue to pay for the coverage or the date you give notice to the Company that you will not return from your leave. If you do not choose to continue (or otherwise cease) such coverage on FMLA leave, you may elect to resume coverage upon your timely return from FMLA leave.

The information contained in this guide is a brief summary of the various benefit programs offered by Rolls-Royce Corporation. It is not intended to describe the programs fully or to serve as a guarantee of program benefit plans. The official plan documents and contracts govern in case of a dispute over program provisions.

Section 5 — Medical

The Welfare Plan offers thee medical plan options, all administered by Anthem Blue Cross Blue Shield. Each plan has different eligibility criteria. Refer to the Basic Choice High Deductible Health Plan ("HDHP") *eligibility* section and PPO and EPO *eligibility* section for the applicable requirements. If you are not currently enrolled in either the EPO or the PPO plan, you are not eligible to enroll as neither plan is open to new participants.

You automatically have prescription drug coverage through Express Scripts when you enroll in one of the medical plan options offered through the Welfare Plan. All plans offer Mental Health and Substance Abuse coverage through the Beacon Health Option network (Anthem Behavioral Health network, beginning January 1, 2021).

If you elect to enroll in the Basic Choice HDHP, the Company will contribute to a Health Savings Account ("HSA") for eligible participants. Refer to the *health savings account (HSA)* section to learn how an HSA works, including the tax advantages and eligibility requirements.

Blue Cross Blue Shield
Basic Choice High Deductible Health Plan

The Basic Choice High Deductible Health Plan ("HDHP") is a consumer driven health plan offered through Blue Cross Blue Shield ("BCBS"). Because this is a HDHP, eligible participants may also contribute to a Health Savings Account ("HSA").

eligibility

In addition to the eligibility criteria outlined in *Section 4 — Health Care and Other Benefits Overview*, you are eligible to enroll in the BCBS Basic Choice HDHP if:

- your date of hire is between March of 2005 and February 25, 2015; or
- you transitioned your health care under the 2011 contract to the HDHP.

how the hdhp works

The Basic Choice HDHP provides comprehensive coverage, including doctor visits, hospital and surgical services, diabetes treatment, behavioral health services and prescription drugs. Certain preventive care such as physical exams and immunizations are free of charge. As with most health plans though, any related deductibles, copayments, coinsurance, per admission deductibles, non-covered services, non-network charges over and above the allowed amount, amounts above the plan limitations, and fees associated with not certifying non-network hospital admissions, are the responsibility of the member.

Under this plan, you have the freedom to choose your doctor or health care facility when you need health care. How that care is covered and how much you pay for your care out of your pocket depends on whether the expense is covered by the plan and whether you choose an **in-network provider** or an **out-of-network provider**.

Generally, when you receive service from an in-network provider, the Welfare Plan pays 80% coinsurance for covered services after the applicable deductible has been satisfied. When non-Anthem providers are used, the Welfare Plan pays 60% coinsurance for covered services after the applicable deductible has been satisfied.

provider network

You and your covered family members receive care from doctors and facilities that belong to the Anthem PPO network. These providers are called "in-network providers." To be selected as a network provider, a doctor or other health care provider must meet certain standards in a process called credentialing. The credentialing process looks at factors such as education, residency, board certification and licensing, and admitting privileges to determine whether or not a provider may participate in the network.

The providers in the network represent a wide range of services, from basic, routine care (general practitioners, pediatricians, internists), to specialty care (OB/GYNs, cardiologists, urologists), to health care facilities (hospitals, skilled nursing facilities). When they join the network, the providers agree to provide services or supplies at negotiated charges.

When you enroll in the plan, you can access a directory of doctors and other providers who belong to the network. The directories are available by calling Anthem Customer Service or online at **anthem.com**. You may also search for network providers by using Castlight Health's website *mycastlight.com/rolls-royce*.

Important note: Doctors and other health care providers join and leave the network from time to time, so the provider directory may not contain the very latest information. You should confirm whether your provider is in the network before receiving services.

using in-network and out-of-network providers

When you need care, you have a choice. You can select a doctor or facility that belongs to the network (an in-network provider) or one that does not belong to the network (an out-of-network provider).

- ***If you use an in-network provider,*** you'll pay less out of your own pocket for your care. You won't have to fill out claim forms, because your in-network provider will file claims for you. You won't have to call for precertification of benefits because your in-network provider will make that call for you.
- ***If you use an out-of-network provider,*** you'll pay more out of your ***own*** pocket for your care. You'll be required to file your own claims and make the telephone call for any required precertification of benefits.
- Further information regarding in-network and out-of-network ***pharmacies*** is available from Express Scripts. You can access information on the internet at **express-scripts.com** or by calling Express Scripts at (800) 987-5248.

This summary shows how the Welfare Plan's level of coverage differs when you use in-network versus out-of-network providers. In most cases, you save money when you use in-network providers.

Important: All benefit maximums shown in *what the plan covers* are combined maximums between in-network and out-of-network care unless stated otherwise.

your primary care physician (PCP)

You may decide to choose a primary care physician ("PCP") for routine care such as checkups, health screenings and care for everyday health problems. A PCP can be a general practitioner, family practitioner, internist or pediatrician. You can choose a different PCP for each member of the family if you like. And you can change your PCP at any time.

You are not required to choose a PCP. But it's a good idea to have a PCP as your personal health care manager. He or she gets to know you and your special needs or problems, and keeps all the records for your care. Your PCP can also recommend a specialist when you need care that he or she can't provide. This can be very helpful since it's often difficult to choose the right specialist.

specialists

Specialists are doctors such as OB/GYNs, oncologists, cardiologists, allergists, chiropractors, neurologists or podiatrists. When you need specialty care, you can make an appointment directly with any network specialist. No referral is required.

If you decide to choose a PCP, he or she can help you find the right specialist when you need one.

centers of excellence

Centers of Excellence are hospitals and facilities that have been vetted and designated as high quality providers based on many factors including surgical outcomes, complication rates and re-admissions. Through Anthem, these high quality facilities and providers make up their **Blue Distinction Specialty Care**, which includes two levels of recognition. 1) **Blue Distinction Centers** that are healthcare facilities and providers recognized for their expertise in delivering specialty care; and 2) **Blue Distinction Centers+** that are healthcare facilities and providers evaluated on cost as well.

For certain procedures, you may be required to use a **Blue Distinction Centers or Blue Distinction Centers+** provider or other center of excellence. Please contact Anthem for more details.

deductible

Before the Welfare Plan begins to pay for medical benefits, you must first meet the deductibles shown below.

If you have individual coverage, the plan will begin paying benefits after you have met your individual deductible. If you have family coverage, the plan will begin paying benefits once your family deductible has been met. The required annual deductible applies toward the out-of-pocket maximum.

The annual deductible does not apply to preventive (wellness) care or preventive medications (see below). Note also that charges for out-of-network care that are in excess of the maximum allowed amount may not be applied to satisfy the annual out-of-network deductible.

The minimum deductibles for high deductible health plans are determined by the IRS. Rolls-Royce monitors these requirements annually and makes adjustments as necessary to maintain compliance.

Active employee annual deductible:

Plan Year 2020		
coverage level	**in-network**	**out-of-network**
Individual	$1,400	$2,400
Family	$2,800	$4,800

Retiree annual deductible: (pre-65/pre-Medicare)

Plan Year 2020		
coverage level	**in-network**	**out-of-network**
Individual	$1,950	$2,400
Family	$3,900	$4,800

*Note: If you are a post- 65 retiree (or a Medicare-eligible retiree), you are not eligible to participate in the group medical plan described in this section. However, you are eligible for an annual reimbursement of $1,300 (or $2,600 if married) for you and your Medicare-eligible spouse toward eligible Medicare Supplement/Medigap and Advantage premiums. You are responsible for purchasing your Medicare Supplement plan. Refer to *Section 11 — Retiree Welfare Benefits* for more information on eligibility for retiree welfare benefits.

out-of-pocket maximum

Plan Year 2020		
coverage level	**in-network**	**out-of-network**
Individual	$3,000	$6,000
Family	$6,000	$12,000

You are responsible to pay the full maximum allowed amount until you reach your deductible. Once the annual out-of-pocket maximum has been met, the plan will pay 100% of the maximum allowed amount for the remainder of the calendar year.

coinsurance

Coinsurance is the percentage of eligible expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain covered services after you meet the annual deductible.

The table below illustrates your coinsurance under each Plan for common covered services.

coinsurance *after deductible*	**in-network**	**out-of-network**
the Plan pays	80%	60%
you pay	20%	40%

If you incur charges for covered services because you choose to go to an out-of-network provider, you will be responsible for 40% of the lesser of (1) the maximum allowed amount, or (2) the actual charges incurred after you meet the out-of-network deductible.

maximum benefits

The Welfare Plan does not have a lifetime maximum for benefit coverage. However, some specific plan provisions include annual or lifetime maximums for particular covered services.

covered services

doctor's office visit

doctor's office visit	in-network	out-of-network
	80% after deductible	60% after deductible

preventive care

Certain preventive care services are covered with no deductible or coinsurance when you utilize an in-network provider and the service is properly coded as preventive care. This means the Plan covers 100% of the maximum allowed amount these certain covered services provided by an in-network provider. Examples include annual physicals, annual well-woman exam, well child care. Additional preventive screenings and services may also be covered, depending on factors like your age and gender. If you see an out-of-network provider, your visit is subject to the deductible and copayments or coinsurance will apply

preventive care	in-network	out-of-network
	80% after deductible	60% after deductible

inpatient hospital coverage

Benefits for covered inpatient hospital expenses will be paid as follows for you and your eligible dependents.

inpatient hospital benefits	in-network	out-of-network
	80% after deductible	60% after deductible

Covered hospitalization expenses include:

- Semi-private room and board;
- Pre-admission testing;
- Medications provided while hospitalized;
- Other hospital supplies;
- X-rays and diagnostic tests; and
- Anesthesiology.

Note: This list is not all-inclusive. Please contact Anthem Customer Service at (888) 823-8576 for answers to your specific questions.

For information on mental health and alcohol/substance abuse coverage, see the section entitled *mental health and alcohol/substance abuse coverage*.

For information on radiology, anesthesiology, and pathology coverage see the section titled *in- and out-of-network medical coverage*.

Remember that if you decide to use out-of-network providers and you need to be admitted to the hospital, you must make sure that your inpatient care is pre-certified. If you do not notify Anthem Customer Service, a precertification penalty will apply. See the section entitled *precertification* for the details on precertification requirements.

For knee and hip replacement surgeries and spine surgeries, you may elect to use an Anthem Blue Distinction+ (BDC+) or Blue Distinction (BDC) Center of Excellence provider for additional benefits. Please contact Anthem to find out more about a Blue Distinction provider ***before services are rendered***. You may also find information about the Blue Distinction providers using Castlight.

surgeries	center of excellence	benefit coverage (after deductible)
knee replacement **hip replacement** **spine surgery**	Anthem's Blue Distinction+ or Blue Distinction	If you use a: - BDC+ or BDC provider: 90% coinsurance - In-network (non-BDC+ or BDC) provider: 80% coinsurance - Out-of-network provider: 60% coinsurance

outpatient hospital coverage

Benefits for covered hospital services and supplies provided to you and your eligible dependents when not admitted on a full-time inpatient basis will be paid as follows.

outpatient hospital coverage	in-network	out-of-network
	80% after deductible	60% after deductible

outpatient surgical facility coverage

Benefits for covered outpatient surgical expenses will be paid as follows for you and your eligible dependents:

benefits for outpatient surgical facility	in-network	out-of-network
	80% after deductible	60% after deductible

Covered outpatient surgical expenses include:

- Surgery center, hospital outpatient department, or physician surgical office visit expenses;
- Pre-operative testing;
- Medications provided by the facility;
- Other hospital supplies;
- X-rays and diagnostic tests; and
- Anesthesiology.

In order to be considered for benefit coverage, outpatient surgical procedures performed at a surgery center or hospital outpatient facility must meet the following requirements:

- The procedure is not expected to result in extensive blood loss, require major or prolonged invasion of a body cavity, or involve any major blood vessels; and
- The procedure can safely and adequately be performed only in a surgery center or in a hospital.

mental health and alcohol/substance abuse coverage

Mental health and substance abuse benefits are administered through a managed care program called **Beacon Health Options** which: (1) has a network of providers, and (2) promotes the delivery of care in appropriate settings.

Beacon Health Options has a toll free telephone number, which is available 24 hours a day. If you have any questions regarding your mental health/substance abuse coverage are looking for a network provider or need services, call **Beacon Health Options** at (**800) 335-7740**. **Remember**, you must use in-network providers to receive full benefits.

Remember that you must contact Beacon Health Options to pre-certify your care before benefits can begin.

Beacon Health Options will begin to pay benefits after you satisfy your deductible. This is the same deductible and out-of-pocket maximum as for other medical expenses. There is not a separate mental health and substance abuse deductible or out-of-pocket maximum.

If you use a Beacon Health Options network provider, they will file the claims on your behalf. If you use a non- network provider, you will be responsible for filing the claims and paying a larger percentage of the fees. Out-of-network services are covered at 60% after the deductible has been satisfied.

Beacon Health Options is an integrated mental health and substance abuse delivery system, which uses:

- ❑ a network of central diagnostic and referral agencies (CDRs) located in most communities. The CDRs are responsible for making assessments required under the Welfare Plan for the development of substance abuse continuing care treatment plans. In addition, they make determinations regarding whether the patient's condition requires mental health and/or substance abuse treatment. The CDRs also make referrals to panel providers, provide short term counseling (up to two visits) and perform aftercare planning and follow up. In addition, CDRs may provide up to three short-term counseling sessions for employees. The CDR may communicate with Employee Assistance Program representatives about assessment and referral activities related to an employee, where appropriate, and when authorized by the employee;

- ❑ a limited nationwide network of inpatient and outpatient mental health and substance abuse professionals, including psychiatrists, Ph.D. psychologists, masters degreed and licensed psychiatric social workers, clinical nurse specialists, hospitals, day/night programs, halfway houses, and detoxification facilities;

The coverage is structured in such a way that every participant will have access to in-network providers.

When you contact Beacon Health Options to receive mental health or substance abuse care, you will be referred to a CDR. The CDR will:

- ❑ assist with decisions about whether the patient's condition requires mental health and/or substance abuse treatment;
- ❑ make referrals to in-network providers;
- ❑ provide short term counseling (up to two visits; three visits for employees);
- ❑ authorize psychological testing (testing visits are not counted against the outpatient visit maximum);
- ❑ perform aftercare planning and follow up;
- ❑ exercise managed care protocols after a total of six outpatient visits and monitor treatment plan(s) to assure appropriate coordinated care; and
- ❑ exercise managed care protocols for treatment for eating disorders, with any alternative benefit plan being limited to the dollar pool created using the 45-day inpatient benefit.

The CDR may communicate with Employee Assistance Program representatives about assessment and referral activities related to an employee, where appropriate, and when authorized by the employee;

The following table provides an overview of your mental health and substance abuse **in-network** benefits. Eligible expenses charged by in-network providers apply to both your medical in-network deductible and out-of-pocket maximum.

<table>
<tr><th></th><th>Mental Health</th><th>Substance Abuse</th></tr>
<tr><td rowspan="2">Outpatient treatment</td><td>Paid at 80%, after deductible</td><td>Paid at 80% after deductible</td></tr>
<tr><td colspan="2">❑ each visit by one or more members of your family for family counseling counts as one (1) visit toward the outpatient treatment maximum.</td></tr>
</table>

	Mental Health	Substance Abuse
Inpatient hospital treatment (Mental Health or Substance Abuse)	45 days combined mental health/substance abuse care covered at 80% after deductible ❑ each day of care reduces the number of available units of day or night care by 2	
Day or night care treatment program	90 days or nights combined mental health/substance abuse care covered at 80% after deductible ❑ each unit of care (day or night) reduces the number of available inpatient treatment days by ½ day	
Skilled nursing facility treatment	90 days per benefit period covered at 80% after deductible ❑ each two days of skilled nursing care reduces the number of available inpatient hospital treatment days by 1	None
Substance abuse halfway house treatment program	Not applicable	90 days per patient lifetime covered at 80% after deductible

A new benefit period begins after you have gone without care for your mental health or substance abuse issue for a continuous period of 60 days. There must be a period of at least 60 consecutive days between the date of your last discharge from any hospital, skilled nursing facility, residential care facility or any other facility to which the 60-day benefit renewal period applies and the date of the next admission, even if no benefits are paid for such admission. If you receive any services as a patient of a psychiatric or substance abuse halfway house, hospice program or home health care program during that 60-day period, you will not start a new benefit period, even if benefits are not paid for these services.

> *For example:* You are admitted to a skilled nursing facility for mental health treatment for 90 days (the maximum period per benefit period). Fifty-nine days after your discharge from the skilled nursing facility, you begin receiving home health services. Because you didn't go 60 days without treatment, you do not start a new benefit period, and will not be eligible for more skilled nursing facility treatment during that same benefit period.

If you use a Beacon Health Options network provider, they will file the claims on your behalf. If you use a non- network provider, you will be responsible for filing the claims and paying a larger percentage of the fees. Out-of-network services are covered at 60% after the deductible has been satisfied. Non-network claims should be sent to:

Beacon Health Options
PO Box 1854
Hicksville, NY 11802-1854

exclusions and penalties (mental health and substance abuse)

Benefits are not available for:

- ❑ treatment of mental disorders that are not amenable to improvement (except that coverage is available to determine that the disorder is not amenable to favorable modification)
- ❑ for the evaluation and diagnosis of mental deficiency

The focus of the substance abuse treatment coverage is to assist employees (and their dependents) in recovering. Toward this end, if an employee discontinues his/her treatment plan, there will be a warning issued for the first occurrence. For the second occurrence, up to $500 will be recovered from the employee as an overpayment. For a third occurrence, up to $750 will be recovered, and for a fourth or subsequent occurrence, up to $1,000 will be recovered. Such overpayments will be recovered from the employee through cash payments or deductions from wages, or deductions from non-pension wage replacement benefits.

Note that beginning January 1, 2021, Mental Health and Alcohol/Substance Abuse coverage will be provided through Anthem Behavioral Health.

prescription drug coverage

The Basic Choice HDHP includes prescription drug benefits through Express Scripts. Prescription drug pharmacy benefits are administered separately by the pharmacy benefits claims administrator, Express Scripts. Benefits include prescription drugs you receive on an outpatient basis (at a pharmacy or through the Mail Order program, and on an inpatient basis (in the hospital).

You can fill your covered prescriptions at a national network of pharmacies and pay only the coinsurance/copayment amounts shown below once you (and enrolled dependents, if applicable) meet the plan's annual deductible.

outpatient prescription drug benefits

The following chart illustrates the benefits for prescription drugs that you receive at a participating Express-Scripts pharmacy and through the Mail Order program.

	You pay…
Preventive drugs*	
ACA preventive drugs	You pay $0
HDHP preventive drugs	You pay applicable coinsurance or copay; not subject to deductible
Retail: up to a 30-day supply	
Generic	$10 copay after deductible
Brand name	$20 copay after deductible
Non-preferred brand	$35 copay after deductible
Mail service: 31 – 90-day supply or pick up at an Express Scripts retail pharmacy (90-day supply only)	
Generic	$15 copay after deductible
Preferred brand	$25 copay after deductible
Non-preferred brand	$40 copay after deductible

NOTE: Due to IRS regulations, outpatient prescription drug coverage has been divided into two groups: Preventive Care Drugs and Non-Preventive Care Drugs.

inpatient prescription drug coverage

For inpatient stays in a hospital, convalescent center, hospice or other covered facility, prescription drug benefits are covered in the same manner as all other eligible inpatient expenses, and subject to any deductibles and copayments that may apply.

preventive drugs

Certain preventive prescription drugs are not subject to the deductible or are available at no cost to you. Preventive drugs include – but are not limited to – some medications for preventing hypertension (high blood pressure), diabetes, heart disease, osteoporosis, asthma, stroke and pregnancy problems. If you take a prescription drug that's classified as preventive, the plan makes those drugs more affordable. There are two categories of preventive drugs:

- **$0 cost to you –** The Affordable Care Act ("ACA") makes certain preventive medications available to you at no cost. For example, aspirin, folic acid, iron supplements, and smoking cessation products. Coverage is generally based on age and gender. The plan pays the full cost of these drugs.
- **Available for copay/coinsurance amount** – These preventive medications are not counted in applying the plan deductible. Instead, you pay the applicable copayment or coinsurance amount, which is applied to your out-of-pocket maximum.

In most cases you will be charged the applicable copay or coinsurance payment (including minimums and maximums) when you fill a prescription for those drugs. (Please contact Express-Scripts for a list of preventive prescription drugs.)

Coverage, ages, and population (i.e., women, men, adult, child) may vary. The below list should be used as a guide and is not a comprehensive list. This list is subject to change as Affordable Care Act (ACA) guidelines are updated or modified. Contact Express-Scripts for coverage details, including limitations.

- ❑ Aspirin;
- ❑ Breast cancer prevention;
- ❑ Colonoscopy preparation agents;
- ❑ Contraceptives;
- ❑ Fluoride supplements;
- ❑ Folic acid supplements
- ❑ Antiretroviral therapy (effective 1/1/2021);
- ❑ Immunizations (vaccines);
- ❑ Statins; and
- ❑ Tobacco cessation products.

Non-Preventive Care Drugs will be subject to the health plan deductible before the coinsurance/copayments above apply. Until the deductible is met, you will be responsible for paying for the Non-Preventive Care Drug cost in full, but may use your HSA.

If you utilize an out-of-network pharmacy or have to pay for a prescription out-of-pocket, you will be reimbursed by Express Scripts. Prescription drug reimbursement forms are available by contacting a Union Benefit Representative.

For maintenance prescriptions (that is, those prescriptions you need on a regular basis to treat an ongoing condition), the Mail Order program provides a larger supply of medication at a reduced cost.

At a retail pharmacy, generally you will receive a 30-day supply. When you use the Mail Order program, generally you will receive a 90-day supply.

mandatory generic substitution

Use of generic medications is mandatory if there is a generic equivalent. Your payment is lowest when you use generic drugs. A generic drug is a lower cost alternative that contains the same ingredients and provides the same therapeutic benefits as the equivalent higher-cost brand-name drug. Generic drugs become available when brand- name drug patents expire.

Prescription drug benefits also cover brand-name drugs. The amount of your payment for brand-name drugs depends on if the drug you need is on the "formulary." A formulary is a list of prescription drugs that have been evaluated and selected by Express Scripts clinical pharmacists for their therapeutic equivalency and efficacy. The formulary includes both brand-name and generic drugs and is periodically reviewed and modified by Express Scripts. You may find the most current formulary on **express-scripts.com**.

how mandatory generic substitution works

Each time you have a prescription for a brand-name drug, the pharmacy and Express Scripts will check to see if an equivalent generic drug is available.

- ❑ If so, you will receive the lower-cost generic drug substitute instead of the brand-name drug. This means a lower payment for you.
- ❑ If for medical reasons your doctor indicates that your prescription should be dispensed exactly as written on the prescription form, you will receive the brand-name drug and pay the higher amount.
- ❑ If you elect to purchase a brand name drug when there is a generic available, and your doctor has not said to dispense the medication as written, then you will receive the brand-name drug and pay double the brand coinsurance / copay.

To find out if a particular drug is preferred, log onto **express-scripts.com** or call Express Scripts at (800) 987- 5248.

maintenance medications

Maintenance prescriptions (also known as "long-term medicine") are those prescriptions that you take on a regular basis to control symptoms or to prevent complications from a condition. There are two ways to purchase maintenance medications under through Express Scripts:

- ❑ **90-day supply at the pharmacy**: You can purchase a 90-day supply of a maintenance medication at the pharmacy in one visit. The payment will be two and half times the normal retail prescription cost.
- ❑ **Mail order program**: You can use Express Scripts' mail order drug program and have a 90-day supply of your maintenance medication mailed directly to your home and pay less than you would to fill the prescription at the

pharmacy. This method will save you money, but will require you to get a new prescription slip for a 90-day supply from your doctor. The Express Scripts Mail Order form is available on the Express Scripts website at **express-scripts.com**.

opioid management program

Opioids are powerful drugs that help patients with certain medical conditions including severe and chronic pain. If used properly, they provide many benefits to the patient. However, these drugs are also addictive and if not managed properly can cause problems for the patients who use them. Express Scripts provides Rolls-Royce with a comprehensive Opioid Management Program.

exclusions: prescription drugs that are not covered

- non-federal legend drugs;
- allergy serum;
- biologicals, blood or blood plasma products;
- contraceptive jellies, creams, or foams;
- diabetes watches and sensors;
- drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only;
- immunization agents and vaccines;
- ostomy supplies;
- pediatric fluoride vitamins for covered persons age 15 and older;
- progesterone receptor modulators;
- therapeutic devices or appliances;
- topical fluoride products;
- drugs labeled “caution limited by federal law to investigational use” or experimental drugs, even though a charge is made to the covered person;
- medication for which the cost is recoverable under any workers’ compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the covered person;
- medication which is to be taken by or administered to the covered person, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician’s original order; and
- charges for the administration or injection of any drug. (This benefit is covered under the Plan’s medical benefits when administered in a doctor’s office.)

in- and out-of-network medical coverage

It is advantageous to use network providers whenever possible. However, there are certain covered services for which network providers are not available. Additionally, some services are covered on an in-network basis only.

