UAW Retirees of the Dana Corporation Health and Welfare Trust

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November 2010

****PLEASE READ CAREFULLY****

IMPORTANT CHANGES TO YOUR HEALTH AND WELFARE BENEFITS

Dear Participant:

The increasing cost of health care benefits is a national problem and the UAW Retirees of the Dana Corporation Trust is not immune.

Beginning January 1, 2011, participants will see some changes in their benefits. Please carefully read the summary of changes below.

Informational meetings are being scheduled in many communities for you to learn more about the new plans and to answer your questions. Please refer to the **Section 6** of this letter, **"Questions Regarding the Changes"** for information on these meetings as well as telephone numbers that you can call for assistance.

Section 1. PRE-MEDICARE ELIGIBLE PARTICIPANTS

Overview of Health and Welfare Benefit Changes

An overview of the health and welfare benefit changes and the effective dates for Pre-Medicare eligible participants are indicated in the following table:

Pre-Medicare Eligible Participants		
Health Benefit	**Change**	**Effective**
Premium Payment	All participants are required to pay an increased monthly premium in order to continue coverage	January 1, 2011
Medical Coverage	Increased Deductible	January 1, 2011
Prescription Drugs	New Co-payments and additional coverage limits	January 1, 2011

Section 1. PRE-MEDICARE ELIGIBLE PARTICIPANTS (cont.)

All changes in the health and welfare plan for pre-Medicare eligible participants are effective January 1, 2011. Pre-Medicare eligible refers to retirees, spouses or dependents who are not eligible for Medicare because they are: (1) under age 65, or (2) not disabled as determined by Social Security.

Medical Plan

The medical plan is a Preferred Provider Organization (PPO), which arranges with network providers (doctors, hospitals, healthcare facilities, etc.) to offer services at reduced fees. Your costs will be lower if your receive care from an in-network provider (physician, hospital, etc.) rather than an out-of-network provider.

Co-Insurance and Deductibles

Effective January 1, 2011, the 20% in-network co-insurance will remain. This means that for in-network services, the Trust will pay 80% of covered expenses and you will be responsible for the remaining 20%. For out-of-network services, the Trust will pay for 60% of covered expenses and you will be responsible for 40%.

Your annual deductible will increase to $300 per single individual from the current $200 per single individual and to $600 per family from the current $400 per family for in-network services. The annual deductible for out-of-network coverage will be $600 per single individual and $1,200 per family, from the current $500 per single individual and $1,000 per family.

Out of Pocket Maximums

The out-of-pocket maximum is the maximum amount you are responsible for paying each calendar year, in addition to the deductible. This amount will not change in 2011.

In-Network Services

The out-of-pocket maximum for in-network services each calendar year will be $1,500 per single individual, and $3,000 per family. This means that once the 20% co-payments for the in-network services for which you are responsible accumulate to a total of $1,500 per individual or $3,000 per family, the Trust will then pay the remainder of covered expenses incurred during that calendar year at 100%.

Out-of-Network Services

The out-of-pocket maximums for out-of-network services each calendar year will be $4,500 per single individual, and $9,000 per family. The required deductible amounts described above do not count toward your out-of-pocket maximum.

Section 2. MEDICARE PARTICIPANTS

Overview of Health and Welfare Benefit Changes

An overview of the health and welfare benefit changes and the effective dates are indicated in the following table:

Medicare Participants		
Health Benefit	**Change**	**Effective**
Premium Payment	Participants monthly premium will remain unchanged	January 1, 2011
Medical Coverage	Plan Design Changes including PPO network and increased deductible	January 1, 2011
Prescription Drugs	New Co-pays and additional coverage limits	January 1, 2011

Effective January 1, 2011, the medical plan will change for all Medicare participants.

Medical Plan

The current Medicare Plus Group Plan, a Medicare Advantage plan, will remain with Blue Cross Blue Shield of Michigan, however, it will no longer be a Private Fee for Service Plan but it will now utilize a Preferred Provider Organization (PPO) network. BCBSM has a nation-wide network--it covers all states and US territories. You can use any participating doctor, specialist or hospital.