The following chart outlines the Welfare Plan benefits for the listed services.

service	BASIC CHOICE HDHP	
	in-network	out-of-network
Pap smears (covered as part of wellness benefits)	100%	60% after deductible
Mammograms (covered as part of wellness benefits)	100%	60% after deductible
Outpatient Radiology (x-rays, radium & radioactive isotope therapy) **Outpatient Anesthesiology** (anesthetics and oxygen) **Outpatient Pathology** (diagnostic lab work)	80% after deductible 80% after deductible 80% after deductible	60% after deductible 60% after deductible 60% after deductible
Outpatient Physical, Occupational, or Speech Therapy	80% after deductible	60% after deductible
Chiropractic care (20 visits per year maximum)	80% after deductible	60% after deductible
Private duty nursing (RN or LPN) $50,000 per year maximum	80% after deductible	60% after deductible
Professional ambulance services	80% after deductible	60% after deductible
Durable medical equipment	80% after deductible	60% after deductible
Medical Supplies	80% after deductible	60% after deductible
Surgical Equipment	80% after deductible	60% after deductible
Artificial limbs and eyes	80% after deductible	60% after deductible

emergency services coverage

Whether you or your covered dependents are at home or away from home, the Welfare Plan covers medical emergencies. A medical emergency is defined as the sudden onset of a serious, possibly life threatening condition requiring immediate medical or surgical care. Examples of emergencies include heart attacks, loss of breathing, loss of consciousness, severe bleeding, broken bones, poisoning, and extreme fever.

Note: This list is not all-inclusive. Please call Anthem Customer Service to answer any specific questions you may have.

The following chart illustrates plan benefits for emergency services:

benefits for emergency services	in-network	out-of-network
emergency room visit	80% after deductible	80% after deducible; or 60% after deductible if not true emergency
urgent care center visit	80% after deductible	80% after deductible; or 60% after deductible if not true emergency

convalescent facility coverage

The Welfare Plan provides benefits for covered convalescent facility expenses in connection with recovery from a disease or injury.

	in-network	out-of-network
benefits for convalescent facility coverage	80% after deductible	60% after deductible
	Maximum of 120 days of coverage per convalescent period (combined in- and out-of-network benefits)	

To be eligible for benefits, the stay must begin during a convalescent period during which:

- the patient is an inpatient in a hospital for at least three consecutive days while covered under the Welfare Plan for treatment of a disease or injury;

- the patient is admitted to the convalescent facility within 14 days after discharge from the hospital; and
- the services received in the convalescent facility are needed to convalesce from the condition that caused the hospital stay. These include skilled nursing and physical restorative services.

A new convalescent period begins only after the patient has been out of the hospital or convalescent facility for at least 90 consecutive days.

Covered expenses include:

- Semi-private room and board;
- Special treatment rooms;
- X-ray and lab work;
- Physical, occupational, and speech therapy;
- Oxygen and other gas therapy; and
- Medical supplies.

convalescent facility exclusions

- Treatment for substance addiction, alcoholism, chronic brain syndrome, senility, mental retardation and any other mental disorder;
- Private duty or special nursing; and
- Physician's services.

hearing aid coverage

Beginning January 1, 2021, hearing aid coverage will be available, subject to the deductible and coinsurance. Employees will be responsible to pay for their hearing aids until they have met their deductible.

After the deductible is met, Rolls-Royce will cover the cost of the hearing aids up to an amount that is reasonable and customary according to the provider of the service. For Plan Year 2020, Anthem's reasonable and customary rate is $2,713. Participants must receive services from an in-network provider in order to be eligible for reimbursement. Benefits for hearing aids are limited to once in a 36 month period.

home health care coverage

Benefits for covered home health care expenses will be paid as follows for you and your eligible dependents:

	in-network	**out-of-network**
benefits for home health care	80% after deductible	60% after deductible
	Maximum of 120 visits/year (combined in- and out-of-network visits)	

To qualify for coverage, home health care must be:

- Administered by a home health care agency;
- Provided as part of a home health care plan; and
- Provided in the covered individual's home.

Covered expenses include:

- Part-time or intermittent care by an RN, or by an LPN if an RN is not available;
- Part-time or intermittent home health aide services for patient care;

- Physical, occupational, and speech therapy; and
- Medical supplies, drugs and medicines prescribed by a physician; and lab services provided by or from a home health care agency (to the extent they would have been covered under the Welfare Plan if the individual had been confined in a hospital or convalescent facility).

home health care exclusions

- Services or supplies that are not part of a home health care plan;
- Services of an individual who usually lives with you or is a member of your or your spouse's family;
- Services of a social worker; and
- Transportation expenses.

Contact Anthem Customer Service for information on certain limitations.

hospice coverage

Benefits for covered hospice care expenses will be paid as follows for you and your eligible dependents if terminally ill:

benefits for hospice	in-network	out-of-network
	80% after deductible	80% after deductible

inpatient benefits

The Welfare Plan pays 80% of the maximum allowed amount after the deductible has been satisfied.

outpatient benefits

The Welfare Plan pays 80% of the maximum allowed amount after the deductible has been satisfied.

bereavement counseling

The Welfare Plan pays 80% of the maximum allowed amount after the deductible has been satisfied. Benefits are limited to a maximum of $200 for services incurred within six months of the patient's death, combined with in-network benefits.

Covered expenses include:

- Facility expense: charges incurred at a hospice facility, hospital, or convalescent facility at not more than the semi-private room rate;
- Other services and supplies furnished to an individual while a full-time inpatient for pain control, and other acute and chronic symptom management;
- Charges made by a hospice care agency for part-time or intermittent nursing care by a RN or LPN for up to eight hours in any one day;
- Medical social services under the direction of a physician, including assessment of the individual's social, emotional, and medical needs and the home and family situation; identification of the community resources available to the individual as well as assisting the individual in obtaining such services;
- Psychological and dietary counseling;
- Consultation of case management services by a physician;
- Physical and occupational therapy;
- Part-time or intermittent home health aide services for up to eight hours in any one day; and
- Medical supplies, drugs, and medicines prescribed by a physician.

Bereavement counseling for covered family members within six months of the patient's death.

precertification

Precertification is required for all inpatient admissions and durable medical equipment (including those for any mental health and/or substance abuse treatment).

If an in-network provider coordinates your admission, that provider will handle all the precertification requirements for you. If you use an out-of-network provider, it will be your responsibility to meet the precertification requirements. The following table illustrates the details you need to know about precertification with Anthem and Beacon Health Options (which coordinates precertification for inpatient admissions involving mental health and substance abuse treatment). If you are uncertain about precertification requirements, contact Anthem at the number printed on your ID card or Beacon at (800) 335-7740.

precertification requirements	in-network	out-of-network
what you need to do:	nothing – Your network provider handles all the details	as soon as you know about your upcoming admission, you should call the Anthem Pre-certification number on your ID card. Or, in the case of mental health and/or substance abuse treatment, call Beacon Health Options at (800) 335-7740. A representative will work with you and your doctor.
what happens if you don't call Anthem	nothing – Your network provider handles all the details.	the maximum allowable amount will be reduced by 20% if services are not precertified.

In an emergency: If you or your covered dependents are hospitalized, you or someone on your behalf must notify Anthem within 48 hours so that your admission can be reviewed and your ongoing care can be pre-certified. If your hospitalization occurs on a Friday or during a weekend, notify Anthem within 72 hours. Anthem's number is located on your Anthem ID card.

exclusions and limitations

As with all medical plans, some items are NOT considered covered expenses. Please see the *exclusions and limitations* section for a general list of exclusions under this medical plan.

health savings account (HSA)

Participants in the Basic Choice High Deductible Health Plan ("HDHP") may also participate in a Health Spending Account ("HSA"). An HSA is a tax-exempt trust or custodial account established by an eligible individual to pay for current and future medical expenses, including during retirement. You can only contribute to an HSA when you are enrolled in a high-deductible health plan such as the Basic Choice High Deductible Health Plan. Contributions to the HSA must be made in cash and may not exceed certain annual limits.

You may use the money from your HSA to pay for eligible out-of-pocket health care expenses that you incur during the year on or after you establish your account. If you don't use all the funds in your HSA by the end of the year, any unused balance will be carried forward to the following year. In addition, your HSA is "portable", which means your account is always yours, even if you leave the Company or retire.

HSA triple tax advantage

The HSA is a tax-favored savings account designed to pay for current and future medical expenses. An HSA provides triple tax advantages:

- Contributions into the account are tax-free (whether made by the employee or the employer);
- Earnings are tax-free; and
- Distributions are tax-free provided they are for qualified medical expenses for an eligible individual and his or her eligible dependents.

other important features of an HSA

- If you use your HSA to pay for non-qualified medical expenses, those expenses will be included in your gross income (so they will be taxed) and a 20% tax penalty will be applied.
- Unused account balance will be carried forward from year-to-year.
- Unused account balance is non-forfeitable and may be rolled over to another HSA (post-employment portability).

HSA eligibility

In order to be eligible to participate in the HSA, you:

- must be enrolled in a qualified high deductible medical plan;
- must not be covered by any other medical plan other than an IRS-qualified high deductible medical plan, even if it is another family member's coverage;
- must not participate in, be eligible for reimbursement under, or receive reimbursement from a general purpose health care Flexible Spending Account ("FSA"), including as a dependent under your spouse's employer's FSA (even if you are not covered under your spouse's medical plan); however, you or your spouse can be enrolled in a limited purpose Flexible Spending Account.
- must not be enrolled in any Medicare plan;
- must not be enrolled in TRCARE;
- must not have received Veterans Administration ("VA") benefits within the past three months (preventive care, dental and vision services are permitted); and
- must not be claimed as a dependent on another person's tax return.

A participant or eligible family member turning 65 or disabled and enrolled in Medicare Part A and/or B are not eligible to contribute to the HSA. (If you are eligible for Medicare, but not enrolled, contributions can still be made to the HSA.)

When both the employee and spouse work for the Company, if only one spouse is covered by the Basic Choice HDHP, and the other is covered by a non-high deductible health plan, both are disqualified for coverage under the family plan. If only one spouse is a participant, only that spouse can contribute to the HSA. If both have qualifying high deductible health plan coverage, the lowest deductible is used to determine contribution limits.

HSA at-a-glance

Benefit detail	
Rolls-Royce contributions	Up to $1,200 automatic contribution depending coverage tier
Minimum	Not applicable
Maximum*	$3,550 or $7,100 depending on coverage tier
Expense type	Medical, dental and vision
Additional information	Must be enrolled in a high deductible health plan
Common qualified expenses	Deductible, copays and coinsurance, other health care expenses

** Maximum limits apply to plan year 2020 and may change, subject to IRS limit adjustments.*

HSA contributions

If you enroll in the Basic Choice HDHP and qualify to make and receive HSA contributions, both you and Rolls-Royce may contribute to your HSA. Contributions are limited to the IRS limits set for a given year. For Plan Year 2020, the IRS limit for individual coverage is $3,550 and the family tier limit is $7,100. You can contribute up to IRS annual limit, which includes Rolls-Royce's contributions.

The law allows for an additional $1,000 "catch-up" HSA contribution for those participants age 55 or older (or turning age 55 during the tax year). Additional catch-up contributions are permitted up to the otherwise applicable IRS maximum.

Once you enroll for Medicare coverage, neither you nor the Company can make contributions to your HSA. However, you may still use the available funds in your HSA for eligible expenses even after you enroll in Medicare.

Your HSA is funded in the following three ways:

1. **Your contributions.** You also can contribute to your HSA. Contributions to your HSA have no expiration date – they remain in the account until you decide to access them or reimburse yourself for an eligible expense you already paid out-of-pocket. You decide when and how to pay.

2. **Rolls-Royce annual automatic contribution** (pro-rated based on your benefits effective date or plan eligibility)

Rolls-Royce will make a contribution to your HSA on a pro-rated basis, based on your HSA enrollment date. If you enroll in:

- individual coverage: Rolls-Royce contributes $600 to your HSA for active employees ($1,200 for pre-65 retirees).
- family coverage: Rolls-Royce contributes $1,200 to your HSA for active employees ($2,400 for pre-65 retirees).

The Rolls-Royce contribution to the HSA will be made in a lump sum as soon as administratively possible you elect the benefit plan or complete the incentive activity. The Rolls-Royce initial contribution will be pro-rated if you are not covered for the full calendar year.

3. **Incentives.** You and your covered spouse may complete designated health activities to earn incentives. The Company will contribute up to $600 for individual coverage and $1,200 for family coverage) into your HSA each year. To earn the annual incentive, you and your spouse (if applicable) must complete and record the health activities. The Company will fund your HSA with earned incentives dollars as soon as administratively possible after the activity is recorded.

The amount contributed by the Company is included in your IRS limit, so it reduces the amount you can contribute to your HSA. You must be covered under Rolls-Royce's high deductible medical plan in order to participate in the HSA and be eligible for Company incentives.

How much you can contribute to your HSA:

Coverage Tier	IRS limit*	Rolls-Royce automatic contribution	Incentive opportunity	Your allowed annual goal IF you complete incentives**
Employee only	$3,550	$600	$600	$2,350
Employee + spouse	$7,100	$1,200	$1,200	$4,700
Employee + child(ren)	$7,100	$1,200	$1,200	$4,700
Family	$7,100	$1,200	$1,200	$4,700

Employees age 55 or older (or who turn 55 during the Plan Year) can contribute an additional $1,000.
** IRS limit includes full incentive.*
*** Does not include $1,000 catch up contribution, if applicable.*

Effective January 1, 2021, Rolls-Royce will pay incentive dollars the year after they are earned. Also beginning in 2021, the designated health activities for incentives are as follows:

- wellness physical;
- dental exam; and
- online health course.

Plan Year	Complete health activities between	Your deadline to report your activity	Rolls-Royce deposits earned incentives:
2020	Jan. 1, 2020 – Dec. 31, 2020		as soon as administratively possible in 2020
2021	Jan. 1, 2020 – Dec. 31, 2020	Jan. 31, 2021	in the first quarter of the following calendar year

You are responsible to monitor your year-to-date contributions to ensure you do not exceed the IRS limit. Rolls-Royce will not deposit earned incentives that will exceed your allowed IRS limit; and, Rolls-Royce will not pay the excess to you in cash.

HSA funds are invested in a fixed-interest account that earns interest.

HSA distributions

Distributions for "qualified medical expenses" are made from the HSA tax-free by using the HSA debit card provided by UMB. Medical expenses are only eligible for reimbursement if they were incurred after the date the HSA was established. Eligible HSA expenses are not eligible for reimbursement by insurance.

Health insurance premiums are not eligible to be paid tax-free from an HSA, except for the following types of coverage:

- COBRA premiums;
- Coverage while receiving unemployment compensation; and
- Long-Term Care.

You may use your HSA for qualified medical expenses as allowed by the IRS. Some expenses may not be covered by your benefit plan, but are considered "qualified expenses" for payment with HSA dollars.

The following list provides some typical examples. For a complete list of IRS-allowable expenses, you can request a copy of IRS publication 502 by calling the IRS at (800) 829-3676 or visit the IRS website at **irs.gov** and click on "Forms and Publications".

Allowable expenses	Expenses that are not allowed
• Deductibles, copayments, and coinsurance • Diagnostic services not covered by the plan • LASIK surgery, glasses or contact lenses • Dental and orthodontic services • Some nursing services • Hearing aids • Wheelchairs • Organ transplants • Over-the-counter drugs without a prescription	• Cosmetic surgery • Health club dues • Nutritional supplements

Please note, Rolls-Royce is not required to determine whether an HSA distribution is used for qualified medical expenses. The IRS has determined that is the responsibility of the individual who is participating in the plan.

To learn more about eligible HSA expenses, review *IRS Publication 502*. There are specific requirements for opening an HSA and making contributions to it as described under the *HSA eligibility* topic.

Non-qualified distributions are included in the participant's gross income and an additional 20% tax penalty applies.

The 20% tax penalty does not apply to:

- Distributions at death;
- Distributions after Medicare-eligibility;
- Distributions after disability;
- Return of excess contributions; or
- "Rollover" to another HSA within 60 days of receipt (once per 12 months).

An HSA may be transferred tax-free to a spouse due to divorce, separation agreement or at death. Other transfers at death may result in taxable income to the recipient.

how to enroll

If you enroll in the Basic Choice HDHP offered through the Welfare Plan, you are automatically eligible for an HSA (unless you are enrolled in Medicare, TRICARE or are otherwise not eligible for HSA contributions as described in the *HSA eligibility* topic). Please contact your UAW representative to open an HSA.

To receive Rolls-Royce contributions or make your own contributions, you must open your Fidelity account.

Step 1: As part of the enrollment process, you will have the opportunity to elect your HSA annual goal — the amount you want to contribute for the calendar year. This amount will be divided by the number of pay periods remaining in the year (e.g., 52 for one year or a fraction of 52 if you enroll mid-year).

Step 2: Open your Fidelity HSA by going to **netbenefits.com**.

Even if you elect to have HSA contributions deducted from you paycheck, IRS requirements do not allow you to receive reimbursement for eligible expenses until you establish your HSA.

Once your account is established, you can go to **netbenefits.com** to manage your HSA, including designating a beneficiary.

HSA frequently asked questions

How do I pay for medical expenses using my HSA?

If you are enrolling the HSA for the first time, you will receive a welcome letter with your HSA card seven to 10 business days after you open your HSA with Fidelity. Use this card to pay for eligible medical expenses. Each time you use your HSA card, your HSA is debited accordingly. You don't need to file claims, but it's recommended that you save your receipts for tax purposes. If you prefer, you can pay for expenses with a check.

Can I change the amount I am currently contributing to my HSA?

You can change your contribution amount at any time by contacting your UAW representative who will assist you in making the desired change.

How can I check my HSA balance?

To view your current HSA balance, log on to your account at **netbenefits.com** or call the Rolls-Royce Benefits Center at (844) 625-5900 (select Option 2 for HSA).

What happens if I have a medical expense that costs more than the amount in my HSA?

An HSA is similar to a checking account — the amount you can spend is limited to the amount in your account. Thus, if medical treatment costs $250, but you only have $200 in your HSA, you will need to pay $50 out of pocket. You can reimburse yourself for medical expenses you pay out of pocket from your HSA if you like. See Fidelity's website for more details.

What happens if I have money in my HSA at the end of the year?

Money in your HSA will roll over to the next year. The funds in an HSA do not expire at the end of the year. You can build up a balance in your HSA for future health care expenses and earn interest as well.

When will my payroll contribution post to my HSA?

It takes approximately four to five business days after the pay date for contributions to post to your HSA.

Blue Cross Blue Shield
PPO and EPO

eligibility

You are eligible for EPO/PPO coverage if you are:

- ❑ an active employee as of January 1, 2012 who retained the PPO/EPO coverage; or
- ❑ a retiree who retired under the Pension Plan, is under the age 65 (and not otherwise eligible for Medicare), and retained the PPO/EPO coverage;
- ❑ a retiree who retired under the Pension Plan on or after January 1, 2012, is under the age 65 (and not otherwise eligible for Medicare), and retained the PPO/EPO coverage.

If you are not currently enrolled in either the EPO or PPO plans, you are not eligible to enroll as neither plan is open to new enrollments.

If you are an eligible retiree, please refer to *Section 12 — Retiree Welfare Benefits* for further information concerning your rights and entitlements under this

how the ppo and epo plans work

This section applies to current participants enrolled one of the following plans:

- ❑ Preferred Provider Organization (PPO)
- ❑ Exclusive Provider Organization (EPO)

The EPO and PPO options provide comprehensive coverage, including doctor visits, hospital and surgical services, diabetes treatment, behavioral health services and prescription drugs. Certain preventive care such as physical exams and immunizations are free of charge. As with most health plans though, any related deductibles, copayments, coinsurance, per admission deductibles, non-covered services, non-network charges over and above the allowed amount, amounts above the plan limitations, and fees associated with not certifying non-network hospital admissions, are the responsibility of the member.

Descriptive materials concerning benefits provided under each option are available from your Union Benefits Representative. Although coverage may differ slightly under the various options, in general, covered expenses include the items detailed below. **This is a general description only and the applicable provisions of the Plan control your eligibility for coverage and specific benefits**.

Refer to the *explanation of certain terms applicable to health care coverage* for common plan term definitions.

plan highlights

Service	Your cost if you use an in-network Provider	Your cost if you use an out-of-network Provider
Out-of-pocket maximum	$1,800 single $3,600 family	EPO: no out-of-network coverage PPO: $4,800 single / $9,600 family
Office visits	20% coinsurance	EPO: not covered PPO: 20% coinsurance
Preventive Care	$0	Not covered
Diagnostic tests/ Imaging	20% coinsurance	EPO: not covered; PPO: 20% coinsurance
Emergency care	20% coinsurance	EPO: not covered; PPO: 20% coinsurance
Hospitalization (facility fee and physician charges)	20% coinsurance	EPO: not covered;

Service	Your cost if you use an in-network Provider	Your cost if you use an out-of-network Provider
		PPO: 20% coinsurance
Outpatient surgery (facility fee and physician charges	20% coinsurance	EPO: not covered; PPO: 20% coinsurance

Once the out-of-pocket maximum is met, the Plan pays 100% (excluding Rx) of the maximum allowed amount.

Preventive care includes: Well-children exams and immunizations as outlined by the American Academy of Pediatrics; annual physicals, Well-woman exams and age appropriate screenings and tests as outlined by the American Medical Association.

covered services

hospital coverage

Hospital coverage provides payment of charges for:

- ❑ up to 365 days of covered care in a semiprivate room in a hospital for general conditions, including maternity care;
- ❑ room, board, and all covered services in a non-psychiatric hospital, and full coverage for the first five days of emergency admissions;
- ❑ up to 730 days of medically necessary care (other than custodial care) in an approved skilled nursing facility for general conditions;
- ❑ most medical needs in a hospital, or approved facility, such as supplies, drugs, dressings, anesthesia, x-rays, laboratory tests, intensive care, and routine nursery care;
- ❑ most services in the outpatient department of a hospital, such as treatment of accidental injuries and certain medical emergencies, surgery, physical therapy (up to 60 treatments per condition per year, which also may be performed in an approved facility other than a hospital), and use of an artificial kidney machine, iron lung or similar equipment;
- ❑ medically necessary transfers by ground ambulance between hospitals, and for transfers from hospitals to facilities with approved CAT scan equipment (air and/or boat ambulance transportation is excluded);
- ❑ services provided by approved home health care programs, including payment for necessary skilled nursing and home health care aides;
- ❑ hospice services for terminally ill enrollees when provided through an approved hospice program; and
- ❑ a case management system to identify – and help avoid – unnecessary or prolonged hospital stays. This system may aid those with catastrophic or severe chronic medical conditions and is available on a voluntary basis.

medical and surgical coverage

Medical and surgical coverage provides payment of network negotiated charges for medically necessary services such as:

- ❑ surgery and anesthesia, including pre- and post-operative care;
- ❑ obstetrical delivery, including pre- and post-natal care;
- ❑ chiropractic services, ten visits per year;
- ❑ annual mammogram each year beginning with age 40;
- ❑ in-hospital consultation;
- ❑ in-hospital medical care by the doctor in charge of the case;

- ❑ doctor's medical visits, at the rate of two per week, for up to 730 days in an approved skilled nursing facility for general conditions;
- ❑ radiation therapy and chemotherapy for certain types of malignant conditions;
- ❑ organ transplants for certain organs;
- ❑ laser surgery which replaces a cutting procedure;
- ❑ necessary and appropriate diagnostic x-ray, laboratory and pathology services;
- ❑ laboratory testing for one routine PAP smear per calendar year;
- ❑ laboratory testing for prostate screening in accordance with guidelines established by the American Cancer Society;
- ❑ outpatient treatment of accidental injuries and certain medical emergencies;
- ❑ voluntary sterilization; and
- ❑ speech therapy for children under six with certain congenital and severe developmental speech disorders.

preventive care coverage

Routine preventive care, based on age and gender are covered at 100%, and include:

- ❑ well-children exams and immunizations as outlined by the American Academy of Pediatrics; and
- ❑ annual physicals, well-woman exams and age appropriate screenings and tests as outlined by the American Medical Association.

Additional preventive screenings and services may also be covered, depending on factors like your age and gender. If you see an out-of-network provider, your visit is subject to the deductible and copayments or coinsurance will apply

prosthetic and orthotic appliances and durable medical equipment coverage

Prosthetic and orthotic appliance and durable medical equipment coverage provides payment for covered appliances and equipment including:

- ❑ the purchase, fitting and repair of certain external prosthetic or orthotic appliances which replace a body part or the functions of a permanently malfunctioning body part (these appliances must be prescribed by a licensed physician and furnished and billed by a hospital or approved provider/supplier); and
- ❑ the rental or purchase of certain durable medical equipment (such as hospital beds, crutches, wheelchairs, portable insulin infusion pumps, home glucose monitors or bone growth stimulators) in appropriate cases and when prescribed by a licensed physician. This equipment must be required for the treatment of a medical condition and be provided and billed by a hospital, skilled nursing facility or approved professional provider.

prescription drug coverage

Both the EPO and PPO plans include prescription drug benefits through Express Scripts. Prescription drug pharmacy benefits are administered separately by the pharmacy benefits claims administrator, Express Scripts. Benefits include prescription drugs you receive on an outpatient basis (at a pharmacy or through the Mail Order program, and on an inpatient basis (in the hospital).

You can fill your covered prescriptions at a national network of pharmacies and pay copayment amounts shown below.

Benefits include:

- ❑ the purchase of drugs which require prescription by a licensed physician under federal law;
- ❑ injectable insulin and disposable syringes and needles when dispensed with the insulin; and/or
- ❑ disposable syringes and needles consistent with the prescribed supply of a covered anti-neoplastic agent.

outpatient prescription drug benefits

There are three ways to fill a prescription:

1. at the retail pharmacy with a 30 day supply;
2. at the retail pharmacy with a 90 day supply; or
3. through the mail order program with a 90 day supply.

The following chart illustrates the benefits for prescription drugs that you receive at a participating Express-Scripts pharmacy and through the Mail Order program.

	You pay…	
Preventive drugs*		
ACA preventive drugs	You pay $0	
Retail:	**up to a 30-day supply**	**90-day supply**
Generic	$10 copay	$17 copay
Preferred brand	$16 copay	$28 copay
Mail service: 31 – 90-day supply or pick up at an Express Scripts retail pharmacy (90-day supply only)		
Generic	$11 copay	
Brand (Both preferred/ & non-preferred)	$18 copay	

If prescription drugs are purchased from an **out-of-network** pharmacy, you will be required to pay the full charge. You then should file a claim with your assigned carrier

Drug quantities are limited to a maximum of a 34-day supply per prescription, except for certain maintenance drugs, which may be dispensed in 100 or 200 unit doses. Disposable syringes and needles are limited to a one month supply, when prescribed with a 1-month supply of insulin or, if greater, 100 syringes and needles, when prescribed with a three month supply of insulin.

preventive drugs

The Affordable Care Act ("ACA") makes certain preventive medications available to you at no cost. For example, aspirin, folic acid, iron supplements, and smoking cessation products. Coverage is generally based on age and gender. The plan pays the full cost of these drugs.

Coverage, ages, and population (i.e., women, men, adult, child) may vary. The below list should be used as a guide and is not a comprehensive list. This list is subject to change as Affordable Care Act (ACA) guidelines are updated or modified. Contact Express-Scripts for coverage details, including limitations.

- Aspirin;
- Breast cancer prevention;
- Colonoscopy preparation agents;
- Contraceptives;
- Fluoride supplements;
- Folic acid supplements;
- Antiretroviral therapy (effective 1/1/2021);
- Immunizations (vaccines);
- Statins; and
- Tobacco cessation products.

maintenance medications

Maintenance prescriptions (also known as "long-term medicine") are those prescriptions that you take on a regular basis to control symptoms or to prevent complications from a condition. There are two ways to purchase maintenance medications under through Express Scripts:

- **90-day supply at the pharmacy**: You can purchase a 90-day supply of a maintenance medication at the pharmacy in one visit. The payment will be two and half times the normal retail prescription cost.

- **Mail order program**: You can use Express Scripts' mail order drug program and have a 90-day supply of your maintenance medication mailed directly to your home and pay less than you would to fill the prescription at the pharmacy. This method will save you money, but will require you to get a new prescription slip for a 90-day supply from your doctor. The Express Scripts Mail Order form is available on the Express Scripts website at **express-scripts.com**.

mail order prescription drugs

If you are enrolled in the EPO or PPO option – the mail order prescription drug program is an option available to you any time you have a prescription to be filled. This program can be particularly helpful and cost effective when you require maintenance drugs over an extended period, or when you do not need to have a prescription filled immediately. Under the mail order program, you can expect to receive your prescription about two weeks from the time you mail your prescription. You will receive a 90-day supply per prescription. Please contact Express Scripts for information about the mail order program.

mandatory generic substitution

Use of generic medications is mandatory if there is a generic equivalent. Your payment is lowest when you use generic drugs. A generic drug is a lower cost alternative that contains the same ingredients and provides the same therapeutic benefits as the equivalent higher-cost brand-name drug. Generic drugs become available when brand- name drug patents expire.

The prescription benefit also covers brand-name drugs. The amount of your payment for brand-name drugs depends on if the drug you need is on the "formulary." A formulary is a list of prescription drugs that have been evaluated and selected by Express Scripts clinical pharmacists for their therapeutic equivalency and efficacy. The formulary includes both brand-name and generic drugs and is periodically reviewed and modified by Express Scripts.

how mandatory generic substitution works

Each time you have a prescription for a brand-name drug, the pharmacy and Express Scripts will check to see if an equivalent generic drug is available.

- If a generic drug is available, you will receive the lower-cost generic drug substitute instead of the brand-name drug. This means a lower payment for you.

- If for medical reasons your doctor indicates that your prescription should be dispensed exactly as written on the prescription form, you will receive the brand-name drug and pay the higher amount.

- If you elect to purchase a brand name drug when there is a generic available, and your doctor has not said to dispense the medication as written, then you will receive the brand-name drug and pay double the brand coinsurance / copay.

To find out if a particular drug is preferred, log onto **express-scripts.com** or call Express Scripts at (800) 987- 5248.

exclusions: prescription drugs that are not covered

- non-federal legend drugs;
- allergy serum;
- biologicals, blood or blood plasma products;
- contraceptive jellies, creams, or foams;
- diabetes watches and sensors;
- drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only;
- immunization agents and vaccines;
- ostomy supplies;

- pediatric fluoride vitamins for covered persons age 15 and older;
- progesterone receptor modulators;
- therapeutic devices or appliances;
- topical fluoride products;
- drugs labeled “caution limited by federal law to investigational use” or experimental drugs, even though a charge is made to the covered person;
- medication for which the cost is recoverable under any workers’ compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the covered person;
- medication which is to be taken by or administered to the covered person, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician’s original order; and

charges for the administration or injection of any drug. (This benefit is covered under the Plan’s medical benefits when administered in a doctor’s office.)

mental health and substance abuse treatment coverage

Mental health and substance abuse benefits are administered through a managed care program called **Beacon Health Options** which: (1) has a network of providers, and (2) promotes the delivery of care in appropriate settings.

Beacon Health Options has a toll free telephone number, which is available 24 hours a day. If you have any questions regarding your mental health/substance abuse coverage or need services, call **Beacon Health Options** at **(800) 335-7740**. **Remember**, you must use in-network providers to receive full benefits.

Beacon Health Options is an integrated mental health and substance abuse delivery system, which uses:

- a network of central diagnostic and referral agencies (CDRs) located in most communities. The CDRs are responsible for making assessments required under the Plan for the development of substance abuse continuing care treatment plans; and
- a limited nationwide network of inpatient and outpatient mental health and substance abuse professionals, including psychiatrists, Ph.D. psychologists, masters degreed and licensed psychiatric social workers, clinical nurse specialists, hospitals, day/night programs, halfway houses, and detoxification facilities;

The coverage is structured in such a way that every participant will have easy access to in-network providers.
When you contact Beacon Health Options to receive mental health or substance abuse care, you will be referred to a CDR. The CDR will:

- make decisions about whether the patient’s condition requires mental health and/or substance abuse treatment;
- make referrals to in-network providers;
- provide short term counseling (up to two visits; three visits for employees);
- authorize psychological testing (testing visits are not counted against the outpatient visit maximum);
- perform aftercare planning and follow up;
- exercise managed care protocols after a total of six outpatient visits and monitor treatment plan(s) to assure appropriate coordinated care; and

- ❑ exercise managed care protocols for treatment for eating disorders, with any alternative benefit plan being limited to the dollar pool created using the 45-day inpatient benefit.

The combined mental health/substance abuse coverage provides for:

<table>
<tr><th></th><th>Mental Health</th><th>Substance Abuse</th></tr>
<tr><td rowspan="2">Outpatient treatment</td><td>35 visits/year
❑ visits 1-20 paid at 100%
❑ visits 21-35 paid at 80%</td><td>35 visits/year
❑ paid at 100%</td></tr>
<tr><td colspan="2">❑ each visit by one or more members of your family for family counseling counts as one (1) visit toward the outpatient treatment maximum.</td></tr>
<tr><td>Inpatient hospital treatment</td><td colspan="2">45 days combined mental health/substance abuse care
each day of care reduces the number of available units of day or night care by two</td></tr>
<tr><td>Day or night care treatment program</td><td colspan="2">90 days or nights combined mental health/substance abuse care
❑ each unit of care (day or night) reduces the number of available inpatient treatment days by ½ day</td></tr>
<tr><td>Skilled nursing facility treatment</td><td>90 days per benefit period
❑ each two days of skilled nursing care reduces the number of available inpatient hospital treatment days by 1</td><td>None</td></tr>
<tr><td>Substance abuse halfway house treatment program</td><td>None</td><td>90 days per patient lifetime</td></tr>
</table>

A new benefit period begins after you have gone without care for your mental health or substance abuse issue for a continuous period of 60 days. There must be a period of at least 60 consecutive days between the date of your last discharge from any hospital, skilled nursing facility, residential care facility or any other facility to which the 60-day benefit renewal period applies and the date of the next admission, even if no benefits are paid for such admission. If you receive any services as a patient of a psychiatric or substance abuse halfway house, hospice program or home health care program, during that 60-day period, you will not start a new benefit period, even if benefits are not paid for these services.

> *For example:* You are admitted to a skilled nursing facility for mental health treatment for 90 days (the maximum period per benefit period). Fifty-nine days after your discharge from the skilled nursing facility, you begin receiving home health services. Because you didn't go 60 days without treatment, you do not start a new benefit period, and will not be eligible for more skilled nursing facility treatment.

exclusions and penalties (mental health and substance abuse treatment)

Benefits are not available for:

- ❑ treatment of mental disorders that are not amenable to improvement (except that coverage is available to determine that the disorder is not amenable to favorable modification);
- ❑ the evaluation and diagnosis of mental deficiency or retardation;
- ❑ out-of-network treatment for substance abuse; and
- ❑ mental health services provided by out-of-network, non-physician providers (psychologists, social workers, etc.).

The focus of the substance abuse treatment coverage is to assist employees (and their dependents) in recovering. Toward this end, if an employee discontinues his/her treatment plan, there will be a warning issued for the first occurrence. For the second occurrence, up to $500 will be recovered from the employee as an overpayment. For a third occurrence, up to $750 will be recovered, and for a fourth or subsequent occurrence, up to $1,000 will be recovered. Such overpayments will be recovered from the employee through cash payments or deductions from wages, or deductions from non-pension wage replacement benefits.

emergency care (mental health and substance abuse treatment)

If mental health or substance abuse services are provided due to an emergency, then the provider must contact the CDR to receive authorization within 24 hours.

out-of-network mental health services

If outpatient mental health services are rendered by an out-of-network physician, then the first visit will be covered. Any additional visits must be authorized by the CDR. Unauthorized visits to an out-of-network physician will be paid at 50% of the amount that would have been paid to an in-network physician. The enrollee is responsible for paying the provider.

Note that beginning January 1, 2021, Mental Health and Alcohol/Substance Abuse coverage will be provided through Anthem Behavioral Health.

hearing aid coverage

Hearing aid benefits are provided if you are enrolled in the EPO or PPO option and you have been examined by an ear specialist (otologist or otolaryngologist). This examination is to determine if your hearing problem is caused by a condition which may be corrected by use of a hearing aid**.** If it is determined that your hearing problem may be corrected by use of a hearing aid, the Plan pays 80% of covered services as described below.

Payment will be made for the **maximum allowed amount**s for the following services, when obtained from an **in-network** provider, once during any period of 36 consecutive months:

- audiometric examination;
- hearing aid evaluation test;
- two hearing aids (acquisition cost and dispensing fee). However only the particular hearing aid prescribed as a result of the hearing aid evaluation test will be covered;
- covered services also include an ear mold, necessary fitting and adjustment of the hearing aid, and a follow-up examination to determine the effectiveness of the hearing aid; and
- binaural (one aid for each ear) hearing aids may be covered for children under age 19. There must be a hearing loss in both ears, and the examination by the ear specialist also must reveal that such an aid will correct, or prevent, speech impairment.

Note that hearing aid benefits are, beginning January 1, 2021, subject to the other applicable terms and conditions of the option in which you participate.

plan exclusions

As with all medical plans, some items are NOT considered covered expenses. Please see the *health care exclusions and limitations* topic for a general list of exclusions under the plans.

The information contained in this guide is a brief summary of the medical benefits under the Rolls-Royce Corporation Welfare Benefits Plan. It is not intended to describe the disability benefits fully or to serve as a guarantee of plan benefits. The official plan documents and contracts govern in case of a dispute over plan provisions.

Section 6 — Dental

The Welfare Plan offers dental benefits, provided through Cigna and offer choices for care including dentists in-network and out-of-network.

Note that beginning January 1, 2021, dental benefits will be provided through Delta Dental.

dental coverage

Dental coverage provides benefits up to the annual maximum for services other than orthodontics (teeth straightening) during any calendar year, January 1 through December 31. The calendar year maximum is $2,100.

The lifetime maximum per person for orthodontics, for any individual whose course of treatment begins before age 19 is $2,400. Orthodontic coverage is not available for treatment begun after attainment of age 19.

covered services

Benefits are payable at 100% of the network contracted rate for in-network dentists (or 100% of the maximum allowable amount for out-of-network dentists) for:

- Oral examinations and prophylaxis (cleaning of teeth) but not more than twice in a calendar year (three cleanings per calendar year if you have a documented history of periodontal disease or four cleanings per calendar year for two full calendar years following periodontal surgery);
- Topical application of fluoride for persons under age 20;
- Space maintainers that replace prematurely lost teeth for persons under age 19; and
- Emergency treatment for temporary relief of pain.

Benefits are payable at 90% of the network contracted rate for in-network dentists (or 90% of the maximum allowable amount for out-of-network dentists) for:

- Dental x-rays, including full mouth x-rays (but not more than once in any period of five consecutive calendar years), and bitewing x-rays (but not more than once in a calendar year);
- Extractions and oral surgery;
- Amalgam, silicate, acrylic synthetic porcelain and composite fillings;
- General anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery;
- Endodontic (nerve and pulp) and periodontal (gum) treatment;
- Injection of antibiotic drugs by the attending dentist;
- Repair of crowns, bridgework or dentures; and relining or rebasing of dentures more than six months after installation, but not more than one relining or rebasing in any period of three consecutive calendar years;
- Inlays, onlays, gold fillings or crowns, but only when the tooth cannot be restored with an amalgam or other filling; and
- Cosmetic bonding of eight front teeth when certain conditions exist for children 8 – 19 years of age, but not more than once in any period of three consecutive calendar years.

The remaining 10% of the charge is your responsibility.

Benefits are payable at 50% of the network contracted rate for in-network dentists (or 50% of the reasonable and customary charge for out-of-network dentists) for:

- ❑ Initial installation of fixed bridgework;
- ❑ Initial installation of removable dentures; including any adjustments during the six-month period following installation;
- ❑ Replacement of an existing denture or fixed bridgework, but only when:
  a) The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or,
  b) The existing denture or bridgework cannot be made serviceable and, it was installed under this coverage, at least five years have elapsed prior to the replacement; or,
  c) 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; and
- ❑ Orthodontic (teeth straightening) procedures and treatment (including related oral examinations) for any person whose course of treatment begins before age 19 (Subject to a maximum lifetime. See chart on previous page). Coverage is not available for treatment begun after attainment of age 19; and
- ❑ Dental implants.

The remaining 50% of the charge is your responsibility.

accidental dental injury

Additional coverage is available for the repair of accidental dental injury to sound natural teeth due to sudden unexpected impact from outside the mouth. If applicable in a given case, the copayments referenced above will apply (depending on the nature of the service), but benefit payments will not count against annual or lifetime maximums.

pre-determination of dental benefits

If a course of treatment can reasonably be expected to involve covered dental expenses of $200 or more, a description of the procedures to be performed and an estimate of the dentist's charges must be filed with the carrier prior to the commencement of the course of treatment.

The carrier will notify the participant and the dentist of the benefits certified as payable based upon such course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services or courses of treatment that may be performed for the dental condition concerned in order to accomplish the desired result.

If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, the carrier reserves the right to make a determination of benefits payable taking into account alternate procedures, services or courses of treatment based on accepted standards of dental practice. To the extent verification of covered dental expenses cannot reasonably be made by the carrier, the benefits for the course of treatment may be for a lesser amount than would otherwise have been payable.

The pre-determination requirement will not apply to courses of treatment under $200 or to emergency treatment, routine oral examinations, x-rays, prophylaxes and fluoride treatments.

benefit exclusions and limitations

While coverage provided under the Welfare Plan is very broad and comprehensive, the Welfare Plan does not cover all dental services and expenses under all circumstances. Therefore, you should seek guidance from your dental carrier before services are rendered if you have questions as to whether or not a particular service or expense is covered under the dental plan. Please see below for a list of some of the exclusions and limits. This list is not all-inclusive.

Procedure	Exclusions and Limitations
Exams	2 per calendar year
Prophylaxis (cleanings)	• 1 routine prophy or perio maintenance procedure per 6-month consecutive period. • Routine is covered at 100%; Perio is covered at 90%.
Fluoride treatments	Unlimited for participants up to age 20
X-rays (routine)	Bitewings: one set in any consecutive 12 month period. Limited to a max of 4 films per set.
X-rays (non-routine)	• Full mouth or Panorex: one per 60 consecutive month period. • Periapical x-rays: 4 in 12 consecutive months if not performed in conjunction with an operative procedure • Intraoral occlusal x-rays: two in 12 consecutive months
Models	Not covered
Fillings	One per tooth per 12 consecutive months (applies to replacement of identical surface fillings only). No composite, white/tooth colored fillings on bicuspid or molar teeth.
Sealants	No age limit. One treatment per tooth per lifetime. Payable on unrestored permanent bicuspid or molar teeth only.
Minor Perio (non-surgical)	Root planning – one per quadrant per 36 consecutive months
Perio surgery	One per 36 consecutive months per area of the month same service)
Crowns and Inlays	Replacement limited to one per 84 consecutive months. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns. Replacement must be indicated by major decay. For participants less than 16 years old, benefits for crowns and inlays are limited to resin or stainless steel.
Stainless steel & resin crowns	One per 36 consecutive months for participants younger than age 16.
Bridges	Replacement limited to one per 84 consecutive months, if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar bridges.
Dentures and partials	Replacement limited to one per 84 consecutive months, if unserviceable and cannot be repaired.
Relines, rebases	Covered if more than 12 months after installation; one per 36 consecutive months.
Adjustments	Covered if more than 12 months after installation; one per 12 consecutive months.
Repairs – bridges	Covered if more than 12 months after installation
Repairs – dentures	Covered if more than 12 months after installation
Endodontics	Root canal re-treatment one per 24 consecutive months, if necessity demonstrated
Prosthesis over implant	One per 84 consecutive months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns/bridges.
Space maintainers	Covered up to age 19
Alternate benefit	When more than one covered dental service could provide suitable treatment based on common dental standards, the dental plan will determine the covered dental service on which payment will be based and the expenses that will be included as covered expenses.

exclusions and limitations

- Services performed primarily for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Initial placement of a full or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan;
- Removal of only a permanent third molar will not qualify for an initial or replacement denture or bridge;
- Overdentures, personalization, precision or semi-precision attachments;

- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion, the restoration of teeth which have been damaged by erosion, attrition or abrasion; bite registration; or bite analysis;
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
- Core buildup, labial veneers;
- Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old;
- Bite registrations; precision or semi-precision attachments; splinting;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Procedures for which a charge would not have been made in the absence of coverage, for which the person is not legally required to pay;
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
- Experimental or investigational procedures and treatments;
- Procedures which are not necessary and which do not have uniform professional endorsement;
- Any injury resulting from, or in the course of, any employment for wage or profit; Any sickness covered under any workers' compensation or similar law;
- Charges in excess of the reasonable and customary allowances;
- IV sedation or general anesthesia, except when medically or dentally necessary and when in conjunction with covered complex oral surgery;
- Fees charged for broken appointments, claim form submission or sterilization;
- Services not included in the list of covered dental expenses, unless Cigna HealthCare agrees to accept such expense as a covered dental expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture;
- Replacement of teeth beyond the normal complement of 32;
- Prescription drugs;
- Athletic mouth guards;
- Myofunctional therapy;
- Charges for travel time; transportation costs; or professional advice given on the phone;
- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);

- Any procedure, service, or supply which may not reasonably be expected to successfully correct the covered person's dental condition for a period of at least three years, as determined by Cigna HealthCare;
- Temporary, transitional or interim dental services;
- Diagnostic casts, diagnostic models, or study models;
- Any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of ($100.00-$200.00) per 12 consecutive month period);
- Procedures that are a covered expense under any other medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- Any charges, including ancillary charges, made by hospital, ambulatory surgical center or similar facility;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which would not have been made if the person had no insurance;
- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents; and
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.

The information contained in this guide is a brief summary of the dental benefits under the Rolls-Royce Corporation Welfare Benefits Plan. It is not intended to describe the disability benefits fully or to serve as a guarantee of plan benefits. The official plan documents and contracts govern in case of a dispute over plan provisions.

Section 7 — VISION

The Welfare Plan offers vision benefits, provided through EyeMed to assist towards the cost of routine eye exams, lenses, and frames through a national network of participating providers, which includes ophthalmologists, optometrists, and optical facilities.

You can use in-network vision providers and pay only a copayment for most expenses; or, you can use an out-of-network provider and be reimbursed based on the *schedule of benefits* when you submit a claim.

> Note that beginning January 1, 2021, vision benefits will be provided through Anthem Blue View Vision.
>
> As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical® and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com.

covered services

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; and
- Materials and professional services connected with the order, preparation, fitting, and 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; and
  - Frames once during each calendar year.

vision schedule of benefits

services	in-network – you pay…	out-of-network reimbursement
exam (with dilation if necessary)	$7 copay	up to $70
Frames	$90 allowance; 80% of charge over $90	up to $22
standard plastic lenses		
- single vision	$10 copay	up to $100
- bifocal	$10 copay	up to $114
- trifocal	$10 copay	up to $159
- lenticular	$10 copay	up to $195
- standard progressive lens	$75 copay	up to $114
- premium progressive lens	$75, 80% of charge less $120 allowance	up to $114

services	in-network – you pay…	out-of-network reimbursement
lens options - UV treatment - tint (solid and graduated) - standard plastic scratch coating - standard polycarbonate - standard anti-reflective coating - polarized - other services	 $15 $15 $15 $40 $45 20% off retail price 20% off retail price	N/A
contact lens fit and follow-up - standard - premium	 Up to $55 10% discount off retail price	N/A
contact lenses - conventional - disposable - medically necessary	 $90 allowance; 15% off $90 allowance; 15% off $0	 up to $65 up to $65 up to $450
laser vision correction - LASIK or PRK from US Laser Network	 15% off the retail price or 5% off the promotional price	N/A

exclusion and limitations

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., orthoptics, vision training);
- Vision examinations, lenses, or frames obtained without cost to you; and
- Vision examinations performed and lenses and frames ordered before you become eligible for coverage or after the termination of your coverage.

The information contained in this guide is a brief summary of the vision benefits under the Rolls-Royce Corporation Welfare Benefits Plan. It is not intended to describe the disability benefits fully or to serve as a guarantee of plan benefits. The official plan documents and contracts govern in case of a dispute over plan provisions.

Section 8 — Life Insurance and Accidental Death & Dismemberment Insurance

The Rolls-Royce Corporation Welfare Benefits Plan offers life and accidental death & dismemberment (AD&D) insurance to provide financial security to you and your family or beneficiary in the event and accident or death.

basic life and accidental death & dismemberment (AD&D) insurance

Rolls-Royce provides eligible employees with basic life and AD&D coverage based on your base hourly rate of pay. This insurance is Company-paid group term coverage. You have the opportunity to purchase additional group term life and AD&D insurance for you and your eligible spouse or child(ren).

The Internal Revenue Service (IRS) requires Rolls-Royce report the value of your basic life insurance in excess of $50,000 as imputed income. This taxable amount will be added to your taxable earnings.

Benefit detail	Basic Life	Basic AD&D
Coverage Amount	- Based on hourly rate of pay. - See *Basic Life Insurance Schedule of Benefits* for your coverage amount.	Basic AD&D is equal to 50% of your Basic Life Insurance.
Maximum	$150,500	$72,250
Accelerated Benefit Option	Up to 50%, not to exceed $72,250	None

In addition to your basic life insurance, you also receive basic accidental death & dismemberment (AD&D) insurance in case you suffer a loss due to an accident. Your coverage amount is 50% of your basic life insurance. The *schedule of benefits* shows the percentage of the amount of coverage the plan will pay if you suffer a covered loss within 24 months of the date of a covered accident. For more information on AD&D insurance, see the Certificate of Coverage, available from the contact the Rolls-Royce Benefits Service Center.

Basic life insurance provides an Accelerated Benefit Option, which is an advance payment before death of a part or the total amount of the plan benefit. Refer to the *accelerated benefit option (ABO)* section for more information.

If you are actively at work when you reach age 65, you may be eligible to continue your basic life insurance — at no cost to you — even after you leave the Company. See the *continuing life insurance after age 65* section for more information.

Refer to the Certificates of Coverage ("COC") for exclusions and limitations. Please see a UAW Benefits Representative for a copy of the COC. Note that the rates for optional insurance outlined in this guide are subject to change by the insurer outside of the contract renewal cycle in certain circumstances.

schedule of benefits — basic life and accidental death insurance

Before Age 65*

SCHEDULE OF BENEFITS							
Base Hourly Rate (1)	**Basic Life Insurance (2)**	**Extra Accident Insurance (3)**	**Total Basic Life and Extra Accident Insurance**	**Base Hourly Rate (1)**	**Basic Life Insurance (2)**	**Extra Accident Insurance (3)**	**Total Basic Life and Extra Accident Insurance**
Under $12.55	$52,000	$26,000	$78,000	24.10 - 24.44	101,000	50,500	151,500
12.55 - 12.89	53,000	26,500	79,500	24.45 - 24.79	102,500	51,250	153,750
12.90 - 13.24	54,500	27,250	81,750	24.80 - 25.14	104,000	52,000	156,000
13.25 - 13.59	56,000	28,000	84,000	25.15 - 25.49	107,000	53,500	160,500
13.60 - 13.94	57,500	28,750	86,250	25.50 - 25.74	108,500	54,250	162,750
13.95 - 14.29	58,500	29,250	87,750	25.75 - 26.09	110,000	55,000	165,000
14.30 - 14.64	60,000	30,000	90,000	26.10 - 26.44	111,500	55,750	168,250
14.65 - 14.99	61,500	30,750	92,250	26.45 - 26.79	113,000	56,500	169,500
15.00 - 15.34	63,000	31,500	94,500	26.80 - 27.14	114,500	57,250	171,750
15.35 - 15.69	64,500	32,250	96,750	27.15 - 27.49	116,000	58,000	174,000

SCHEDULE OF BENEFITS							
Base Hourly Rate (1)	**Basic Life Insurance (2)**	**Extra Accident Insurance (3)**	**Total Basic Life and Extra Accident Insurance**	**Base Hourly Rate (1)**	**Basic Life Insurance (2)**	**Extra Accident Insurance (3)**	**Total Basic Life and Extra Accident Insurance**
15.70 - 16.04	66,000	33,000	99,000	27.50 - 27.84	117,500	58,750	176,250
16.05 - 16.39	67,500	33,750	101,250	27.85 - 28.19	119,000	59,500	178,500
16.40 - 16.74	69,000	34,500	103,500	28.20 - 28.54	120,500	60,250	180,750
16.75 - 17.09	70,500	35,250	105,750	28.55 - 28.89	122,000	61,000	183,000
17.10 - 17.44	72,000	36,000	108,000	28.90 - 29.24	123,500	61,750	185,250
17.45 - 17.79	73,500	36,750	110,250	29.25 - 29.59	125,000	62,500	187,500
17.80 - 18.14	75,000	37,500	112.500	29.60 – 29.94	126,500	63,250	189,750
18.15 - 18.49	76,000	38,000	114,000	29.95 – 30.29	128,000	64,000	192,000
18.50 - 18.84	77,500	38,750	116,250	30.30 – 30.64	129,500	64,750	194,250
18.85 - 19.19	79,000	39,500	118,500	30.65 – 30.99	131,000	65,500	196,500
19.20 - 19.54	80,500	40,250	120,750	31.00 – 31.34	132,500	66,250	198,750
19.55 - 19.89	82,000	41,000	123,000	31.35 – 31.69	134,000	67,000	201,000
19.90 - 20.24	83,500	41,750	125,250	31.70 – 32.04	135,500	67,750	203,250
20.25 - 20.59	85,000	42,500	127,500	32.05 – 32.39	137,000	68,500	205,500
20.60 - 20.94	86,500	43,250	129,750	32.40 – 32.74	138,500	69,250	207,750
20.95 - 21.29	88,000	44,000	132,000	32.75 – 33.09	140,000	70,000	210,000
21.30 - 21.64	89,500	44,750	134,250	33.10 – 33.44	141,500	70,750	212,250
21.65 - 21.99	91,000	45,500	136,500	33.45 – 33.79	143,000	71,500	214,500
22.00 - 22.34	92,000	46,000	138,000	33.80 – 34.14	144,500	72,250	216,750
22.35 - 22.69	93,500	46,750	140,250	34.15 – 34.49	146,000	73,000	219,000
22.70 - 23.04	95,000	47,500	142,500	34.50 – 34.84	147,500	73,750	221,250
23.05 - 23.39	96,500	48,250	144,750	34.85 – 35.19	149,000	74,500	223,500
23.40 - 23.74	98,000	49,000	147,000	35.20 – 35.54	150,500	75,250	225,750
23.75 - 24.09	99,500	49,750	149,250				

(1) Your base hourly rate of pay is used to calculated the basic life insurance volume. The hourly rate includes premiums necessary for seven-day operations, but does not include overtime, night shift premium or any cost-of-living allowance.

(2) Beginning on the first day of the month following the month of your 65th birthday, your basic life insurance volume is reduced 2% each month.

(3) Three times the scheduled amount may be payable for an occupation-related death.

* See the *continuing life insurance after age 65* section for information on your basic life insurance after age 65.

optional life insurance

You have the opportunity to elect optional life insurance for yourself, your spouse and your child(ren). You must elect optional life insurance. You are not automatically covered by optional life insurance like you are with basic life insurance.

You are eligible for optional life insurance on the first day of the calendar month after obtaining seniority and have basic life insurance in force. This coverage may be continued until age 80 while basic life insurance is in force.

In order to elect optional life insurance for an eligible dependent, you must have optional life insurance in force. Generally, an eligible dependent includes your spouse and dependent children over 14 days of age who qualify as dependents under the Rolls-Royce Corporation Welfare Benefits Plan.

You must be actively at work before any optional life insurance coverage is effective. This requirement applies to your initial effective date and any subsequent increases in coverage, if applicable. If you are not actively at work on the date coverage

normally starts, your optional life insurance will not begin until you return to being actively at work. Refer to Certificate of Coverage for additional dependent insurance nonconfinement requirements.

If your spouse is age 75 or older on their insurance effective date, life insurance is not available. If your spouse is under age 75 on the insurance effective date, coverage for your spouse ends on their 75th birthday.

Benefit detail	Employee		Spouse*		Dependent Child(ren)
Coverage Amounts	$10,000 $20,000 $30,000 $40,000 $50,000 $75,000 $100,000	$125,000 $150,000 $200,000 $225,000 $250,000 $275,000 $300,000 $500,000**	$10,000 $25,000 $50,000 $75,000 $100,000	$125,000 $150,000 $175,000 $200,000 $225,000**	$5,000 per child $10,000 per child $25,000 per child
Minimum	$10,000		$10,000		$5,000
Maximum	$300,000		$200,000		$25,000
Limitations	$450,500 combined with basic life		- 50% of employee's combined basic and optional life - Available until spouse reaches age 75		Available until age 26
Guarantee Issue*	$300,000		$200,000		• $25,000
Accelerated Benefit	None		None		• None

* *At your initial eligibility period, you may elect the maximum coverage without evidence of insurability. Refer to the evidence of insurability section for limitations if you elect to enroll in optional coverage following 60 days after your initial eligibility.*

** *Increased optional life insurance coverage amounts of $500,000 for employee and $225,000 for spouse is effective January 1, 2022.*

Once you enroll one child for optional dependent life insurance, each succeeding child is automatically covered as long as that child qualifies as a dependent.

cost of coverage

Rolls-Royce pays the entire cost for basic term life coverage. You do not pay for any part of the coverage.

You pay premiums for optional term life and optional dependent life coverage through after-tax payroll deductions each pay period. Rolls-Royce does not contribute to the premium.

The premium rate for optional life is calculated based on your coverage amount, which is calculated based on the level of coverage chosen and your age. Both your optional life insurance and optional spouse life insurance are based on your age.

Optional life insurance for employee	
Age band	**Monthly rate per $1,000**
Under 30	$.04
30-34	$.06
35-39	$.07
40-44	$.12
45-49	$.18
50-54	$.36
55-59	$.58
60-64	$1.03
65-69*	$1.79
70+*	$3.26

Optional Spouse Life Insurance	
Age band	**Monthly rate per $1,000**
Under 30	$0.04
30-34	$0.06
35-39	$0.07
40-44	$0.10
45-49	$0.17
50-54	$0.27
55-59	$0.47
60-64	$0.85
65-69*	$1.52
70+*	$2.96

Optional Child(ren)Life Insurance	
Total monthly cost for all child(ren)	
$5,000	$0.50
$10,000	$1.00
$25,000	$2.50

**** age-reductions rules apply***

calculating your cost

Using the age and rate chart, below is an illustrative example of how to calculate your cost.

If you are 45 years old and you elect $30,000 in optional coverage, your rate is $.18 per thousand dollars. Divide 30,000 by 1,000 (which equals 30) then multiply the number by the rate. $.18 x 30 = $5.40 - your monthly cost for Optional Life Insurance (To obtain a weekly cost, multiply this number by 12 and divide by 52).

During the online enrollment process, you will see your actual premium due before submitting your elections. Your premiums will change during the year if your hourly-rate of pay increases or if your birthday causes you to move to a higher age-band during the year.

optional accidental death and dismemberment insurance

For an additional layer of protection, you may purchase optional Accidental Death & Dismemberment (AD&D) for yourself, your spouse and your eligible child(ren) that pays benefits if you or a covered dependent dies or is severely injured in a covered accident.

You are eligible for optional AD&D insurance on the first day of the calendar month after obtaining seniority and have basic life insurance in force. You are eligible for optional dependent AD&D coverage on the date you become eligible for optional AD&D employee coverage, provided you have at least one eligible dependent. An eligible dependent for purposes of optional AD&D insurance shall be the same as defined for purposes of dependent life insurance except that a child will be covered from live birth.

You must be actively at work before any optional AD&D coverage is effective. This requirement applies to your initial effective date and any subsequent increases in coverage, if applicable. If you are not actively at work on the date coverage normally starts, your optional AD&D insurance will not begin until you return to being actively at work..

If your spouse is age 70 or older on their insurance effective date, optional AD&D insurance is not available. If your spouse is under age 70 on the insurance effective date, coverage for your spouse ends on their 70th birthday.

Benefit detail	Employee		Spouse*		Dependent Child(ren)
Coverage Amounts	$10,000 $25,000 $50,000 $100,000	$200,000 $250,000 $300,000 $400,000 $500,000	$10,000 $25,000 $50,000 $100,000	$200,000 $250,000 $300,000 $400,000 $500,000	$10,000 per child $20,000 per child $30,000 per child $40,000 per child $50,000 per child
Minimum	$10,000		$25,000		$10,000
Maximum	$500,000		$500,000		$50,000
Limitations	Available until you reach age 70		- You must elect optional AD&D insurance for yourself. - Maximum cannot exceed Optional Employee AD&D coverage. - Available until spouse reaches age 70.		- You must elect optional AD&D insurance for yourself. - Coverage level cannot exceed your Optional AD&D coverage level. - Available until age 26.
Guarantee Issue*	$500,000		$500,000		$50,000
Accelerated Benefit	None		None		None

* *Optional AD&D does not require Evidence of Insurability at initial enrollment or Annual Enrollment.*

cost of optional AD&D

You pay the full cost of optional AD&D insurance as indicated in the rate table below.

Employee Level / Monthly Cost	
$10,000	$0.32
$25,000	$0.80
$50,000	$1.60
$100,000	$3.20
$200,000	$6.40
$250,000	$8.00
$300,000	$9.60
$400,000	$12.80
$500,000	$16.00

Spouse Level / Monthly Cost	
$10,000	$0.32
$25,000	$0.80
$50,000	$1.60
$100,000	$3.20
$200,000	$6.40
$250,000	$8.00
$300,000	$9.60
$400,000	$12.80
$500,000	$16.00

Child Level / Monthly Cost	
$10,000	$0.32
$20,000	$0.64
$30,000	$0.96
$40,000	$1.28
$50,000	$1.60

schedule of covered AD&D losses

Under basic AD&D, optional employee AD&D and optional dependent AD&D, the AD&D plan pays benefits for the covered losses listed below. The covered amount is equal to the coverage that you elected.

Accident resulting in*:	The benefit paid is:
Loss of life	The full amount
Loss of both hands or both feet	The full amount
Loss of one hand and one foot	The full amount
Loss of the entire sight of both eyes	The full amount
Loss of speech and hearing	The full amount *
Loss of the entire sight of one eye and one hand or foot	The full amount
Loss of one hand or one foot	½ the full amount
Loss of the entire sight of one eye	½ the full amount
Loss of speech or hearing	½ the full amount*
Loss of thumb and index finger (of the same hand)	¼ the full amount*
Coma	1% of covered amount beginning on 31st day

If you have optional AD&D for yourself or dependents, the AD&D plan also pays benefits for the following covered loses:

Accident resulting in*:	The benefit paid is:
Paralysis of both arms and both legs	The full amount
Paralysis of both legs	¾ The full amount
Paralysis of the arm and leg on either side of the body	½ the full amount
Paralysis of one arm or leg	¼ the full amount

**Refer to the Certificate of Coverage for how the AD&D plan defines loss of sight, thumb and index finger of same hand, speech, hearing, coma and paralysis.*

Benefits are only payable for covered losses if you or a covered dependent suffer a loss due to an accidental injury within 24 months of the accident.

Three times the scheduled benefit amount of accidental death and dismemberment insurance in force may be payable if death results from an accidental bodily injury caused solely by employment with Rolls-Royce Corporation. ***To apply for life and accidental death and dismemberment insurance benefits***, a beneficiary needs to make a claim for benefits. Please contact a UAW Benefits Representative for the necessary forms and assistance.

In addition to age limitations for optional dependent insurance for your spouse, generally your insurance for your dependents ends when your insurance ends under the terms of the group policy. If your spouse is eligible for a survivor benefit under the Pension Plan, and you die while optional AD&D insurance for your spouse is in effect, your surviving spouse may be eligible to continue coverage following your death.

additional benefits with optional AD&D

Benefits described in this section are contingent on coverage is in effect on the date of the accidental death and proof is provided according to terms in the Certificate of Coverage.

Common Disaster Benefit

If you elect optional AD&D for yourself and your spouse, and if you and your insured spouse are injured in the same accident and die within 48 hours as a result of those injuries, you are eligible for the common disaster benefit. The benefit amount payable for your spouse's death will increase to the full amount payable for your death.

If you or your insured dependent sustain a covered loss, the AD&D plan will pay benefits to you. If you or your insured dependent sustain more than one covered loss due to an accidental injury, the benefit amount will not exceed the full amount of coverage.

If you and any covered dependent die within a 24-hour period as a result of the same accident, the AD&D plan will pay your designated beneficiary or beneficiaries the benefit amount for the dependent insurance including payments for other applicable additional benefits described in this section.

Child Care Center

If you elect optional AD&D for yourself or your spouse, and if you or your insured spouse die as a result of an accidental injury that is covered under this plan, , the AD&D plan will pay this additional child care benefit if, on the date of death of either you or your insured spouse if a child up to age 13 was:

- was enrolled in a child care center; or
- within three months after the date of your death — or insured spouse's death —enrolled in a child care center.

For each child meets these qualifications, the AD&D plan will pay child care center costs incurred for up to four consecutive years, not to exceed a $5,000 annual maximum and overall maximum of 5% of your full benefit coverage option. The AD&D plan will pay this benefit quarterly when the plan receives proof that child care center charges have been paid.

If there is no dependent child who qualifies, the plan will pay your beneficiary $1,000.

Child Education

If you elect optional AD&D for yourself or your spouse, and if you or your insured spouse die as a result of an accidental injury that is covered under this plan, the AD&D plan will pay this additional child education benefit if the plan receives proof that on the date of the death a child was:

- enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or
- at the 12th grade level and, within 365 days after the date of death, enrolls as a full-time student in an accredited college, university or vocational school.

For each child who qualifies for this benefit, the AD&D plan will pay tuition charges incurred for up to four consecutive academic years, not to exceed a $5,000 academic year maximum and an overall maximum of 5% of your full benefit coverage option. The AD&D plan will pay this benefit semi-annually when the plan receives proof that tuition charges have been paid.

If there is no dependent child who qualifies, the plan will pay your beneficiary $1,000.

Spouse Education

If you elect optional AD&D for yourself and you die as a result of an accidental injury that is covered under this plan, you are eligible for an additional spouse education benefit if on the date of your death, your spouse:

- was enrolled as a full-time student in an accredited school; or
- within 365 days after the date of your death, your spouse enrolls as a full-time student in an accredited school.

The Plan will pay tuition charges incurred for up to three academic years, not to exceed a $5,000 academic year maximum and an overall maximum of 5% of your full benefit coverage option. The AD&D plan will pay this benefit semi-annually to the spouse when the plan receives proof that tuition charges have been paid.

Common Carrier

If you die as a result of an accidental injury, the AD&D plan will pay the full amount of coverage available under basic AD&D and your optional AD&D, if applicable, to your beneficiary.

If your dependents are covered by this plan's optional AD&D and die as a result of an accidental injury, the AD&D plan will pay benefits to you.

A common carrier refers to airplanes, trains, buses, trolleys, subways and boats regulated by a government entity that is in the business of transporting fare-paying passengers. It does not include chartered or other privately arranged transportation, taxis or limousines.

Spousal Occupational Training Benefit. 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 $5,000.

Additionally, the spouse or dependent children of a deceased active employee will be entitled to utilize the remaining balance of the deceased employee's current year Tuition Assistance Program benefit. This unused benefit (maximum $3,800) can be used at any time for college or educational pursuits during a period equal to the length of the current Agreement following the date of the employee's death.

Only one amount will be paid (i.e., the greatest amount) for all losses resulting from any one accidental injury.

exclusions for the accident insurance (AD&D)

MetLife will not pay benefits for any loss caused or contributed to by:

- physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- infection, other than infection occurring in an external accidental wound;
- suicide or attempted suicide;
- intentionally self-inflicted injury;
- service in the armed forces of any country or international authority, except the United States National Guard;
- any incident related to:
  - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self- preservation;
  - travel in an aircraft or device used:
    - for testing or experimental purposes;
    - by or for any military authority; or
    - for travel or designed for travel beyond the earth's atmosphere;
- committing or attempting to commit a felony;
- 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; or
- war, whether declared or undeclared; or act of war, insurrection, rebellion or riot; or
- for Optional Accidental Death and Dismemberment Insurance, any incident related to travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger.

continuing life insurance after age 65

years of participation

For the purpose of life insurance, you earn one year of participation in any calendar year in which you have 1,700 or more paid hours. Paid hours include holiday pay, paid absence allowance, jury duty pay, bereavement pay and vacation pay allowance. If you have fewer than 1,700 paid hours, you will receive proportionate credit, to the nearest 1/10 of a year, based on your paid hours.

In figuring your credited service, hours at premium pay are considered as straight-time hours.

If you are on an approved military leave, or on a disability leave and receive workers' compensation, you may receive credited service during those absences.

amount of coverage after age 65

While you are actively at work with the Company after your turn age 65, your basic life insurance is subject to the age- reduction provisions. In addition, the amount of life insurance you may continue considers (1) *year of participation* which you earn after you reach age 65 and (2) any subsequent changes in your pay.

When you turn age 65 and are actively at work, the plan's age reduction rules take effect the first of the month following your 65th birthday. The amount of your basic life insurance will be reduced by 2% on the first day of each succeeding month, until the amount equals 1½% for each *year of participation*, times the amount in force at age 65. Once this amount is reached, it is no longer reduced.

> *For example*, an employee with 30 years of participation, who has $80,000 of basic life insurance at age 65, would have the amount of coverage reduced by $1,600 each month ($80,000 x 2% = $1,600) and $36,000 of continuing life insurance after all reductions, determined as follows:
>
> 1-1/2% x 30 = 45% x $80,000 = $36,000

If you have ten or more *year of participation*, when you reach age 65 and are actively at work, the plan's age reduction rules described above apply, to a minimum of $5,000 except as otherwise described below. In addition, the volume in force after the age-reduction rules apply will continue — at no cost to you — until your death.

If you have less than ten years *year of participation* when you reach 65, the age-reduction rules shall be made until the earlier of 25 months of layoff, 12 months of leave of absence other than for disability, or the date your employment ends, and any amount remaining in effect will be discontinued.

If you attain 10 years of enrollment in basic life insurance after your 65th birthday, the amount of your basic life insurance at the end of the month in which You reached age 65, or the amount as described under schedule of benefits for your base hourly rate on the last day you are actively at work, shall be reduced and continued as described above.

evidence of insurability

Evidence of insurability (EOI) is not required for basic life insurance or optional life insurance (for you or your dependents) if you meet the enrollment requirements during your initial eligibility.

Generally, the Plan requires EOI for optional life insurance when you elect to enroll yourself or an eligible dependent 60 days after initial eligibility. You are required to submit EOI if you elect to enroll or increase coverage for yourself, your spouse or dependent children during:

- annual enrollment; and
- 31 days following a qualified event

If you apply for an increase in coverage, you will receive written notice of the effective date if approved. If your request is not approved, the increase will not take effect. The plan does not require EOI for AD&D insurance.

beneficiary designations

For optional dependent life and optional dependent AD&D coverage, you are automatically the beneficiary. Your dependents do not get to designate a beneficiary.

You may name anyone you wish as your beneficiary or beneficiaries for the following coverages:

- ❑ basic life insurance;
- ❑ basic accidental death and dismemberment;
- ❑ optional life insurance; and
- ❑ optional accidental death and dismemberment.

You beneficiary designation may include a person or persons, trust, charitable institution or your estate. You may select different beneficiaries for optional life insurance than who you designate for your basic life insurance. However, the beneficiary will be the same as you designate for your basic life insurance unless you designate a different beneficiary.

multiple beneficiaries

You may designate two or more beneficiaries for basic and optional life insurance. The benefit will be shared equally among them unless otherwise specified. If one of the beneficiaries dies before you, the surviving beneficiary (or beneficiaries) receives the death benefit.

primary and contingent beneficiaries

You may designate primary and contingent beneficiaries for basic and optional life insurance. A primary beneficiary receives a death benefit after you die. If the primary beneficiary dies after you but before receiving payment, the death benefit goes to the estate of the primary beneficiary. A contingent beneficiary receives the whole death benefit amount only if the primary beneficiary dies before you.

changing beneficiaries

You may change your beneficiary at any time without the consent of the current beneficiary. If circumstances in your life change, such as marriage, birth of a child, death of a spouse or divorce, you may want to consider the appropriateness of your beneficiary designation. Please see a UAW Benefits Representative to designate or to make changes to your beneficiary.

You are the beneficiary if you suffer accidental bodily injury resulting in one of the losses described in the *schedule of covered AD&D losses* chart. You also are the beneficiary if your spouse or eligible dependent child suffers an accidental loss of life or other loss as described in the *schedule of covered AD&D losses* chart. In the event you are not alive, refer the *payout if no surviving or designated beneficiaries* section for information.

For your life and AD&D insurance, **the benefit will be paid out to the beneficiary of record at the time of your death. "Of record" means the signed beneficiary form on file with Rolls-Royce at the time of death. If there is more than one beneficiary form on file, then the most recently dated form will be used. If there is no beneficiary on file, then the benefit will be paid in the order described below.**

You may change your beneficiary at any time. If circumstances in your life change, such as marriage, birth of a child, death of a spouse or divorce, you may want to consider the appropriateness of your beneficiary designation. Please see a UAW Benefits Representative to designate or to make changes to your beneficiary.

payout if no surviving or designated beneficiaries

If you do not designate a beneficiary, the beneficiary dies before you and there is no contingent beneficiary named, or the contingent beneficiary has also died before you, the death benefit may be paid to your survivors in the following order:

- Your spouse;
- Your child(ren);

- Your parent(s); or
- Your sibling(s).

For dependent life insurance, benefits are automatically paid to you or, if you're deceased, the death benefit may be paid to your survivors in the order listed above. For your life insurance or dependent life insurance, instead of making payment to any of the above, benefits may be paid to your estate.

benefit payment

life insurance

If you die while covered under basic term life or optional term life insurance, benefits will be paid to the person, persons, trust, or institution you named as your beneficiary in the amount in force at the time of your death.. If a covered dependent dies, benefits will be paid to you. Generally, payments are in one sum. Note: age-reduction rules apply at age 65.

To receive benefits, your beneficiary or you must follow the steps to file a claim. You or your beneficiary should contact a UAW Benefits Representative, refer to the claim form and contact MetLife for details at (800) 638-6420

accidental death and dismemberment

If you suffer a covered accidental bodily injury while covered under basic or optional AD&D insurance, benefits will be paid to you. If you die while covered under the basic or optional AD&D insurance, the person, persons, trust, or institution you named as your beneficiary in the amount in force at the time of your death. If a covered dependent suffers a covered accidental bodily injury or dies, benefits will be paid to you. Payments are based on the amount in force at the time of the covered accidental injury or death and paid according to the schedule of benefits. If any single accidental injury results in more than one covered loss, the plan will only pay one amount equal to the greatest amount in the schedule of benefits.

If you and any dependent die within a 24 hour period, the AD&D plan will pay the dependent's life insurance to the beneficiary receiving payment of your life insurance or the plan may pay your estate. If a beneficiary or a payee is a minor or incompetent to receive payment, the plan may pay that person's guardian.

If the benefit amount payable to a beneficiary is $5,000 or more, the claim may be paid by MetLife through the establishment of a Total Control Account (TCA). The TCA is a settlement option or method used to pay claims in full. MetLife establishes an interest-bearing account that provides your beneficiary with immediate access to the entire amount of the insurance proceeds. MetLife pays interest on the balance in the TCA from the date the TCA is established, and the account provides for a guaranteed minimum rate. Your beneficiary can access the TCA balance at any time without charge or penalty, simply by writing drafts in an amount of $250 or more. Your beneficiary may withdraw the entire amount of the benefit payment immediately if he or she wishes. Please note the TCA is not a bank account and not a checking, savings or money market account.

If an eligible dependent should die from any cause while you have dependent life insurance in force benefits are payable to you. If the benefit amount payable to a beneficiary is $5,000 or more, the claim may be paid by MetLife through the establishment of a Total Control Account (TCA). The TCA is a settlement option or method used to pay claims in full. MetLife establishes an interest- bearing account that provides your beneficiary with immediate access to the entire amount of the insurance proceeds. MetLife pays interest on the balance in the TCA from the date the TCA is established, and the account provides for a guaranteed minimum rate. Your beneficiary can access the TCA balance at any time without charge or penalty, simply by writing drafts in an amount of $250 or more. Your beneficiary may withdraw the entire amount of the benefit payment immediately if he or she wishes. Please note the TCA is not a bank account and not a checking, savings or money market account.

accelerated benefits option

Basic life insurance provides an Accelerated Benefit Option (ABO), which is an advance payment before death of a part or the total amount of the plan benefit. If you are diagnosed as having a terminal illness with a life expectancy not to exceed 12 months, you may be eligible to receive the ABO payment up to 50%, but not less than $1,000, of your basic life insurance. However, if your basic life insurance would be reduced within twelve months following the date the ABO is approved for payment, the ABO payment will be limited to 50% of the fully reduced amount of your basic life insurance. An ABO payment will not affect any accidental death and dismemberment insurance benefits to which you may be entitled.

The total of an ABO payment and the amount of basic life insurance payable at your death may never exceed the amount of basic life insurance which would otherwise have been payable without the payment of the accelerated benefit.

An accelerated benefit option payment will be made (1) as of the date the insurance company certifies all eligibility requirements are met, (2) only once, regardless of the amount elected, (3) only in one lump sum and (4) only if you are living when payment is to be made.

accelerated benefit option reductions

An accelerated benefits option payment will be reduced by any benefits paid to you under any Rolls-Royce Corporation benefit plan which should not have been paid or should have been paid in a lesser amount.

restrictions on accelerated benefits

An accelerated benefits option payment will not be made if (1) your basic life insurance is not in force, (2) you are making contributions for basic life insurance, (3) all or a portion of your basic life insurance is to be paid to a former spouse and/or to your child(ren) as part of a divorce agreement or court order, (4) the amount of payment would be less than $1,000, (5) you previously received an accelerated benefits option payment, regardless of the amount paid or (6) you are not living as of the date the insurance company certifies all eligibility requirements are met or payment is to be made.

examinations

You may be asked to be examined by a doctor, clinic or other medical authority designated by the insurance company, at the insurance company's expense, for the purpose of determining if you are terminally ill and have a life expectancy not to exceed 12 months.

death

After your death, basic life insurance proceeds payable to your beneficiary will be reduced by the amount of the accelerated benefits option payment.

how to apply

To apply for an accelerated benefits option payment you need to make a claim for benefits. Please contact a UAW Benefit Representative for the necessary forms and assistance.

conversion options

When your coverage ends, you will have the option to convert your basic term life, optional term life, and optional dependent term life coverage to individual life insurance policies. Your spouse or dependent child(ren) may also convert their optional term life or dependent term life coverage in the event of your death or if he or she no longer meets the eligibility requirements.

The Rolls-Royce Benefits Center will send you written notice of your conversion options.

life insurance conversion option for you

You will have the option to convert when your life insurance ends because:

- you cease to be in an eligible class;
- your employment ends;
- this group policy ends, provided you have been insured for life insurance for at least five continuous years; or
- this group policy is amended to end all life insurance for an eligible class of which you are a member, provided You have been insured for at least five continuous years; or
- your life insurance is reduced:
    - on or after the date you attain age 60;

- because you change from one eligible class to another; or
- due to an amendment of the group policy.

conversion option for your dependents

You will have the option to convert life insurance for a dependent when life insurance for the dependent ends because:

- you cease to be in an eligible class;
- your employment ends;
- the group policy ends, provided you have been insured for life insurance for the dependent for at least five continuous years; or
- the group policy is amended to end all life insurance for dependents for an eligible class of which you are a member, provided you have been insured for life insurance for the dependent for at least five continuous years; or
- life insurance for the dependent is reduced:
  - on or after the date you attain age 60;
  - because you change from one eligible class to another; or
  - due to an amendment of the group policy.

A dependent will have the option to convert when:

- the dependent life insurance ends because that dependent no longer qualifies as a dependent as defined in the certificate; or
- you die.

how conversion works

- conversion application must be sent to MetLife within 31 days after the termination of coverage. If you die during this 31-day conversion period, benefits will be paid to your beneficiary whether or not the policy had been converted. If your dependent dies within the 31-days of the conversion process, benefits will paid in the amount that could have been converted.
- the maximum amount that can be converted is the coverage amount when your coverage under the group policy ends.
- premiums you pay for the converted policy are based on your current age at the time of conversion and will differ from the rates you paid while employed.
- the insured is not required to undergo a physical examination before converting the coverage.
- if you or an eligible dependent do not submit a conversion application with 31 days of termination of coverage, you or your eligible dependent will not have the option to convert at a later date.

how to apply — conversion

Upon termination of group coverage through Rolls-Royce, you will receive an informational letter regarding conversion of coverage. If the conversion information is dated within 15 days after the date your coverage ends or is reduced, you will have 31 days from the date your coverage ends to apply for conversion following the instructions in the letter.

If the conversion information is dated more than 15 days but within 91 days from the date your coverage ends or is reduced, you will have 15 days from the date of the conversion information letter to apply for conversion following the instructions in the letter, but not to exceed 91 days.

survivor benefits for pension-eligible employees

If you die while dependent life insurance is in effect, your surviving spouse may continue this coverage. Coverage can be continued if your spouse is eligible for a survivor benefit under the Pension Plan. Your surviving spouse must pay the required monthly contribution as a deduction from these survivor benefits. Your surviving spouse may continue this coverage until the earliest of (1) remarriage, (2) age 80, or (3) death.

Under survivor benefits, spouses may only elect one half (50%) of the employee total life insurance. If 50% falls between two coverage amounts listed above, then the spouse coverage will be reduced to the lower coverage amount.

> *For example*: The employee is covered for $120,000. Fifty percent would be $60,000 for the spouse. However that falls between two coverage levels, so they would only be eligible for $50,000.

For employees/retirees over age 65 whose basic life insurance has been reduced as described in the *continuing life insurance after age 65*, the spouse's life insurance coverage will reduce accordingly.

maximum amount of new policy

Generally, the maximum amount you or your covered dependents can convert is the coverage amount when your coverage under the group policy ends.

Refer to the Certificate of Coverage for complete policy details and requirements regarding your option to convert.

assignment

Assignment is the transfer of ownership of life insurance to another individual, corporation, or trustee. You are still the insured person, but you no longer own the insurance. You may assign your life insurance and accidental death and dismemberment insurance rights and benefits under the group policy. Refer to the *certificate of coverage* for details.

filing a claim

claims for life insurance benefits

When there has been the death of an insured person, notify your UAW Benefits Representative as soon as reasonably possible after the death. The beneficiary or beneficiaries should complete the claim form and send it and Proof of the death to Us as instructed on the claim form.

claims for accidental death and dismemberment

When there has been a covered loss, notify your UAW Benefits Representative as soon as is reasonably possible but in any case within 20 days of the covered loss. A claim form will be sent to you or the beneficiary or beneficiaries of record. The claimant must submit proof of the covered loss no later than 90 days after the date of the covered loss.

estate resolution services

The Plan provides, at no additional cost, estate resolutions services to employees covered by optional life insurance. These services include a Will Preparation Service and Probate Service. If you are eligible to receive these services and would like to speak with a representative from Hyatt Legal Plans or get the name of a Plan Attorney that you can speak with about these Services, call (800) 821-6400.

> The information contained in this guide is a brief summary of the life and AD&D insurance benefits under the Rolls-Royce Corporation Welfare Benefits Plan. It is not intended to describe these benefits fully or to serve as a guarantee of Plan benefits. The official plan documents and contracts govern in case of a dispute over plan provisions.

Section 9 — Disability Benefits

The Rolls-Royce Corporation Welfare Benefits Plan offers disability benefits to provide income protection if you have a medically certified health condition and are unable to perform some or all of your job responsibilities. This is a self-funded disability income coverage provided by the Company. The disability administrator is Lincoln Financial Group ("Lincoln"). Lincoln does not insure the benefits described in this section, as this coverage is self-funded by the Company.

eligibility

In addition to the *eligibility* criteria outlined in the Health Care and Other Benefits Overview section, eligible employees are covered under disability benefits the first of the month following six months of employment. Eligible employees do not need to enroll is disability benefits. You are automatically enrolled and covered once you satisfy the eligibility requirements. Disability benefits is provided at no cost to you.

You must be actively at work before any disability benefits are effective. If you are not actively at work on the date coverage normally starts, your disability benefits will not begin until you return to being actively at work.

disability benefits at-a-glance

The elimination period — or waiting period — is the period of your disability that you do not receive benefits. The elimination period begins on the day your become disabled and continues for the period shown below. Benefits are payable at the end of the applicable elimination period. The maximum benefit period is the maximum duration you can receive disability benefits.

Disability benefit	Elimination period	Benefits are payable	Maximum benefit period
Sickness disability benefits*	Seven calendar days	On the eighth calendar	52 weeks
Accident disability benefits**	None	First day of certified disability	52 weeks
Extended disability benefits	52 weeks		Duration of disability or SSNRA

* *if hospitalized or when confined in an approved substance abuse treatment facility*

** *if hospitalized or treated by an approved doctor or the plant medical department during the first seven days of certified disability*

Benefits can begin the day after surgery, in case of outpatient surgery where a surgical benefit of $25, or more, is payable under the Rolls-Royce Corporation Welfare Benefits Plan. Sickness and accident benefits also may be payable if you are (1) disabled from surgery for sterilization, or (2) hospitalized for testing to determine your suitability to be a donor for an organ or tissue transplant.

if you have less than 52 weeks of service at the time

If you have less than 52 weeks of Rolls-Royce Corporation employment, benefits are payable on a time-for-time basis which commences on your date of hire. This means benefits will be payable for a period equal to your length of employment (or your years of participation as defined under Rolls-Royce Corporation Welfare Benefits Plan, if longer) at the time you become disabled. If you have less than 52 weeks of employment when you become disabled, benefits may continue beyond the time-for-time (but not beyond 52 weeks) while you are hospitalized, or while you are receiving workers' compensation payments from Rolls-Royce Corporation.

qualifying for disability benefits

To qualify for disability benefits, you must:

- ❑ be eligible for coverage under disability benefit;
- ❑ be actively at work on the scheduled day before the onset of disability or on an approved leave of absence that is covered by Welfare Plan (e.g., a medical leave, family leave, workers' compensation leave or personal leave);
- ❑ have a medically certified health condition that lasts longer than the disability waiting period and prevents you from performing the essential duties of your job;

- ❑ be under the care of an approved care provider; and
- ❑ receive appropriate care and treatment for your medically certified health condition.

if you are unable to work

If you are unable to work your regular work schedule, you must notify your supervisor immediately. If you are aware of an impending absence because of a planned medical procedure, you should provide your manager with at least 30 days' advance notice.

If you are not working your regular work schedule with approved absences and if you believe you are disabled as a result of any injury or sickness which prevents you from performing the essential duties of your occupation, you must notify your supervisor in writing of your disability within 20 days after (1) the onset of the sickness, or (2) the accident causing your injury.

If you continue to be disabled after the period for which you are entitled to receive sickness and accident benefits, you may be eligible for monthly extended disability benefits (long-term disability).

medically certified health condition definition

For purposes of disability benefits, a medically certified health condition is generally defined as a disabling injury or illness that:

- ❑ is documented by clinical evidence as provided and certified by an approved care provider. Clinical evidence may include medical records, medical test results, physical therapy notes, mental health records, and prescription records.
- ❑ prevents you from performing the essential functions, duties, and regular schedule of your position as of the last day worked for longer than the disability elimination period.

applying for disability benefits

To apply for disability benefits, you and your attending physician must complete a claim form provided by the disability administrator, currently Lincoln Financial Group. You should contact Lincoln Financial Group at (877) 562-9977 as soon as possible if you become disabled.

proof of your disability

It is your responsibility to ensure that Lincoln receives requested medical proof of your disability, which may include medical records, test results, and hospitalization records, within the designated time frame. If Lincoln has not received the requested medical documentation and valid medical proof within the designated time frame, your request for disability benefits may be denied.

verification of disability

You may be asked 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 or extended disability 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, at the applicable IRS medical mileage rate ($.17 per mile in 2020) for travel to and from the examination, if your residence is more than 40 miles (one-way) from the examiner's office.

schedule of disability benefits

		Monthly Extended Disability Benefit (3)	
Your Base Hourly Rate (1)	Weekly Sickness and Accident Benefit (2)	Schedule I	Schedule II
Under $12.55	$295	$1,070	$1,180
$12.55 – $12.89	$305	$1,100	$1,215
$12.90 – $13.24	$315	$1,135	$1,245
$13.25 – $13.59	$320	$1,165	$1,280
$13.60 – $13.94	$330	$1,195	$1,315

		Monthly Extended Disability Benefit (3)	
Your Base Hourly Rate (1)	**Weekly Sickness and Accident Benefit (2)**	**Schedule I**	**Schedule II**
$13.95 – $14.29	$340	$1,225	$1,345
$14.30 – $14.64	$345	$1,255	$1,380
$14.65 – $14.99	$355	$1,285	$1,415
$15.00 – $15.34	$365	$1,315	$1,445
$15.35 – $15.69	$375	$1,345	$1,480
$15.70 – $16.04	$380	$1,375	$1,515
$16.05 – $16.39	$390	$1,405	$1,545
$16.40 – $16.74	$400	$1,435	$1,580
$16.75 – $17.09	$405	$1,465	$1,615
$17.10 – $17.44	$415	$1,500	$1,645
$17.45 – $17.79	$425	$1,525	$1,680
$17.80 – $18.14	$430	$1,560	$1,715
$18.15 – $18.49	$440	$1,590	$1,745
$18.50 – $18.84	$450	$1,620	$1,780
$18.85 – $19.19	$455	$1,650	$1,815
$19.20 – $19.54	$465	$1,680	$1,845
$19.55 – $19.89	$475	$1,710	$1,880
$19.90 – $20.24	$480	$1,740	$1,915
$20.25 – $20.59	$490	$1,770	$1,945
$20.60 – $20.94	$500	$1,800	$1,980
$20.95 – $21.29	$505	$1,830	$2,015
$21.30 – $21.64	$515	$1,860	$2,045
$21.65 – $21.99	$525	$1,890	$2,080
$22.00 – $22.34	$530	$1,920	$2,115
$22.35 – $22.69	$540	$1,950	$2,145
$22.70 – $23.04	$550	$1,985	$2,180
$23.05 – $23.39	$555	$2,015	$2,215
$23.40 – $23.74	$565	$2,045	$2,245
$23.75 – $24.09	$575	$2,075	$2,280
$24.10 – $24.44	$585	$2,105	$2,315
$24.45 – $24.79	$590	$2,135	$2,350
$24.80 – $25.14	$600	$2,165	$2,380
$25.15 – $25.49	$620	$2,225	$2,450
$25.50 – $25.74	$625	$2,255	$2,470
$25.75 – $26.09	$635	$2,285	$2,505
$26.10 – $26.44	$645	$2,315	$2,540
$26.80 – $27.14	$660	$2,375	$2,605
$27.15 – $27.49	$670	$2,405	$2,640
$27.50 – $27.84	$675	$2,434	$2,670
$27.85 – $28.19	$685	$2,465	$2,705
$28.20 – $28.54	$695	$2,495	$2,740
$28.55 – $28.89	$700	$2,525	$2,770
$28.90 – $29.24	$710	$2,555	$2,805
$29.25 – $29.59	$720	$2,585	$2,840
$29.60 – $29.94	$725	$2,615	$2,870
$29.95 – $30.29	$735	$2,645	$2,905
$30.30 – $30.64	$745	$2,675	$2,940
$30.65 – $30.99	$750	$2,705	$2,970
$31.00 – $31.34	$760	$2,735	$3,005
$31.31 – $31.69	$770	$2,765	$3,040
$31.70 – $32.04	$775	$2,795	$3,070
$32.05 – $32.39	$785	$2,825	$3,105
$32.40 – $32.74	$795	$2,855	$3,140

		Monthly Extended Disability Benefit (3)	
Your Base Hourly Rate (1)	**Weekly Sickness and Accident Benefit (2)**	**Schedule I**	**Schedule II**
$32.75 – $33.09	$800	$2,885	$3,170
$33.10 – $33.44	$810	$2,915	$3,205
$33.45 – $33.79	$820	$2,945	$3,240
$33.80 – $34.14	$825	$2,975	$3,270
$34.15 – $34.49	$835	$3,005	$3,305
$34.50 – $34.84	$845	$3,035	$3,340
$34.85 – $35.19	$850	$3,065	$3,370
$35.20 – $35.54	$860	$3,095	$3,405

*Lowest bracket applicable to employees hired or rehired prior to the effective date.

(1) For this purpose, Base Hourly Rate includes premium for necessary continuous seven-day operations, but does not include overtime, night shift premium, or any cost-of-living allowance.

(2) Weekly Sickness and Accident Benefits will be adjusted for disability occurring prior to the day one-year of seniority is attained.

(3) Schedule II applies to eligible employees who have ten or more years of participation under the Plan on their last day worked preceding a continuous period of disability. Schedule I applies to all other employees eligible for Extended Disability Benefits.

sickness and accident benefits (short-term disability)

recurrent condition

If your medically certified health condition starts again within three months after you have been released to return to work, your condition may be considered a recurrent condition. A recurrent condition is due to the same or related disability resulting from the initial medically certified health condition. It will be treated as a continuation of your initial medically certified health condition, and you will not have to satisfy a new waiting period. The maximum amount of time you may receive sickness and accident benefits for the same condition is 52 weeks, which includes the waiting period. Your covered pay for purposes of determining your disability benefit will be based on your covered pay at the time the condition originally started, versus when the condition starts again, unless you are required to file a new claim.

> *For example*, if you were disabled and received sickness and accident benefits for 20 weeks, returned to work and then became disabled again eight weeks later from the same condition, you would be eligible for 32 additional weeks of benefits, without a new waiting period. If your second absence results from a different disability, the first absence does not affect the benefits or waiting period, if any, for the second absence.

integration with other disability income

Your sickness and accident benefit amount will be offset by other sources of income paying during your period of disability, such as:

- primary Social Security Disability Insurance Benefits (SSDIB) or unreduced Social Security old age insurance (including retroactive amounts paid for the same period of disability);
- workers' compensation payments;
- unemployment compensation;
- special statutory disability benefits; and
- overpayments.

If you are receiving other income, you must furnish the disability administrator with proof of the amount in the form of an award letter, pay stub or other documentation. Refer to the *recovery of benefit payments* section.

You may be required to apply for Social Security Disability Benefits ("SSDIB") if your disability is expected to continue for 52 weeks or longer.

extended disability benefits

Extended disability benefits are payable under the Rolls-Royce Corporation Welfare Benefits Plan after you have used all available sick and accident benefits. For the purpose of extended disability benefits, you earn one year of participation in any calendar year in which you have 1,700 or more paid hours. Paid hours include holiday pay, paid absence allowance, jury duty pay, bereavement pay and vacation pay allowance. If you have fewer than 1,700 paid hours, you will receive proportionate credit, to the nearest 1/10 of a year, based on your paid hours.

In figuring your credited service, hours at premium pay are considered as straight-time hours.

If you have ten or more years of participation when you become disabled, benefits are payable until recovery, but generally not beyond the end of the month in which you attain age 65.

If you have less than ten years of participation when you become disabled, 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 are received), but generally not beyond the end of the month in which you attain age 65.

If you become disabled after age 63, you may receive extended disability benefits for a period beyond age 65.

eligibility

To receive extended disability benefits, you must (1) not be regularly employed, and (2) be totally disabled so as to be unable to perform any job at the plant where you have seniority.

integration with other disability income

Your extended disability benefit amount will be offset by other sources of income paying during your period of disability, such as:

- any benefit for which you are eligible under any Rolls-Royce Personal Savings Plan;
- certain Social Security benefits;
- workers' compensation;
- any federal or state lost-time disability benefits;
- special statutory disability benefits; and
- overpayments.

Increases in any of these benefits payable after extended disability benefits commence will not be deducted, unless the increase represents an adjustment in the original determination of the benefit amount and results in an overpayment. If a retroactive award of any additional sources of benefit payment creates an overpayment of extended disability benefits that were paid during the same period of disability, you will be required to repay the overpayment. You will be required to 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 will be required to repay an overpayment incurred due to receipt of an SSDIB award. Refer to the *recovery of benefit payments* section.

life, AD&D and disability insurance while you are disabled

Your basic life, , accidental death and dismemberment, disability and survivor income benefit insurance will be continue for any period during which you are:

- entitled to receive sickness and accident benefits while totally disabled, and

- totally and continuously disabled and remain on an approved disability leave of absence, but not to exceed the period equal to your years of participation under the Rolls-Royce Corporation Welfare Benefits Plan as of the first day of disability.

Also, upon cancellation of your disability benefits, your coverage may be continued for as long as you are entitled to receive monthly extended disability benefits.

If you are deemed no longer disabled and return to work, and you again become totally disabled so as to be unable to work within three working days of the date your leave was canceled, all coverage to which you were entitled will be continued at no cost to you 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.

If eligible to continue, you must pay the required monthly contributions to continue any optional life, optional dependent life, and/or personal accident insurance.

Basic life insurance must remain in force to continue optional life and dependent life insurance.

health coverage while you are disabled

In most cases, Company contributions for health care coverage will be continued for the duration of an approved disability leave of absence. If your disability leave is canceled because the period of the leave equals your seniority prior to the leave, the coverage may be continued while you remain entitled to receive sickness and accident or extended disability benefits. Exceptions to the above include, but are not necessarily limited to, the following cases:

- If you are off work because of layoff or personal leave of absence, and your coverage has been discontinued while you are off, and if upon reporting for work you are found disabled and are placed on disability leave of absence without returning to work, you will not be eligible for reinstatement of coverage and continuation while on disability leave (unless otherwise required by law); and

- If you are recalled from permanent layoff, return to work, and become disabled prior to working 12 pay periods during the calendar year, Company contributions while on disability leave of absence will be limited to the number of months of such continuation you were entitled to as of the end of the month prior to your return to work, plus two months.

social security disability insurance benefits (SSDIB)

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.

Your nearest Social Security office can give your information regarding the amount of Social Security benefits payable because of disability.

It is important for you to apply for Social Security Disability Insurance Benefits for these reasons:

- Failure to claim a Social Security disability award may result in a lesser Social Security old age benefit. Your dependents also may qualify for Social Security benefits.

- You become eligible for Medicare after 24 months of Social Security Disability Insurance Benefits.

If you are receiving Social Security Disability Insurance Benefits and return to work, you may be eligible to continue these benefits, in addition to your wages, up to 12 months. You should contact your nearest Social Security office for additional information.

If you are receiving sickness and accident or extended disability benefits, you may be required to complete an authorization form which allows the Social Security Administration to inform Rolls-Royce Corporation of the status of your claim for Social Security Disability Insurance Benefits. If you fail to complete this authorization, your sickness and accident or extended disability benefits will be suspended until the authorization is received.

recovery of benefits overpayment

If it is determined that any benefit(s) paid to an employee under a Rolls-Royce Corporation disability plan, should not have been paid or should have been paid in a lesser amount, written notice will be provided to the employee and the employee is required repay the amount of the overpayment.

If the employee does not repay the amount of overpayment promptly, the Company will arrange to recover the amount of the overpayment from any monies then payable, or which may become payable, to the employee in the form of wages or benefits payable under a Rolls-Royce Corporation benefit plan (excluding the Rolls-Royce Corporation Personal Savings Plan).

The information contained in this guide is a brief summary of the disability benefits under the Rolls-Royce Corporation Welfare Benefits Plan. It is not intended to describe the disability benefits fully or to serve as a guarantee of plan benefits. The official plan documents and contracts govern in case of a dispute over plan provisions.

Section 10 — PENSION PLAN

The Rolls-Royce Corporation Hourly-Rate Employees Pension Plan (the "Pension Plan") is a defined benefit plan designed to provide you with an income after you retire. This summary outlines the terms of the Pension Plan as of March 2020. Pension Plan benefits are payable in addition to any Social Security benefits you may receive. References to Social Security in this document are based on the Social Security provisions in effect on January 1, 2020.

pension plan features

- ❑ your contributions — None. The Company pays for your benefits in full.
- ❑ Vesting — You will be 100% vested in your Pension Plan benefit after five years of service.
- ❑ normal retirement age — Age 65.
- ❑ when your benefit is paid — When you reach retirement age, die or become disabled.
- ❑ how your benefit is paid — Your benefit is paid as an annuity during your life and may provide a benefit to your eligible surviving spouse after your death.

eligibility

To be considered an eligible employee, you must be a regular full-time hourly employee of Rolls-Royce Corporation who is employed in the United States and is covered by the collective bargaining agreement between Rolls-Royce Corporation and the UAW. Part-time employees covered by the UAW collective bargaining agreement ("Agreement") are also eligible, provided they work one-half or more of the employing unit's regular work week.

The following employees are not eligible under the plan:

- ❑ Leased employees;
- ❑ Employees hired on or after September 18, 2006 (including "tier 2" employees);
- ❑ Temporary employees and part-time employees who work less than one-half of the employing unit's regular work week;
- ❑ Hourly-rate employees who are not covered by the UAW collective bargaining agreement; and
- ❑ Employees of a wholly-owned or substantially wholly-owned subsidiary of the Company acquired or formed on or after December 1, 1993.

You are eligible to participate in the Pension Plan when you acquire seniority. You acquire seniority after completing 90 days of employment.

how the pension plan works

Your benefits under the Pension Plan are determined based on your:

Credited service	Credited service affects the amount of your benefit and your eligibility for certain forms of benefit.
Vesting service	Vesting service affects your ownership of your benefit.
Age when benefit begins	Age affects the reduction in your benefits if they start before age 62.

credited service

Any calendar year in which you have 1,700 or more paid hours will count as a full year of credited service under the Pension Plan. Holiday pay, paid absence allowance, jury duty pay, bereavement pay and vacation pay allowance are included in paid

hours. If you have fewer than 1,700 paid hours, you will receive proportionate credit, to the nearest 1/10 of a year, based on your paid hours.

In figuring your credited service, hours at premium pay are considered as straight-time hours.

If you are on an approved military leave, or on a disability leave and receive workers' compensation, you may receive credited service for such absence.

loss of credited service

You will lose all credited service under the Pension Plan if you quit, are discharged, or "break" seniority for any other reason. However, if you have worked one hour on or after January 1, 1994 and you have five or more years of credited service, your pension benefits are vested. If you are re-employed by Rolls-Royce Corporation and reacquire seniority, your credited service may be reinstated, upon proper application. If you have prior credited service, which has not been reinstated, you should contact Human Resources.

annual statement

Each year you will be given a statement showing your:

- Credited service under the Pension Plan for the preceding calendar year; and
- Total credited service up to the end of the preceding calendar year

If you have any questions concerning the correctness of your credited service, as shown on the statement, you should contact Human Resources or your Union Benefit Representative.

vesting service

Any calendar year in which you have 750 or more paid hours will count as a full year of vesting service under the Pension Plan.

An hour of service is each hour you are paid by the Company for performing your job. You also earn hours of service for paid non-work hours (including such things as military leave, sick leave, disability, vacation, holidays, jury duty, layoff, or leave of absence). You also may be credited with hours of service for unpaid leaves of absence such as military leave (upon reemployment in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994), Family and Medical Leave Act leave and parental leave.

You first become eligible to be covered for the "service" provision when you (1) attain age 21, or (2) complete one year of "service," whichever is later. You get one year of "service" when you complete 750 hours of "service" in a 12 consecutive month period, beginning with your employment date. You complete an hour of "service" for each hour for which you are paid by Rolls-Royce Corporation for working, or for having been entitled to work.

No "service" is granted for any (1) period of employment prior to age 18, or (2) year in which you are paid by Rolls- Royce Corporation for working fewer than 750 hours.

A one-year break in "service" will occur if you do not complete 375 hours of "service" in any 12 consecutive month period. Hours paid for vacation and sickness or disability, which are not worked, may be counted to prevent a break in "service." In addition, certain periods of absence because of pregnancy, childbirth, adoption or child care immediately following birth or placement of a child related to adoption, may be counted after October 1, 1985, to prevent a break in "service." You will lose your years of "service" if the number of consecutive one-year breaks equals, or exceeds, the greater of (1) the aggregate years of "service" you had before such break, or (2) five years.

If you are on leave from work for reasons established under the Family and Medical Leave Act of 1993, your absence may be counted to prevent a break in "service".

retirement dates

Your final pension plan benefit is intended to be a retirement benefit and is designed to remain in the plan until your normal, early, or deferred retirement as described below. Remember, however, that the earlier you begin receiving your benefits, the smaller those benefits will be.

normal retirement

Your normal retirement date is the first day of the month on or immediately after your 65th birthday. If you terminate employment with the Company on or before your normal retirement date, payment of your vested Plan benefits will generally begin as of this date.

disability retirement

Your disability retirement date is the first day of the month on or immediately after the date you become totally and permanently disabled if you have 15 or more years of credited service on that date.

early voluntary retirement

You may retire before age 65 if you:

- are at least age 60 and have ten or more years of credited service,
- are at least age 55 and your age plus your years of credited service total 85 or more, or
- have 30 or more years of credited service (at any age).

mutually satisfactory retirement

You may be able to retire as early as age 55 (age 50 in the closing of a “remote” plant or under a negotiated special separation program) if you have ten or more years of credited service, are otherwise eligible, are not working at another Rolls-Royce facility and meet certain other requirements.

deferred retirement

If you continue working for the Company after age 65, you will continue to accrue additional benefits. In general, payment of your vested Pension Plan benefits will begin as of the first day of the month following your actual retirement.

retirement benefits

normal retirement benefits

Your monthly basic retirement benefit is determined by your basic benefit rate times your years of credited service. Your basic benefit rate depends on your benefit class code (Schedule I) and your Retirement date (Schedule II), as follows:

Schedule I

For Job Classifications Having a Maximum Base Hourly Rate of	Benefit Class Code
$20.80 and over	D

Schedule II

Benefit Class Code D	Retirements On or After March 1, 2020 Monthly Basic Benefit Rate ($) Per Year of Credited Service
	March 1, 2020 $60.94

For example, if you retire at age 65 with 40 years of credited service, your monthly basic benefit will be calculated as follows:

$60.94 x 40 = $2,437.60

early voluntary retirement

If you retire early, your early retirement benefit will be determined using your years of credited service as of your early retirement date. If your benefits begin on or after your 62nd birthday, there will be no reduction in your monthly basic benefit.

If your benefits begin before your 62nd birthday, you will receive a reduced monthly basic benefit because you will be expected to receive benefit payments over a longer period.

Under certain circumstances, you may qualify for an early retirement or interim supplement to your reduced monthly basic benefit until you reach age 62 and one month.

reduction for retirement prior to age 62

The monthly basic benefit payable to you if you retire prior to age 62 and one month will be reduced so that only the percentage of the monthly basic benefit set out in the following table will be paid:

Age When Pension Commences	Percentage of Basic Benefit Paid*
62 or over	100.0%
61	93.3%
60	86.7%
59	80.8%
58	75.2%
57	69.4%
56	63.5%
55	57.9%
54	53.2%
53	48.9%
52	45.0%
51	41.5%
50	38.3%
49	35.4%
48	32.8%
47	30.4%
46	28.2%
45	26.1%
44	24.3%
43	22.6%
42	21.0%

The percentage differences for each year are prorated on the basis of the number of complete calendar months by which you are under the age you will attain on your next birthday.

> *For example,* if you retire on or after March 1, 2020 at age 60 with 40 years of service, you will receive 86.7% of your monthly basic benefit or $2,113.40 calculated as follows:
>
> $60.94 x 40 = $2,437.60
>
> $2,437.60 x 0.867 = $2,113.40

early retirement supplement if you have 30 or more years of credited service

If you have 30 or more years of credited service when you retire voluntarily before age 62 and one month, you will receive monthly basic benefits, reduced as shown above. If payment of benefits begins within five years of your separation from service, your reduced basic benefit will be supplemented so that retirees with benefits payable commencing March 1, 2020 or later will have a total monthly benefit amount of $3,950. After you qualify for 80% of unreduced Social Security benefits (but not earlier than age 62 and one month), the early retirement supplement will stop and your monthly basic benefits will no longer be reduced because of your age at retirement.

> *For example*, if you retire on or after March 1, 2020 at age 60 with 40 years of service, you will receive a reduced monthly basic benefit of $2,113.40 as calculated above, and a temporary monthly early retirement supplement of $1,836.60 ($3,950.00 - $2,113.40) until you qualify for 80% of unreduced Social Security benefits. At that time, the temporary early retirement supplement will stop, and your monthly basic benefit will increase to $2,437.60 (your unreduced monthly basic benefit).

interim supplement if you have fewer than 30 years of credited service

If you have fewer than 30 years of credited service when you retire voluntarily before age 62 and one month, you will receive monthly basic benefits, reduced as shown above. In addition, if payment of benefits begins within five years of your separation from service, you will receive a monthly "interim" supplement, payable until you qualify for 80% unreduced Social Security benefits. The amount of this supplement is based on your age at retirement, as follows:

Monthly Amount * and Effective Date Of Interim Supplement Payable Prior to Age 62 and One Month for Each Year of Credited Service	
Age at Retirement	**Benefits Payable Commencing On or After March 1, 2020**
55	$23.00
56	$26.80
57	$32.05
58	$37.15
59	$42.30
60-61	$58.40

*Prorated for intermediate ages computed on the basis of the number of complete calendar months by which you are under the age you will attain on your next birthday.

> *For example*, if you retire on or after March 1, 2020 at age 59 with 26 years of credited service, you will receive a total monthly benefit of $2,380.03 calculated as follows:
>
> $60.94 x 26 = $1,584.44 x 0.808 = $1,280.23
>
> Your interim supplement will be an additional $1,099.80 calculated as follows:
>
> $42.30 x 26 = $1,099.80
>
> for a total monthly benefit prior to age 62 and one month equal to $2,380.03.

In general, after you reach the date when you qualify for 80% of your unreduced Social Security benefit (but not earlier than age 62 and one month), the interim supplement will stop and you will continue to receive a reduced monthly basic benefit. However, if your age and credited service at retirement total 85 or more, the early retirement supplement will stop and your monthly basic benefits will no longer be reduced because of your age at retirement once you qualify for a benefit equal to 80% of your unreduced Social Security benefit.

early retirement and interim supplements — limitations

The total of your monthly basic benefit plus early retirement or interim supplement may not exceed 70% of your final monthly base pay.

If you retire voluntarily and become eligible for a Social Security Disability Insurance Benefit ("SSDIB"), your monthly supplement will be reduced by the temporary benefit amount in effect at the time of your SSDIB award. This temporary benefit amount will be computed the same as for retirement under mutually satisfactory conditions, as described below.

mutually satisfactory retirement

You may be retired under conditions mutually satisfactory to you and to Rolls-Royce Corporation after age 55 (age 50 in the event of a closing of a Rolls-Royce Corporation plant in an area where no other Rolls-Royce Corporation plant is located, or under a negotiated special separation program). In such event, you will receive a monthly basic benefit.

temporary benefit

In addition, you may receive a monthly temporary benefit until you qualify for 80% of unreduced Social Security benefits or, if earlier, until you become eligible for a Social Security Disability Insurance Benefit, or an unreduced Social Security benefit.

The amount of your monthly temporary benefit will be based on your years of credited service, up to 30, and your retirement date.

Retires with Benefits Commencing	Monthly Temporary Benefit	
	Per Year of Credited Service	Maximum
March 1, 2011 and After	$50.85	$1,525.50

If you retire with 30 or more years of credited service, you also could receive a monthly early retirement supplement, payable until you qualify for 80% of unreduced Social Security benefits. The total monthly benefit amount includes the temporary benefit shown above.

disability retirement

You may be eligible, upon application, for a monthly disability pension benefit. To be eligible, you:

- need to be currently employed with at least 15 years of credited service;
- must become totally and permanently disabled before age 65, and
- must have been on disability leave for at least five months.

You will be considered to be totally and permanently disabled if you:

- are not engaged in regular employment or occupation for pay or profit; and,
- are found to be wholly and permanently prevented from engaging in regular employment or occupation with the Company at the plant or plants where you have Seniority on the basis of medical evidence satisfactory to the Company as a result of bodily injury or disease, either occupational or non-occupational in cause.

You will not be considered totally and permanently disabled if the disability resulted from service in the armed forces of any country, unless you become totally and permanently disabled after accumulating at least five years of Seniority following separation from service in the armed forces.

While you are receiving a disability retirement benefit, you may be required to submit to a physical examination by a doctor no more than twice a year. If you refuse to have a physical examination, your disability retirement benefits may be suspended until you complete a physical examination.

If you become eligible, this benefit will cease if, prior to age 65, you (1) recover from your total and permanent disability, or (2) become gainfully employed for purposes other than rehabilitation. Otherwise, upon reaching age 65 you will be reclassified as a regular retiree.

Your monthly basic pension benefit rate will be the same as if you had retired at or after age 62. Your rate will be multiplied by your credited service at the time of your disability retirement.

> *For example,* if you are eligible on or after March 1, 2020 for disability retirement at age 50 and you have completed 20 years of credited service, your monthly basic benefit will be determined as follows and will not be reduced for your age:
>
> $60.94 x 20 = $1218.80

In addition, if Social Security determines that you are not eligible for disability benefits under the Social Security Act, you may receive an additional temporary pension benefit from Rolls-Royce Corporation each month. This monthly temporary benefit will be computed the same as for retirement under mutually satisfactory conditions. The temporary benefit is payable until you qualify for 80% of unreduced Social Security benefits, or, if earlier, to the age you become eligible for Social Security Disability Insurance Benefits.

If you have 30 or more years of credited service and are under age 62, you also may be eligible to receive a monthly early retirement supplement, payable until you qualify for 80% of unreduced Social Security benefits. In addition, a Special Benefit payable monthly after you attain age 65, or, earlier, while you are enrolled in Medicare Part B.

vested benefit

If you break seniority before age 65 and have five or more years of credited service but do not qualify for a retirement benefit (early voluntary retirement, mutually satisfactory retirement or disability retirement), you will be eligible for a vested benefit when you reach age 65. Your vested benefit will equal your monthly vested benefit based on your years of credited service as of the date you break seniority.

Vested Benefit Rate Payable Per Year of Credited Service	
Date Seniority Broke	March 1, 2011 and after
Per Year of Credited Service	$56.94

If you break seniority before age 65 and have fewer than five years of credited service, but have five years of "vesting service", as defined earlier, you also will be eligible for a vested benefit. (When you are "vested" in your pension, you have earned a right to a pension benefit that cannot be taken away from you.)

> *For example*, if you have only four years of credited service, but have five years of "vested service", the five years of "vested service" will entitle you to a vested benefit. However, the monthly benefit amount would be based on your four years of credited service.

If you are eligible for a vested benefit, you do not have to wait to age 65 to begin receiving your vested benefit. You may request to have payment of your vested benefit begin as early as age 55, but your monthly basic benefit will be permanently reduced based on your age at the time benefit payments begin:

Age When Vested Benefit Commences	Percentage*of Monthly Basic Benefit Received
55	42.8%
56	46.8%
57	51.2%
58	55.5%
59	59.6%
60	64.0%
61	71.2%
62	78.4%
63	85.6%
64	92.8%
65	100%

* Prorated for intermediate ages computed on the basis of the number of complete calendar months by which the Employee is under the age attained at the Employee's next birthday.

If you break seniority before age 65 and before completing five years of credited service or five years of vesting service, you will not receive a benefit from the Pension Plan.

form of pension payment

All forms of payment are approximately equal in total value to the life annuity payable at your normal retirement age, which is the normal form of benefit under the Pension Plan.

For example, under a 50% joint and survivor annuity, the payments may be made over a longer period than your life expectancy. Therefore, the payments you receive during your lifetime are reduced to reflect this longer payment period. This adjustment in value is called "actuarial equivalence."

mandatory cash-out

If the actuarial equivalent present value of your monthly basic benefit, reduced as appropriate for your age and credited service, is $1,000 or less, it will be paid to you as soon as practicable after you terminate employment in one lump sum cash payment. You may elect to have this amount transferred to another employer's qualified plan or to an individual retirement account ("IRA").

consent required

If the actuarial equivalent present value of your monthly basic benefit, reduced as appropriate for your age and credited service, is worth more than $1,000, you must consent to receive a distribution. If you break seniority before your 65th birthday, you may defer payment of your benefit until the later of (1) age 65 or (2) your termination of employment.

normal form of payment

Life Annuity. If you are unmarried when your benefits begin, you will be paid your monthly benefit, reduced as appropriate for age and credited service, on the first day of each month, beginning with your retirement date and ending on the first day of the month which contains your date of death. No benefits will be paid to anyone after your death. This is called a "life benefit."

Joint & Survivor Benefit. ***If you were married*** throughout the twelve month period ending on the date your benefits first become payable, you will receive your monthly benefit in the form of a joint and survivor ("J&S") benefit. Your monthly basic benefit, reduced as appropriate for your age and credited service at retirement, will be further reduced during your lifetime to account for the fact that benefits may be paid to your spouse over a period longer than your own life expectancy. In general, payments equal to 60% or 75% of that reduced amount will be continued after your death to your surviving spouse during his or her lifetime.

The reduction for survivor coverage is determined as follows:

- ❑ if you are retired for disability before age 55 and have fewer than 30 years of credited service, you will receive a 50% J&S benefit if you die before age 55. The reduction for the J&S benefit will be based on your age and the difference between your age and your spouse's age:

	Age Difference Between Disabled Employee and Spouse				
	Spouse is:				
Age of Employee When Benefits Commence	10 Years Younger	5 Years Younger	Same Age	5 Years Older	10 Years Older
30	8.6%	8.1%	7.5%	6.7%	5.9%
35	10.4%	9.9%	9.2%	8.3%	7.2%
30	12.5%	11.8%	11.0%	10.0%	8.8%
45	14.3%	13.5%	12.7%	11.6%	10.3%
50	13.9%	13.2%	12.4%	11.4%	10.2%
51	13.1%	12.5%	11.7%	10.8%	9.7%
52	10.4%	9.9%	9.3%	8.6%	7.7%
53	3.4%	3.2%	3.0%	2.8%	2.5%
54	3.4%	3.3%	3.1%	2.8%	2.5%

NOTE: Actuarial reduction factors for ages not shown will be calculated on the same basis as the factors shown.

- ❑ if you qualify for a benefit for any reason other than disability before age 55 with fewer than 30 years of credited service, (or if you retired for disability before age 55 with fewer than 30 years of service, and subsequently attain age 55) the reduction for a 60% J&S benefit will be based on the difference between your age and your spouse's age:

Reduction in Monthly Benefit Based on Age of Spouse Compared to Your Age										
Spouse is younger by (reduction increases by 0.5% per year)					**Spouse's age is within 5 years of your age**	**Spouse is older by (reduction decreases by 0.5% per year)**				
10 years	9 years	8 years	7 years	6 years		6 years	7 years	8 years	9 years	10 years
7.5%	7%	6.5%	6%	5.5%	5%	4.5%	4%	3.5%	3%	2.5%

If you elect a 75% J&S benefit, your benefit will be further adjusted to be the actuarial equivalent of a 60% J&S benefit.

You may waive this automatic J&S benefit in writing and elect an optional form of benefit. Your spouse must consent in writing to the optional form of benefit, and his or her consent must be witnessed by a notary public.

available forms of payment

Lump sum payment. If the actuarial equivalent present value of your monthly basic benefit, reduced as appropriate for your age and credited service, is worth:

- more than $1,000 but $5,000 or less, your benefit will be paid in a cash lump sum, but you may elect to receive the lump sum immediately (instead of waiting until the date your benefits would otherwise begin);
- more than $5,000 but less than $10,000, you may elect (with spousal consent, if appropriate) to receive your benefit in a cash lump sum. This lump sum payment will be made on the date your benefits would otherwise begin.

You may elect to have this amount transferred to another employer's qualified plan or to an individual retirement account ("IRA").

Life annuity. ***Married participants*** may waive the J&S coverage (with spousal consent) and elect to have benefits paid during the participant's lifetime only. The monthly benefit will not be reduced for survivor benefits, and no benefits will be paid to your eligible surviving spouse after your death.

changes in benefits after payments begin

In general, you may not change your form of benefit after payments begin. However, you may revoke the regular J&S coverage after you begin receiving your monthly basic benefit if:

- Your designated spouse dies;
- You are divorced by final court decree and a Qualified Domestic Relations Order does not require continued J&S coverage; or
- You provide written spousal consent witnessed by a Notary Public which acknowledges the effect of the revocation.

If you revoke this coverage, your basic benefit will be restored to the amount payable without the J&S coverage. Restoration is effective after proper notice and documents are received by the Company. Your previously designated survivor will no longer be eligible for a benefit following your revocation.

If you have a Qualified Domestic Relations Order you should send it to:

Rolls-Royce North America Inc.
HR Shared Service Center
PO Box 420 N-3
Indianapolis, IN 46206

If you marry, or re-marry, after retirement and you had not previously rejected the survivor coverage when it was available to you, you may elect, or re-elect, the coverage with respect to your new spouse. The form necessary for such election or re-election can be obtained from Human Resources and **MUST** be completed and received by Rolls-Royce Corporation prior to the date you have been married 18 months.

spousal consent rules

These rules only apply if you are married. As discussed above, you must have your spouse's written consent to choose a form of payment other than the joint and surviving spouse annuity.

Your spouse's agreement must:

- Show that he/she understands the meaning of his/her agreement and
- Be witnessed by a notary public or by a representative of the Plan Administrator.

A spouse's consent applies only to that spouse. If you are divorced and then remarry, the consent of your former spouse does not apply to your new spouse. Your new spouse automatically will be your beneficiary, and the form of payment automatically will be the 50% joint and survivor annuity with your new spouse as beneficiary (subject to any "qualified" domestic relations

court order, described later in this summary), unless your new spouse consents to a different beneficiary and/or form of payment.

For purposes of this plan, your "spouse" is the person to whom you are legally married when you die or when your benefits begin. In some cases, a qualified domestic relations order may entitle your former spouse to a share of your benefits under this plan.

workers' compensation offset

Workers' compensation benefits paid to retired employees will be deducted from Rolls-Royce Corporation pension benefits otherwise payable. No such deduction will be made where workers' compensation payments are paid under a claim filed within two years after breaking seniority.

application for pension

You may apply for Pension Plan benefits by contacting your Union Benefit Representative.

re-employment after retirement

If you are re-employed by the Company after you start to receive monthly benefits, your monthly payments will be stopped. During your period of reemployment, you will receive credit for additional credited service. When you finally stop working for the Company, your pension benefits will be recalculated, based on your additional service.

surviving spouse benefits

If you die after your benefit payments begin, the Pension Plan will pay a death benefit only if you elected a form of payment that provides a death benefit to your surviving spouse.

If you die after completing at least five years of credited or vesting service and before your benefit payments begin, your surviving spouse will be eligible to receive a survivor benefit, provided you were married for the one year period ending on the date of your death. This survivor benefit is referred to as joint and survivor ("J&S") coverage.

If the actuarial equivalent present value of the J&S coverage for your surviving spouse is:

- $5,000 or less, it will be paid to your surviving spouse in a single cash lump sum payment; and
- More than $5,000 and not more than $10,000, it may be paid to your surviving spouse in a single cash lump sum payment at your spouse's election.

If you do not have an eligible surviving spouse on your date of death, no survivor benefits will be paid from the Pension Plan.

preretirement J&S coverage

Preretirement J&S coverage will be provided automatically for your eligible surviving spouse as follows:

- If you are not eligible for voluntary early retirement on the date of your death (but have completed five years of credited or vesting service), your surviving spouse will receive a preretirement J&S benefit equal to 50% of your actuarially adjusted monthly vested benefit.
- If you retire due to total and permanent disability before age 55 with fewer than 30 years of credited service, and you die before age 55, your surviving spouse will receive a preretirement J&S benefit equal to 50% of your actuarially adjusted monthly disability benefit.

The survivor benefit, unreduced for age, is payable when the deceased employee would have attained age 65. At the election of the eligible surviving spouse, the benefit payments may begin, reduced for age, at the earliest age the deceased employee could have retired voluntarily.

You can revoke this pre-retirement J&S coverage if (1) your spouse dies, or (2) you are divorced before you attain age 55. Revocation is effective the first of the month following receipt by Rolls-Royce Corporation of evidence satisfactory to Rolls-Royce Corporation of the spouse's death or the third month after proper notice to Rolls-Royce Corporation of your divorce.

regular J&S coverage

Regular J&S coverage becomes available on the first of the month following your attainment of age 55, whether or not you reject the pre-retirement J&S coverage. This means that you may (1) reject the pre-retirement J&S coverage prior to age 55, and (2) still be eligible for the regular J&S coverage at age 55. Under the regular J&S coverage, your spouse will be paid 60% (or 75% if elected) of your actuarially reduced monthly benefit if you die before your benefit payments begin.

The surviving spouse of an employee or former employee who dies after becoming eligible for retirement and before benefit payments begin will automatically be provided a monthly income for life under the Pension Plan. To be eligible, the surviving spouse must have been married to the deceased employee at least one year prior to the employee's death. This benefit is available if the deceased employee or former employee would have been eligible to retire voluntarily, immediately prior to his death, as follows:

- at age 65 or older;
- at age 60 or older with ten or more years of credited service;
- at age 55 or older with years of age and credited service totaling 85 or more;
- at any age with 30 or more years of credited service;
- was eligible for a vested benefit and died after reaching age 55; or
- was taking disability retirement and died after reaching age 55.

The monthly benefit for the eligible surviving spouse is determined as though the employee had retired voluntarily on the date of death and had not rejected the joint and survivor coverage. Any monthly benefit amount payable to an eligible surviving spouse is equal to 60% of the employee's monthly basic benefit (determined as of his or her date of death).

The following chart provides answers to some of the more common questions asked about pension survivor coverage.

QUESTIONS	ANSWERS
PRE-RETIREMENT SURVIVOR BENEFIT	
Is the pre-retirement survivor benefit the same as the regular surviving spouse benefit?	No. The pre-retirement survivor benefit is 50% of your reduced age 65 deferred vested benefit. The regular post-employment, survivor benefit is 60% of your reduced age 62 basic benefit.
How do I elect the pre-retirement survivor coverage?	The pre-retirement survivor coverage is automatic.
How long is the pre-retirement survivor coverage in effect?	The pre-retirement survivor coverage is in effect until you become, or could become, eligible for the regular survivor coverage. The regular survivor coverage is available when you attain the earliest age at which you would be eligible to retire voluntarily.
REGULAR SURVIVOR BENEFIT	
When does the regular survivor coverage become effective?	The regular survivor coverage becomes effective at the latest of: (1) your retirement, (2) one year of marriage, if married when the coverage otherwise would have been effective, or (3) your attainment of age 55 following disability retirement with fewer than 30 years of service.
What information must I supply to Rolls-Royce Corporation?	Proof of your marriage, proof of your spouse's age and your spouse's Social Security number.
What would be the reduction in my basic pension while I am living if my spouse and I are within five years of the same age?	5% of your age 62 basic pension benefit.
What would be the reduction if my spouse is more than five years younger than I am	The 5% reduction would increase by ½% for each 12 months of age difference in excess of five years.
What monthly benefit would be payable to my surviving spouse after my death?	The regular survivor benefit is 60% (or 75% if elected) of your reduced age 62 basic benefit.
Can I revoke the regular survivor coverage if (1) my spouse dies, or (2) we are divorced?	Yes, in both cases. To do so, you must provide Rolls- Royce Corporation a copy of the death certificate or certified copy of

QUESTIONS	ANSWERS
	final court decree of divorce which does not prohibit revocation of the coverage.
If I remarry after I retire, may I elect the regular survivor coverage for my new spouse?	Yes, provided you previously had not rejected the regular survivor coverage when it was available to you. You must apply prior to the first of the month in which you have been married eighteen (18) months for the coverage to be effective.

rollovers by surviving spouses or alternate payees

Your surviving spouse, or your spouse or former spouse who is an alternate payee under a qualified domestic relations order (see section entitled *assigning your plan benefit*) and who receives a lump sum benefit payment from the Plan may make a direct rollover to a traditional IRA or another employer's plan.

social security benefits

Social Security benefits are in addition to your Rolls-Royce Corporation pension benefits. You and Rolls-Royce Corporation contribute equally to the cost of your Social Security benefits. Your share of the cost is deducted from your pay. Social Security old age benefits may begin as early as age 62 in a permanently reduced amount.

Social Security Disability Insurance Benefits begin at any age.

Your spouse's Social Security benefit at age 65 generally will be equal to one-half of your unreduced Social Security benefit, unless your spouse is eligible for a higher benefit based on your spouse's earnings. Your spouse may receive a permanently reduced benefit commencing as early as age 62 (age 60 if your spouse is a widow or widower).

Social Security benefits are not automatic. You must apply for them. To obtain more information about Social Security benefits and your current entitlement, please contact your local Social Security office.

things that can affect your benefit

Benefits may be denied, lost or suspended, or you may not qualify or be eligible for benefits, under the following circumstances:

- You are not eligible to participate in the Pension Plan.
- You are an eligible participant who leaves Rolls-Royce Corporation before you are vested.
- If you die after retirement and did not choose a payment option that provides a benefit to your surviving spouse after your death, any monthly benefit payments will stop upon your death.
- If you are not married when you die, no benefit payments will be made upon your death.
- If the Plan cannot make a payment because you or your surviving spouse cannot be found, the benefit may be forfeited. If the person entitled to the payment is located at a later date, benefits which were due but could not be paid will be paid in a single sum and the right to future benefits will be reinstated in full.
- If you receive a benefit payment that is larger than it should be, you must repay the excess to the Pension Plan.
- Benefit accruals and/or benefit payments may be suspended if the plan fails to meet funding targets set by law.

Other circumstances which could affect the amount of your benefit include:

other federal rules and restrictions

There are a number of federal rules that apply to the payment of benefits. One of these rules requires that benefits be used primarily for retirement and not as a legacy for your heirs. Also, federal law limits the total annual benefit amount that can be paid to individual participants under the Plan. We'll let you know if any of these limits apply to you.

annuity contracts

The Company reserves the right to settle or partially settle its obligations through the purchase of an irrevocable annuity contract.

federal taxes

You will normally have to pay Federal income taxes on any monthly benefits you receive from the Pension Plan. You will also have to pay Federal income taxes on any lump sum payment you receive from the Pension Plan.

In fact, Federal law requires the Pension Plan to withhold 20% of your lump sum payment for Federal income taxes unless you choose a direct rollover to another eligible retirement plan or individual retirement account. If you receive a lump sum distribution before age 59½, your benefit also may be subject to a 10% early distribution penalty, unless you choose a direct rollover or are age 55 or older when you terminate.

If you elect the direct rollover, you will not pay taxes on the lump sum payment until you later withdraw the money.

state taxes

The state income tax rules that apply to distributions from the Plan change from state to state. Those rules are too complicated to list here. You should talk to your tax advisor about any state income taxes you may owe.

assigning your plan benefit

Your creditors cannot take your pension benefit to pay your debts. But a court can order all or some of your benefit be paid to an “alternate payee” (like a former spouse or minor child) under a qualified domestic relations order.

The plan administrator has rules for deciding if a domestic relations order is qualified. You should call the Benefits Resource Center at 888-702-3633 to get a copy of the rules if you are involved in a divorce or paternity suit.

plan insurance

Since the Pension Plan is a defined benefit plan, your pension benefits under this Plan are insured by the Pension Benefit Guaranty Corporation (“PBGC”), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the Plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than five years at the time the Plan terminates; (3) benefits that are not vested because you have not worked long enough for the company; (4) benefits for which you have not met all of the requirements at the time the Plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop you when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan’s normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your Plan Administrator or contact the PBGC’s Technical Assistance Division, 1200 K Street, N.W., Suite 930, Washington, D.C. 20005-4026, or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at (800) (877) 8339 and ask to be connected to 202-326-4000. Additional information about the PBGC’s pension insurance program is available through the PBGC’s website at http://www.pbgc.gov.

> The information contained in this guide is a brief summary of the benefits under the Rolls-Royce Corporation Hourly-Rate Employees Pension Plan. It is not intended to describe the plan fully or to serve as a guarantee of plan benefits. The official plan documents and contracts govern in case of a dispute over plan provisions.

Section 11 — RETIREE WELFARE BENEFITS

eligible retirees

In general, you are eligible for retiree welfare benefits if you retired from active service and are receiving benefits under the Pension Plan (except deferred vested benefits). Eligible retirees may continue medical, dental and vision benefits. In addition, you are eligible for retiree healthcare coverage (under the HDHP only) if you meet the following criteria:

1. You were hired:

    a. between September 18, 2006 and February 26, 2015 as a "Tier 2" employee within the meaning of the 2005 Collective Bargaining Agreement (also known as a "Condition 1" employee); or

    b. before September 18, 2006, retired after January 31, 2012 and were participating in the Rolls-Royce high deductible health plan at the time of your retirement.

2. You meet one of the following requirements as of your Rolls-Royce retirement date (determined without regard to whether you are eligible to participate in the Pension Plan):

    a. have 30 or more years of credited service (within the meaning of the Pension Plan);

    b. are age 60 or older and have ten or more years of credited service (within the meaning of the Pension Plan);

    c. have a combination of years of age and years of credited service (within the meaning of the Pension Plan) equal to or greater than 85; or

    d. are totally and permanently disabled (within the meaning of the Pension Plan).

eligible dependents

If you are an eligible retiree who participates in retiree welfare benefits, you may elect to have your eligible dependents participate in the Welfare Plan. You must participate if you wish to enroll your dependents.

pre-age 65 retiree benefits (not eligible for Medicare)

health care coverage

If you meet the Welfare Plan's retiree eligibility requirements and are not eligible for Medicare, you and your eligible dependents may be eligible for one of the following three Blue Cross Blue Shield Basic Choice health care plans:

Health Plan	Eligibility criteria
PPO and EPO Retiree Plans (additional terms/conditions outlined below)	You retired under the Pension Plan prior to January 1, 2012 and you retained PPO/EPO coverage.
PPO and EPO Plans	You retired under the Pension Plan on/after January 1, 2012 and you retained PPO/EPO coverage.
High Deductible Health Plan ("HDHP")	You meet the criteria outlined above for HDHP retiree coverage and you have HDHP coverage at retirement.

Refer to *Section 4 — Health Care Coverage Overview* for general information, including health care coverage overview, exclusion and limitations, maximum allowed amount and other important information about the plans.

Refer to *Section 5 — Medical Plans* for medical plan details, including provider network, covered services, cost share, limits and exclusions, reduction in benefits). Note that the additional terms and conditions for the PPO and EPO Retiree Plans are separately outlined below.

PPO and EPO Retiree Plans – Differences in the Schedule of Benefits

Coverage details for the PPO and EPO Retiree Plans are the same as the PPO and EPO Plans outlined in *Section 5 — Medical Plans*, including prescription drug copayments. However, while covered services are similar, the schedule of benefits may differ. Below is what the plan pays for covered services.

Service	Your cost if you use an in-network Provider	Your cost if you use an out-of-network Provider
Deductible	$0	$0
Out-of-pocket maximum	$0	EPO: no out-of-network coverage PPO: $500 single / $1,000 family
Office visits	EPO: $15 copay PPO: 35% coinsurance	EPO: not covered PPO: 35% coinsurance
Preventive Care	$0	Not covered
Diagnostic tests/ Imaging	EPO: $0 PPO: $0	EPO: not covered PPO: 20% coinsurance
Emergency care	EPO: $0 PPO: $0; 30% if not an emergency	EPO: $0; PPO: 20% coinsurance; 30% if not an emergency
Hospitalization (facility fee and physician charges)	EPO: $0 PPO: $0	EPO: not covered PPO: 20% coinsurance
Outpatient surgery (facility fee and physician charges)	EPO: $0 PPO: $0	EPO: not covered PPO: 20% coinsurance

If you incur charges for covered services because you choose to go to a non-network provider you will be responsible for a greater amount of the cost, unless it is a true emergency.

hearing aid coverage

Hearing aid benefits are provided if you are enrolled in the EPO or PPO option and you have been examined by an ear specialist (otologist or otolaryngologist). This examination is to determine if your hearing problem is caused by a condition which may be corrected by use of a hearing aid. If it is determined that your hearing problem may be corrected by use of a hearing aid, the Plan pays 100% of covered services as described in *Section 5 — Medical Plans*.

mental health and substance abuse treatment coverage

The combined mental health/substance abuse coverage provides for:

<table>
<tr><th></th><th>Mental Health</th><th>Substance Abuse</th></tr>
<tr><td rowspan="2">Outpatient treatment</td><td>• visits 1-20 paid at 100%
• visits 21-35 paid at 80%
• visits 36+ paid at 80%*</td><td>Limit of 35 visits/year
• visits 1-35 paid at 100%</td></tr>
<tr><td colspan="2">❑ Each visit by one or more members of your family for family counseling counts as one (1) visit toward the outpatient treatment maximum.</td></tr>
<tr><td>Inpatient hospital treatment</td><td colspan="2">45 days combined mental health/substance abuse care paid at 100%
❑ Each day of care reduces the number of available units of day or night care by two</td></tr>
<tr><td>Day or night care treatment program</td><td colspan="2">90 days or nights combined mental health/substance abuse care paid at 80%*
❑ Each unit of care (day or night) reduces the number of available inpatient treatment days by half day</td></tr>
<tr><td>nursing facility treatment</td><td>90 days per benefit period paid at 80%*
❑ each two days of skilled nursing care reduces the number of available inpatient hospital treatment days by one</td><td>None</td></tr>
<tr><td>Substance abuse halfway house treatment program</td><td>None</td><td>90 days per patient lifetime paid at 80%*</td></tr>
</table>

*Please note: the deductible will apply for these services for the PPO plan only

If you terminate participation in the Retiree Welfare Program for any reason other than death or eligibility for Medicare, your otherwise eligible dependents participation will terminate on the same date that your coverage ends.

effect of Medicare eligibility

Your eligibility to participate in a retiree group medical plan continues until the date you become eligible for Medicare. However, you may continue your dental and vision coverage post-age 65.

If you or an eligible dependent becomes entitled to Medicare before reaching age 65, you (or your eligible dependent) will no longer be eligible to continue a the group medical plan. Instead, Medicare will become your (or your eligible dependent's) primary medical coverage.

If you and your spouse are different ages, you will become eligible for Medicare at different times.

- If you become eligible for Medicare before your spouse does, your spouse can continue to receive retiree welfare benefits (until his/her 65th birthday or the date he/she otherwise become entitled to Medicare beforehand) while you receive Medicare benefits.

- If your spouse becomes eligible for Medicare before you do, you can continue to receive retiree welfare benefits (until your 65th birthday or the date you otherwise become entitled to Medicare beforehand) while your spouse receives Medicare benefits.

As described below, you will be entitled to obtain reimbursement of up to $1,300 (or $2,600 if married) of the cost of a Medicare supplement plan of your choice each year for you or your spouse (upon becoming Medicare eligible). For more information, see the *post-age 65 retiree benefits (or Medicare eligible)* section.

survivor benefits

If you should predecease your covered dependents, they may be eligible to elect to continue their existing coverage through COBRA for a period of up to 36 months. If your dependent has other group insurance or Medicare and elects COBRA continuation coverage, coverage will need to be coordinated. One plan will be considered primary and the other plan will be secondary depending on the circumstances.

post-age 65 retiree benefits (or Medicare-eligible)

Post-65 eligible retiree participants — or those otherwise eligible for Medicare — must be enrolled in both Medicare Part A and Medicare Part B in order to enroll in a Medicare Supplement insurance plan and receive the Rolls-Royce premium subsidy. See the *Medicare supplement premium subsidy* section.

Once you or an eligible dependent becomes eligible for Medicare (even if prior to reaching age 65), it will become your (or your eligible dependent's) primary medical coverage. You may be automatically enrolled in Medicare Parts A and B if you are receiving Social Security benefits when you become eligible. Otherwise, you must enroll yourself.

Medicare supplement premium subsidy

Post-65 retirees may be eligible under a separate retiree health program for an annual reimbursement of $1,300 (or $2,600 if married) for themselves and their spouse over age 65 toward Medicare supplement premiums. You are responsible for purchasing your own Medicare Supplement insurance plan.

hearing aid coverage

If you are enrolled in Medicare and a hearing aid is deemed medically necessary as described above, Rolls-Royce provides benefits for the following functional designs under a separate retiree health program: in-the-ear (ITE), behind-the-ear (BTE -- including air conduction and bone conduction types) and on-the-body. Benefits for hearing aids are subject to: (i) the hearing aid is prescribed based upon the most recent audiometric examination and most recent hearing aid evaluation examination; and (ii) the hearing aid provided by the dealer is the make and model prescribing by the treating physician or audiologist and is certified by the physician or audiologist.

Coverage includes the hearing aid, acquisition and dispensing fee. Benefits do not include expenses or services above the minimum specifications and/or reasonable and customary charges. Benefits are limited to a single purchase per hearing-impaired ear every 36 months.

Until December 31, 2020, Medicare-eligible participants may only receive these benefits from M.R. Ralph, the preferred UAW Medicare hearing provider. Beginning in 2021, these benefits will be provided through Anthem.

retiree life and accidental death & dismemberment insurance (Pension Plan eligible employees)

If you are eligible for PPO/EPO retiree coverage, your basic life and accidental death and dismemberment insurance (if you are eligible to continue such insurance) under the Rolls-Royce Corporation Welfare Benefits Plan will continue.

Optional life insurance for you and/or your dependent(s) in force when you retire may be continued to age 80, provided (1) your basic life insurance remains in force, and (2) you pay the required monthly contributions.

Basic accidental death and dismemberment (AD&D) ceases when you reach age 65.

Optional accidental death and dismemberment (AD&D) in force when you retire may be continued provided you pay the required contributions. However, if you are insured for an amount greater than $100,000, such amount shall be automatically reduced to $100,000 on the effective date of your retirement. Additionally, personal accident insurance in force for a dependent family member also will automatically reduce as may be appropriate. Personal accident insurance may be continued during retirement whether or not basic life insurance is in effect.

when coverage ends

Your retiree welfare benefits will end upon the occurrence of any of the following events:

- When you fail to pay the required premiums, if applicable;
- When the Company terminates the retiree program; or
- When you die.

The coverage of your eligible dependents will end upon the occurrence of any of the following events:

- When dependent coverage under the program is terminated;
- When you fail to pay the required premium for a dependent, if applicable; or
- When such individual no longer qualifies as a “dependent” under the program.

In the event a dependent ceases to qualify for retiree welfare benefits, you may be able to continue health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) for up to 36 months at your own expense. It is your responsibility to notify the Company of any change in your dependents’ eligibility status.

Refer to *Section 4 - when coverage ends* for coverage continuation details.

annual required legal notices applicable to health care coverage

Refer to *Section 4 - annual required legal notices applicable to health care coverage*.

health care program coverage for survivors of Pension Plan eligible employees

If you die while actively employed but before you are eligible to retire under the Pension Plan, your surviving spouse will be eligible to continue company-paid health care coverage (other than dental and vision). Coverage for dependent children may be continued while your surviving spouse is eligible to continue coverage and while they continue to meet the eligibility criteria for dependent children.

Credited Service at Date of Death	Months of Company-Paid Coverage
0 – 4.9 years	0
5.0 – 9.9 years	3
10.0 - 14.9 years	6
15.0 - 19.9 years	12
20.0 or more years	24

To receive the company-paid coverage described above, the surviving spouse must enroll for COBRA coverage in accordance with plan procedures. The Company will make COBRA payments while the surviving spouse otherwise qualifies for coverage under plan rules. The surviving spouse will have the opportunity to continue COBRA coverage on a self-pay basis for the remaining COBRA period of entitlement at the end of the company-paid coverage period.

If you die after becoming eligible for retiree health care and leave no surviving spouse, coverage for your dependents will cease at the end of the month in which you die. Any surviving dependent children are only eligible for COBRA continuation or conversion coverage.

If you die after retirement, or after you are eligible to retire voluntarily under the pension plan, health care coverage that was available to you will be provided to your surviving spouse and eligible dependents. If you are eligible only for self-pay continuation coverage in retirement, your surviving spouse will be limited to self-pay continuation (or other applicable COBRA coverage).

If you die as a result of an accidental bodily injury caused solely by employment with Rolls-Royce Corporation, health care coverage that was 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 on the same basis as indicated earlier.

Your surviving spouse also will be eligible for coverage if you die (1) while an active employee if you are 65 or older, or (2) after terminating your seniority at or after age 65 (for any reason other than discharge for cause) and have Company paid coverage in effect.

The information contained in this guide is a brief summary of the retiree health and life insurance benefits under the Rolls-Royce Corporation Welfare Benefits Plan. It is not intended to describe those benefits fully or to serve as a guarantee of those benefits. The official plan documents and contracts govern in case of a dispute over plan provisions.

Section 12 — Claims Procedures

procedures for handling questions or disputes about your benefits

If you have questions, or would like further information about your benefits, you should contact your Union Benefit Representatives.

Each benefit plan described in this booklet contains a procedure for appealing the denial, in whole or in part, of any application for benefits. Should you disagree with a decision denying your benefits, you may appeal the decision under the applicable benefit plan or program's appeal procedure. If that procedure does not apply to your claim for benefits, you may appeal in writing within sixty (60) days to the Plan Administrator.

Representatives assigned by Rolls-Royce Corporation and the UAW will comprise a Company Union Benefits Committee which will construe, interpret, and administer the employee benefit plans. Decisions of the representatives are final and binding. Under certain circumstances, you also may wish to discuss your questions with your Union Benefit Representative. Provisions with respect to such discussions, and procedures for making appeals are set forth below.

personal savings plan and pension plan claims

initial claim decision

If your claim for Personal Savings Plan and/or Pension Plan benefits is denied, in whole or in part, , the Plan Administrator or its designee will respond to your claim within 90 days after receiving it unless special circumstances require an extension of the time for processing the claim. The Plan Administrator may request additional time, up to 90 days, to process your claim. If the extension is necessary, Plan Administrator will notify you in writing prior to the end of the initial 90-day period. The notice will:

- Provide the special circumstances requiring an extension; and
- The date the Plan Administrator expects to make a decision.

If you file a claim involving a disability determination, similar rules apply; however, the time for the Plan Administrator to respond to your claim is shortened from 90 days to 45 days. The Plan Administrator may request up to two 30-day extensions. If an extension is necessary, the Plan Administrator will notify you before the initial 45-day period is over. If a second extension is needed, the Plan Administrator will notify you before the end of the first 30-day extension period. The notice will:

- Provide the special circumstances requiring an extension;
- The date the Plan Administrator expects to make a decision;
- The specific standards on which such entitlement to a benefit is based;
- The unresolved issues that prevent a decision on the claim; and
- Any additional information needed to resolve those issues.

You will have 45 days to submit any necessary additional information for the Plan Administrator to review. If an extension is necessary because you have not submitted information necessary to make a decision on your claim, the Plan's timeframe for making a benefit determination pauses on the date the Plan Administrator sends you the extension notification until the date you respond to the request for additional information.

notice of initial claim determination

If you claim is denied in whole or in part, you will receive written notice of the Plan's determination, which will notify you of your rights under ERISA and include the following:

- Provide specific reasons why your claim has been denied;
- Refer to the Plan provision(s) on which the denial was based;

- ❑ Describe any additional material or information necessary for your claim and an explanation why this material or information is necessary; and
- ❑ Describe the Plan's appeal procedures and time limits applicable to the procedures including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

If you file a claim involving a disability determination, you will receive a written claim denial notice as described above. In addition, the written notice will include the following:

- ❑ A discussion of the decision that includes the basis for disagreeing with or not following:
  - the views presented by your health care professionals treating you and vocational professionals who evaluated you;
  - the views of medical or vocational experts whose advice was obtained on the Plan's behalf, regardless of whether the advice was relied on in making the benefit denial; and
  - a disability determination made by the Social Security Administration (SSA), if presented to the Plan.
- ❑ If the decision was based on medical necessity or experimental treatment (or a similar exclusion or limit), either:
  - an explanation of the scientific or clinical judgment for the denial, applying the plan terms to your medical circumstances; or
  - a statement that this explanation will be provided free of charge upon request.
- ❑ Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied on in making the denial, or notice that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.
- ❑ Notice that you are entitled to receive (on request and free of charge) reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

appealing a denied claim

If your initial claim is denied (in whole or part), you have the right to request that the Plan Administrator review the denial. You will:

- ❑ Have 60 days following receipt of the denial within which to appeal the determination;
- ❑ Have the opportunity to submit written comments, documents and records relating to your claim;
- ❑ Be (i) given reasonable access to and copies of documents and records related to your claim, and (ii) permitted to request such copies free of charge; and
- ❑ Be entitled to a review of your claim that takes into account all information submitted by you relating to your claim, without regard to whether that information was submitted or considered in the initial benefit determination.

If you file an appeal regarding a disability determination, similar rules apply; however, the time for you to file a written appeal is extended from 60 days to 180 days.

Note: A request for plan documentation does not extend the period you have to file your appeal.

appeal decision

After you have made an appeal, the Plan Administrator will make its decision no later than 60 days after it receives your request for a review. The Plan Administrator may obtain an extension of up to 60 days by notifying you before the close of the initial 60-day period that the decision will be delayed and why and when a decision can be expected. In the event an extension is necessary due to your failure to submit necessary information, the Plan's timeframe for making a benefit determination pauses on the date the Plan Administrator sends you the extension notification until the date you respond to the request for additional information.

If you file an appeal regarding a disability determination, similar rules apply; however, the time for the Plan Administrator to respond to your claim is shortened from 60 days to 45 days. The Plan Administrator may request an extension for 30 days. If, prior to the end of the first 30-day extension period, the Plan determines that, due to matters beyond its control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for an additional 30 days. In addition, before issuing an adverse benefit determination, the Plan Administrator will notify you with any new or additional evidence considered and relied upon in making the decision in order to give you a reasonable opportunity to respond. The Plan's timeframe for making a benefit determination pauses on the date the Plan Administrator sends you this notification until the date you respond, but no later than 45 days.

If your claim is denied on review, the Plan Administrator will provide you written notice of its determination. The notice will provide you:

- The specific reasons for the decision;
- Specific references to the Plan's provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
- Notice of your right to bring civil action under federal law following an adverse benefit determination on review.

All decisions made by the Plan Administrator are final and binding. If you need any assistance with the Plan's claims procedures, contact the Plan Administrator.

bonus program payment claims

If you disagree with a determination concerning a denial of a Bonus Program payment, you may, within a reasonable period as established by Rolls-Royce Corporation, submit a request to Rolls-Royce Corporation for a full and fair review of the decision denying your request.

health care benefit claims

The Rolls-Royce Corporation Welfare Benefits Plan covers medically **necessary** health care expenses that are incurred while your coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply.

The Plan does not pay benefits for expenses incurred before your coverage starts or after it ends, even if the expenses were incurred because of an accident, injury or disease that occurred, began or existed while your coverage was in effect. In some cases, however, your coverage can be continued beyond when it would normally end, as discussed elsewhere in this booklet.

Claim forms are available from the Union Benefits Representative or by calling Anthem Customer Service at 888-823-8576. A claim form must be submitted when:

- You use an out-of-network physician;
- You go to a physician for services that are not available through network providers; or
- Anthem needs additional information in order to process your claim, such as coordination of benefits or dependent information not included in a network provider's filing.

Please contact Anthem Customer Service at 888-823-8576 for the claim filing address.

All claims must be submitted for payment in a timely manner after the services involved were rendered. In-network providers file the claims on the patient's behalf within a timeframe specified in the doctor's contract with Anthem. For an out-of-network provider, the employee or patient is responsible for submitting the claim to Anthem, and must do so within two years and ninety days of the date of service.

You will receive an Explanation of Benefits (EOB) from Anthem detailing each claim submission from all parties explaining what medical treatments and/or services were paid for on your behalf. The EOB generally describes the payee, the payer, the patient, date and description of service, the amount (if any) that you are responsible to pay and adjustment reasons, if applicable. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment and how you

may appeal an adverse benefit decision. You may also access your EOBs via Anthem's website at **anthem.com**. If you have a question regarding an EOB statement, please contact Anthem Customer Service at 888-823-8576 for further explanation.

If your health benefit claim is wholly or partially denied, you will be notified of the decision, after the Plan's receipt of your claim within the time limit shown below for the type of claim submitted.

claims process for health, disability and other welfare benefits

initial claim determination

When you submit a claim, the insurer or other decision-maker has a certain amount of time to make a determination regarding payment of the claim. The length of time the decision-maker is required to make a determination of your claim varies depending on the type of claim. For non-group health plan claims, the time is 90 days (45 days for disability claims). The decision-maker may obtain an extension of up to 90 days (two extensions, each of up to 30 days, for disability claims) by notifying you before the close of the initial review period that a decision on your claim will be delayed, the circumstances causing the delay and when a decision can be expected. In addition, the applicable determination response may be extended if the claim is filed improperly, the claim is incomplete, or due to matters beyond the decision-maker's control.

For group health plan claims, the time will depend on the type of claim. There are three types of group health plan claims:

1. Urgent care request for benefits: a request for benefits provided in connection with urgent care services;

2. Pre-service request for benefits: a request for benefits which the insurer must approve or in which you must notify the Claims Administrator before non-urgent care is provided; and

3. Post-service: a claim for reimbursement of the cost of non-urgent care that has already been provided.

The applicable time for these claims are outlined below:

Urgent Care Group Health Plan Claims *	
Type of request for benefits	**Timing**
If your request for benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for benefits to the Claims Administrator within:	**48 hours** after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for benefits.

Pre-Service Group Health Plan Claims*	
Type of request for benefits	**Timing**
If your request for benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
- if the initial request for benefits is complete, within: - after receiving the completed request for benefits (if the initial request for benefits is incomplete), within:	15 days 15 days
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination

Pre-Service Group Health Plan Claims*	
Type of request for benefits	**Timing**
The Claims Administrator must notify you of the appeal decision within:	**30 days** after receiving the appeal (15 days if two levels of appeal are provided)

*The Claims Administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond their control.

Post-Service Group Health Plan Claims	
Type of Claim	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
- if the initial claim is complete, within: - after receiving the completed claim (if the initial claim is incomplete), within:	30 days 30 days
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	**60 days** after receiving the appeal (30 days if two levels of appeal are provided)

notice of initial determination

For all claims, you will receive written notice of the initial determination. If you claim is denied, you will receive an adverse benefit determination. You have the right to appeal an adverse benefit determination.

All claim determination letters will notify you of your rights under ERISA and include the following:

- ❑ The specific reason(s) for the determination and reference to any specific benefit provision(s) on which the determination is based.
- ❑ A description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary.
- ❑ A description of the appeal procedures and applicable time limits.
- ❑ A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- ❑ For urgent care claims, the notice will describe the expedited review process applicable to urgent care claims. Urgent care determinations may be provided orally and followed with written notification.

For group health plan and disability benefit claims, the notice will include the following information:

Group Health Claims	Disability-Related Claims
The date of service, the health care provider, the claim amount (if applicable) and the denial code and its corresponding meaning, as well as a statement that the claimant may request the applicable diagnosis and treatment codes (and their meanings)	Not applicable
The specific reason or reasons for the denial	
Reference to the specific benefit provisions on which the denial was based	
A description of any additional material or information necessary to perfect your claim and an explanation of why such material or information is necessary	
If the claim is for Urgent Care, a description of the expedited review process applicable to such claims	Not applicable

Group Health Claims	Disability-Related Claims
A description of the review procedures and the time limits applicable to such procedures, including a statement of your right to pursue the claim in court if it is denied on appeal.	
If the denial is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided to you free of charge upon request	The specific internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the adverse determination or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.
If the denial is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request	
The statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."	Not applicable
The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act to assist individuals with the internal claims and appeals and external review procedures	Not applicable
Any other information required by law.	

Disability-related claims. If a claim for disability benefits is denied, in addition to the information listed above, the notice of denial will also contain a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- the opinions of health care professionals treating the claimant and vocational professionals who evaluated the claimant, provided by the claimant;
- the views of medical or vocational experts whose advice was obtained in connection with a claimant's benefit denial, without regard to whether the advice was relied upon in making the denial; and
- a disability determination regarding the claimant made by the Social Security Administration, provided by the claimant.

The notice will also include a statement that you are entitled to receive, upon request and at no cost, reasonable access to all documents relevant to the claim, and copies of those documents.

appealing a denied health benefit or disability claim

If your health benefit claim or disability claim is denied in whole or in part, you may ask for a review within 180 days of the initial denial as described in the applicable insurance booklet. You may also request a review if your health coverage was retroactively removed. In accordance with federal law, you have both an internal and external appeals process; however, the external appeals process is only available in certain circumstances. Contact the applicable claims administrator for more information.

A request for review should contain your name and address, the date you received notice your claim was denied, and your reason(s) for disputing the denial. You may submit written comments, documents, records, and other information relating to your claim. If you request, you will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

The review will take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether such information was submitted or considered in the initial denial of your claim. The review will be conducted by someone other than the person or persons (or subordinate of such person or persons) who conducted the initial claim determination. The reviewer will provide an independent, full and fair review of your claim and will give no consideration to the initial adverse determination.

Group Health Claims. The following rules apply to a benefit denial that is based in whole or in part on a medical judgment, including decisions about whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate:

- The reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- The health care professional consulted by the reviewer cannot be the same individual or the subordinate of the individual who was consulted in connection with the original benefit denial; and
- The medical or vocational experts whose advice was obtained in connection with a claimant's benefit denial will be identified, even if the advice was not relied upon in making the benefit determination.

Disability-related claims. Before issuing a denial on review of a disability benefit claim, the claims administrator must also provide the claimant, free of charge, with the following information:

- Any new or additional evidence considered, relied upon, or generated by the plan, claims administrator, or other person making the benefit determination in connection with the claim. Such evidence must be provided as soon as possible, giving the claimant a reasonable opportunity to respond before the reviewer's deadline for making a decision on review; and
- Any new or additional rationale used to issue an adverse benefit determination. The rationale must be provided as soon as possible, giving the claimant a reasonable opportunity to respond before the reviewer's deadline for making a decision on review.

You will receive a written notice of the decision on review. If the claim is denied on review, the notice will contain the following information:

Group Health Claims	**Disability-Related Claims**
The date of service, the health care provider, the claim amount (if applicable) and the denial code and its corresponding meaning, as well as a statement that the claimant may request the applicable diagnosis and treatment codes (and their meanings)	Not applicable
The specific reason or reasons for the denial	
Reference to the specific Plan provisions on which the denial was based	
A statement that you are entitled to receive, upon request and at no cost, reasonable access to all documents relevant to the claim, and copies of those documents.	
A statement of your right to bring a civil action in court	A statement of your right to bring a civil action in court, including a description of any limitations period that applies to the right to bring an action, and the calendar date on which the limitations period expires
If the denial is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided to you free of charge upon request	The specific internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the adverse determination or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.
If the denial is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request	Not applicable
The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act to assist individuals with the internal claims and appeals and external review procedures	Not applicable
Any other information required by law	

Procedures for obtaining impartial medical determinations in sickness and accident and extended disability benefits claims have also been developed by Rolls-Royce Corporation and the Union. These medical determinations are final and binding upon you, Rolls-Royce Corporation, the Union, and the insurance company.

external review of a denied health benefit claim

You or your authorized representative may, in certain limited circumstances, submit a denied health benefit claim to an independent review organization for external review. Contact the Claims Administrator (Anthem) for more information on this option.

life insurance and accidental death and dismemberment (AD&D) appeals

If you (1) disagree with a carrier's disposition of your benefit claim, (2) have any question regarding lack of coverage, or (3) are concerned about an anticipated claim, you may request the assistance of your union benefit representative to provide assistance with your problem. If your union representative cannot resolve your problem, your case may be referred to the International Union and the Rolls- Royce Corporation for further consideration. If your case involves a denial of benefits, and the International Union and the Rolls-Royce Corporation cannot resolve the issue, the International Union may request Rolls-Royce Corporation to have your case reviewed by the appropriate carrier.

If your claim for a life insurance or AD&D benefits is denied, your beneficiary (or you or your authorized representative for AD&D), may submit a complaint or dispute of the denied claim to the insurer as outlined in the insurance booklet. You should submit a written request to the address in the claim denial letter.

If your appeal is denied, the Claims Administrator will provide you written notice of its determination. The notice will provide you:

1. The specific reason(s) for the determination and reference to any specific benefit provision(s) on which the determination is based.

2. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and

3. A statement describing any voluntary appeals procedures and your right to bring an action under ERISA Section 502(a).

finality of determinations

All claims determinations regarding a benefit claim are final, conclusive and binding. If you wish to preserve your rights to bring a civil action under ERISA section 502(a), you must follow those procedures and file your civil action within one year of the date on which your claim for benefits is denied upon final review.

For questions about your rights, these claims procedures, or for assistance, you can contact the Employee Benefits Security Administration at 866-444-EBSA (3272).

Section 13 — ADMINISTRATIVE INFORMATION: ERISA

This section includes information on plan administration and other matters required to be addressed in summary plan descriptions for ERISA-covered programs.

types of ERISA-covered plans

The Rolls-Royce Corporation Personal Savings Plan for Hourly-Rate Employees (known as the Personal Savings Plan) is a defined contribution plan providing benefits to employees who elect to participate in this Plan. Personal Savings Plan benefits are provided through a trust, the trustee for which is Fidelity Management Trust Company.

The Rolls-Royce Corporation Welfare Benefits Plan (known as the Welfare Plan) is a welfare benefit plan providing:

- life and disability insurance coverage to employees. Life insurance is provided by MetLife. Sickness and accident and extended disability benefits are provided through Lincoln Financial Group; and
- self-insured health coverage for employees and their eligible dependents. Health care coverage is provided through Anthem Blue Cross/Blue Shield. Prescription drug coverage is provided by Express Scripts. Dental coverage is provided by Cigna and vision coverage is provided by EyeMed.

Beginning January 1, 2021, dental coverage will be provided through Delta Dental and vision coverage will be provided through Anthem Blue View Vision.

The Rolls-Royce Corporation Hourly-Rate Employees Pension Plan (known as the Pension Plan) is a defined benefit plan providing benefits to employees who are eligible to participate in this Plan. Pension Plan benefits are provided through a trust, the trustee for which is State Street Bank & Trust Company.

plan year

December 31 is the last day of the fiscal year Personal Savings Plan, Welfare Plan and Pension Plan. Records of these plans are kept on a calendar year basis.

named fiduciary

The named fiduciary for the Personal Savings Plan, Welfare Plan and Pension Plan is the Rolls-Royce North America Fiduciary Committee.

sponsoring employer and administrator

Rolls-Royce Corporation is the sponsoring employer of, and Rolls-Royce North America Fiduciary Committee is the Plan Administrator for, the Personal Savings Plan, Welfare Plan and Pension Plan. The administrator's address is: 1900 Reston Metro Plaza, Suite 400, Reston, VA 20190. Its telephone number is 703-834-1700.

identification number

Rolls-Royce Corporation's employer identification number is 35-1899021. Plan numbers are as follows:

PLAN	
NAME	**NUMBER**
Rolls-Royce Corporation Personal Savings Plan for Hourly-Rate Employees	002
Rolls-Royce Corporation Welfare Benefits Plan	511
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In addition, some employees are eligible to participate in the Rolls-Royce North America Section 125 Cafeteria Plan, the applicable employer identification number for which is 54-1967187.

legal process

Service of legal process on Rolls-Royce may be made at Rolls-Royce Corporation, Legal Department, P.O. Box 420, Indianapolis, IN 46206-0420.

Service of process may also be made upon the Administrator or Trustee of the Plans, as applicable.

funding for benefits

Rolls-Royce Corporation Personal Savings Plan for Hourly-Rate Employees – benefits are funded by both participants and Rolls-Royce Corporation and are paid from assets held in the Personal Savings Plan's trust fund.

Rolls-Royce Corporation Hourly-Rate Employees Pension Plan – benefits are funded by Rolls-Royce Corporation and are paid from assets held in the Pension Plan's trust fund.

Rolls-Royce Corporation Welfare Benefits Plan – benefits are funded through a combination of participant and Employer contributions and insurance as described below:

- Health, dental and vision benefits are self-insured by the Employer. Benefits are paid from the Employer's general assets;
- Health Savings Accounts are funded by participant and Employer contributions;
- Basic life and accidental death and dismemberment benefits are funded by premiums paid by the Employer and are insured by MetLife;
- Optional life insurance, dependent life insurance and personal accident insurance benefits are funded by premiums paid by the participant and are insured by MetLife;
- Sickness and accident benefits (short-term disability) are self-insured by the Employer. Benefits are paid from the Employer's general assets; and
- Extended (long-term) disability benefits are self-insured by the Employer.

Rolls-Royce Corporation Retiree HRA Plan – Retiree benefits are self-insured by the Employer and paid from the Employer's general assets.

claims administrators

Medical	Prescription drugs	Vision Care	
		Plan Year 2020	Effective January 1, 2021
Anthem P. O. Box 105187 Atlanta, GA 30348-5187 (888) 823-8576 *anthem.com*	Express Scripts P. O. Box 14711 Lexington, KY 40512 (800) 987-5248 express-scripts.com	EyeMed 4000 Luxottica Place Mason, OH 45040 (866) 723-0513 *eyemed.com*	Anthem Blue View Vision P.O. Box 8504 Mason, OH 45040 (866) 723-0515 anthem.com

Dental		Life/AD&D	Disability
Plan Year 2020	Effective January 1, 2021		
CIGNA P.O. Box 188037 Chattanooga, TN 37422-8037 (800) 244-6224 *mycigna.com*	Delta Dental P.O. Box 9085 Farmington Hills, MI 48333 (800) 524-0149 deltadental.com or deltadentalin.com (IN only)	MetLife P. O. Box 6100 Scranton, PA 18505-6100 (800) 638-6420	Lincoln Financial Group P. O. Box 7206 London, KY 40742-7206 (877) 562-9977

Mental Health & Alcohol/Substance Abuse	
Plan Year 2020	Effective January 1, 2021
Beacon Health Options* PO Box 1854 Hicksville, NY 11802-1854 (800) 335-7740	Anthem Behavioral Health P.O. Box 105187 Atlanta, GA 30348-5187 (844) 792-5141

achievesolutions.net/rollsroyce beaconhealthoptions.com	anthem.com

COBRA administrator

HealthEquity (formerly WageWorks)
P. O. Box 223684, Dallas, TX 75222-3684
(866) 747-0039

trustees and custodian

Personal Savings Plan Trustee	HSA Custodian	Pension Plan Trustee
Fidelity Management Trust Company 245 Summer Street Boston, MA 02210	Fidelity Management Trust Company 245 Summer Street Boston, MA 02210	State Street Bank & Trust Company 801 Pennsylvania Avenue Kansas City, Missouri 64105

your ERISA rights

As a participant in Rolls-Royce Corporation benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled by law to:

receive information about your plan and benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, 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 Pension and Welfare Benefit 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.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age under the plan, and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve months. The plan must provide the statement free of charge.

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.

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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA.

enforce your rights

If your claim for a pension or welfare 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 suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. However, no legal action may be commenced or maintained against the Plan prior until after you exhaust the Plan's claims procedures, which are described in this document.

assistance with your questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272.

Rolls-Royce Corporation right to amend, modify, suspend or terminate

Rolls-Royce Corporation intends that the benefit plans will continue indefinitely. No changes may be made until the expiration of the 2020 Collective Bargaining Agreement, except as required by law or as mutually agreed between Rolls-Royce Corporation and the UAW. The 2020 - 2025 Collective Bargaining Agreement expires February 2025.

No person has the authority to commit the Company to any benefit or benefit provision not provided for under the applicable benefit plan, or to change the eligibility criteria or any other provisions of such benefit plan.

welfare plan

Upon termination of Rolls-Royce Corporation Welfare Benefits Plan, coverage will cease as of the effective date of termination. Benefits for covered services received or eligible expenses incurred prior to program termination will be covered if claims for those benefits are submitted timely.

personal savings plan

Upon termination of the Personal Savings Plan, no further savings may be contributed to the accounts of participants. Participant accounts under the Plan will be 100% vested.

pension plan

Upon termination of the Pension Plan, participant benefits under the Plan will be 100% vested (to the extent the Plan is funded). This is true regardless of the how much vesting service you have at that time. No change to the Plan can reduce benefits that are already credited to you, or reduce the vested interest you have earned before the change. The plan may, however, be changed to reduce or discontinue future benefit accruals.

collective bargaining agreement

The Rolls-Royce Corporation Welfare Benefits Plan, Bonus Program, Personal Savings Plan, and the Pension Plan, each as described in this booklet, are maintained pursuant to a collective bargaining agreement with the UAW. A copy of the agreement may be obtained upon your written request to your union representative or the Plan Administrator.

Section 14 — General Information about Your Benefits

cost of your benefit plans

Rolls-Royce Corporation pays the full cost of your medical, dental, vision, basic life, basic accidental death and dismemberment (AD&D) and disability insurance premiums (after you become eligible while you are in active service). The Company also pays the full cost of the Pension Plan for eligible participants. You pay the full premium cost of optional life, optional dependent life and optional AD&D insurance. Refer to details about the cost of coverage in each applicable benefit section.

If you elect to enroll in coverage under COBRA, you are generally required to pay the full premium, the 2% administration fee, as well as pay any coinsurance, deductibles or sanctions required under the rules of the Rolls-Royce Corporation Welfare Benefit Plan.

The Company also generally pays the administrative costs for, and makes contributions for eligible participants to, the Personal Savings Plan. The amount of Rolls-Royce Corporation's contribution to the Personal Savings Plan is determined under a formula set out in the Plan. The amount of employee contributions that you can make to the Personal Savings Plan is also determined under the terms of the Plan.

recovery of benefit payments

If any benefit paid to you or on your behalf (or to one of your dependents or on his or her behalf) should not have been paid, or should have been paid in a lesser amount, and you fail to promptly repay the amount, the 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 a Rolls-Royce Corporation benefit plan (excluding the Rolls-Royce Corporation Personal Savings Plan for Hourly-Rate Employees and the Rolls-Royce Corporation Hourly Employees Pension Plan).

life, accidental death & dismemberment, and health care benefits

The life and disability benefits under the Rolls-Royce Corporation Welfare Benefits Plan will be administered in compliance with state insurance laws to the extent legally required and to the extent such laws are not preempted by federal law.

for employees returning from permanent layoff

life and disability coverage

Upon return to active work from permanent layoff, you will be eligible for disability benefits on the first day you are at work after you have received earnings for 12 pay periods within a calendar year following your return to work. If you become disabled prior to meeting this earnings eligibility requirement, you may be eligible for reinstated disability benefits. See *Section 9 — Disability Benefits* for more information.

health care coverage

Upon return to active work from layoff, any coverage discontinued while on layoff with seniority will be reinstated the day you return to work. Company contributions also will resume at that time.

for employees on non-disability leave

If you are granted a non-disability leave of absence, you will be given a notice explaining (1) your life and disability benefit and health care program continuance privileges, and (2) any monthly contributions you may have to make.

life and disability coverage

Coverage may be continued for the following periods, after the month in which you last worked prior to an approved leave of absence (other than for disability).

- ❑ for the first month, basic life, accidental death and dismemberment, and disability benefit coverage in force are continued at no cost to you.

- ❑ thereafter, you may continue basic life and accidental death and dismemberment coverage up to 11 months, provided you contribute $.50 per month per $1,000 of basic life insurance.

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 benefit coverage, which are discontinued at the end of the month following the month in which you last worked, may be reinstated. For disability coverage to be reinstated, you must (1) have been making contributions to continue your basic life insurance, and (2) present medical evidence satisfactory to Rolls-Royce Corporation that you are totally disabled. Reinstatement will be made effective as of the date you present satisfactory medical certification of your disability. Rolls-Royce Corporation will pay the full cost of your life and disability coverage. Such contributions will start the first of the month in which you present evidence satisfactory to Rolls-Royce Corporation of your total disability.

If eligible to continue, you must make the required monthly contributions to continue optional life, dependent life and personal accident insurance. Basic Life Insurance must remain in force in order to continue optional life and dependent life insurance.

health care coverage

Your health care coverage as an active employee ends at the end of the month in which you are last in active service. Thereafter, you may continue coverage under the applicable provisions of Federal Law (see *continue group health plan coverage* section). If for some reason you are ineligible to continue coverage under COBRA, you may continue coverage, on a self-paid basis, for up to 12 months while your seniority remains unbroken.

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

the family and medical leave act of 1993 (FMLA)

Under the Family and Medical Leave Act of 1993 (FMLA) you may be eligible to take unpaid leave for a period of up to twelve (12) work - weeks per calendar year because of:

- ❑ the birth of a child or the placement of a child for adoption or foster care,
- ❑ the need to provide care for a family member (child, spouse, parent) with a serious health condition, or
- ❑ a serious health condition which makes you unable to do your job.

Rolls-Royce Corporation will maintain your health care coverage during an approved FMLA leave on the same basis as if you remained an active employee.

If you do not return to work following an FMLA leave, your eligibility for continuation of health care coverage, if any, and the basis of such continuation, will be governed by the Rolls-Royce Corporation Welfare Benefit Plan provisions applicable to what is determined to be your status as of and following the date you fail to return to work. However, under the FMLA, Rolls-Royce Corporation can recover the cost of health care coverage continued during the FMLA leave, if you do not return to work, unless your failure to return is caused by another serious health condition or another reason beyond your control.

for employees terminating employment

life and disability benefits

If you (1) cease active work at or after age 60, but before age 65, (2) had five or more years of participation at the end of the month in which you attained age 60, and (3) were insured from age 60 to the date you cease work, you may continue your basic life and accidental death and dismemberment insurance to the end of the month in which you attain age 65, provided you contribute $.50 per month per $1,000 of basic life insurance.

health care benefits

If you terminate employment with Rolls-Royce Corporation at age 65 or older for any reason other than discharge for cause, your health care coverage may be continued consistent with the Welfare Plan provisions.

when your coverage terminates

Health care coverage ends on the last day of the month in which you quit voluntarily or are discharged.

Basic life and accidental death and dismemberment, as well as disability benefit coverage, terminates on your last day of active employment if you quit voluntarily or are discharged. If your employment is terminated for any other reason, except retirement, all coverage continues until the last day of the month in which your seniority is broken.

However, in any case where an employee files a grievance protesting loss of seniority, life insurance and disability coverage will remain in effect until the last day of the month in which seniority is broken. While the grievance is pending, an employee may continue life insurance coverage, by making the required monthly contributions.

Optional life insurance terminates on the earliest of the following dates: (1) on the date that your basic life insurance ceases, (2) on the last day of the calendar month preceding the month for which a required contribution was due, but not paid, or (3) when you attain age 70 or the last day of the calendar month preceding your retirement effective date, if later. Dependent Life Insurance also ceases when you no longer have an eligible dependent.

Optional Accidental Death and Dismemberment (AD&D) insurance terminates on the earliest of the following dates: (1) on the date your basic life insurance ceases, except during periods of layoff or leave of absence or retirement, or (2) on the last day of the calendar month preceding the month for which a required contribution was due but not paid. Optional dependent AD&D terminates when that covered person no longer is an eligible dependent. If you quit voluntarily, or are discharged, all insurance ceases immediately.

Conversion privileges are described below.

program conversion privileges

During the 31 days following cancellation of your life insurance and/or health care coverage:

- ❑ you may convert, at your expense, all, or part, of your basic life and optional life to an individual policy, without medical examination. Any type of life insurance policy, except term insurance, then being issued by MetLife may be selected. You will be sent the conversion notice by the Rolls-Royce Benefits Service Center, but you will work directly with MetLife on the conversion process.
- ❑ you may obtain, at your expense, whatever “direct pay” individual contract for basic health care (but not for prescription drugs, hearing aid, vision or dental) coverage then available from the carrier through which you have been enrolled. Application must be made in accordance with a notice that you will receive from the carrier.

Section 15 — IMPORTANT INFORMATION AND RESOURCES

notify a Union Benefit Representative as soon as possible if:

- ❑ you change your address;
- ❑ your marital status changes;
- ❑ your dependents change;
- ❑ you become disabled;
- ❑ your spouse dies;
- ❑ your beneficiary dies;
- ❑ you desire to change your beneficiary;
- ❑ you, your spouse or a dependent become eligible for Medicare part B;
- ❑ you are laid off and secure other employment;
- ❑ you become eligible for social security disability insurance benefits;
- ❑ you become eligible for Social Security Disability Insurance Benefits; and
- ❑ you want survivor coverage and are eligible for it.

Use your employee ID number in all of your communications to Rolls-Royce Corporation. You will also need to notify the Human Resources Shared Service Center at (317) 230-7777 (or toll-free at (877) 787-6247) if your address changes.

social security or Medicare-related questions

Contact your local Social Security office at (800) 772-1213 if you have any questions about Social Security or Medicare.

important phone numbers and websites

Benefit and Carrier		Phone number	website
Rolls-Royce Benefits Center		(844) 625-5900	RRbenefitscenter.com
Medical	**Anthem Customer Service** **Medical Pre-Certification** **Cost Comparison**	(888) 823-8576 (866) 513-6934 (866) 670-7221	anthem.com mycastlight.com/rolls-royce
Prescription drug	**Express Scripts**	(800) 987-5248	express-scripts.com
Dental *Effective 01/01/2021*	**Cigna** **Delta Dental**	(800) 244-6224 (800) 524-0149	mycigna.com deltadental.com or deltadentalin.com (Indiana only)
Vision *Effective 01/01/2021*	**EyeMed** **Anthem Blue View Vision**	(866) 723-0513 (866) 723-0515	eyemed.com anthem.com
Flexible Spending Accounts (FSAs)	**Benefit Strategies**	(888) 401-3539	benstrat.com
Health Savings Account (HSA)	**Fidelity**	(844) 625-5900 (Option 2)	netbenefits.com
Telemedicine	**Teladoc**	(800) TELADOC (800) 835-2362.	teladoc.com/myconsults
Disability	**Lincoln Financial**	(877) 562-9977	mylincolnportal.com
Life and AD&D insurance	**MetLife**	(800) 638-6420	metlife.com
Wellness Program	**Propel RR Wellbeing**	(888) 339-4131	RRwellbeing.com

Benefit and Carrier		Phone number	website
Behavioral health/substance abuse *Effective 01/01/2021*	**Beacon Health Options** **Anthem Behavioral Health**	(800) 335-7740 (844) 792-5141	achievesolutions.net/rollsroyce anthem.com
Employee Assistance Program (EAP)	**Beacon Health Options**	(800) 335-7740	achievesolutions.net/rollsroyce
Personal Savings Plan	**Fidelity**	(844) 625-5900 (Option 5)	netbenefits.com

The information contained in this guide is a brief summary of the various benefit programs offered by Rolls-Royce Corporation. It is not intended to describe the programs fully or to serve as a guarantee of program benefit plans. The official plan documents and contracts govern in case of a dispute over program provisions.