Within the next few weeks, you will receive in the mail, information regarding the Blue Cross Blue Shield of Michigan Medicare Plus Group Plan. This material will include a detailed description of the benefits.

You will also receive new ID cards from Blue Cross Blue Shield of Michigan in January 2011. Please begin using your new ID cards on or after January 1, 2011.

Section 2. MEDICARE ELIGIBLE PARTICIPANTS (cont.)

Medical Plan

The new medical plan is a Preferred Provider Organization (PPO), which arranges with network providers (doctors, hospitals, healthcare facilities, etc.) to offer services at reduced fees. Your costs will be lower if your receive care from an in-network provider (physician, hospital, etc.) rather than an out-of-network provider.

Co-Insurance and Deductibles

Effective January 1, 2011, the 20% in-network co-insurance will remain. This means that for in-network services, the Trust will pay 80% of covered expenses and you will be responsible for the remaining 20%. For out-of-network services, the Trust will pay for 60% of covered expenses and you will be responsible for 40%.

Your annual deductible will increase to $300 per single individual from the current $200 per single individual and to $600 per family from the current $400 per family for in-network services. The annual deductible for out-of-network will be $600 per single individual and $1,200 per family, from the current $500 per single individual and $1,000 per family.

Out of Pocket Maximums

The out-of-pocket maximum is the maximum amount you are responsible for paying each calendar year, in addition to the deductible. This will not change.

In-Network Services

The out-of-pocket maximum for in-network services each calendar year will be $1,500 per single individual, and $3,000 per family. This means that once the 20% co-payments for the in-network services for which you are responsible accumulate to a total of $1,500 per individual or $3,000 per family, the Trust will then pay the remainder of covered expenses incurred during that calendar year at 100%.

Out-of-Network Services

The out-of-pocket maximums for out-of-network services each calendar year will be $3,000 per single individual, and $6,000 per family. The required deductible amounts described above do not count toward your out-of-pocket maximum.

Section 3. Prescription Drug Coverage: ALL PARTICIPANTS

Effective January 1, 2011, your prescription drug benefit is changing. The changes include:

- ***Copayment Increases***

Retail (1 month supply): From $0 to $5 for generic drugs, from $25 to $30 for single source brand name drugs and from $75 to $80 for multi-source brand name drugs (i.e., a generic is available)

Mail Service (3 month supply): From $0 to $10 for generic drugs, from $50 to $60 for single source brand name drugs and the $170 for multi-source brand name drugs (i.e., a generic is available) will remain the same

- ***Elimination of Coverage for Protein Pump Inhibitors (PPI) which can be purchased over the counter without a prescription, such as Nexium, and Prilosec, etc.***

  Your prescription drug coverage will continue to be provided through CVS Caremark.

  Your ID card for prescription drugs will not change. You may continue to use your current ID card for prescription benefits now and after January 1, 2011. Within the next few weeks, you will receive in the mail more information regarding your prescription benefits.

Section 4. NEW Discount Vision Program through Davis Vision: PRE-MEDICARE ELIGIBLE PARTICIPANTS & MEDICARE PARTICIPANTS

Effective January 1, 2011, a new discount vision program will be available. Enclosed is information on the benefits, and a toll free telephone number for you to use to locate a Davis Vision provider in your area. Although you will be responsible for the cost of the services and products, by using a Davis Vision provider, that cost will be greatly reduced. ***(See attached)***

Section 5. Required Monthly Premiums: PRE-MEDICARE ELIGIBLE PARTICIPANTS & MEDICARE PARTICIPANTS

Effective January 1, 2011, your monthly premium contribution will be as outlined below. Your monthly premium for the new health plan depends upon your Coverage Status as indicated in the following table:

PRE-MEDICARE ELIGIBLE PARTICIPANTS

Coverage Status: Pre-Medicare Eligible Participants	Current 2010 Premium Amount	New 2011 Premium Amount
Single	$201	$231
Two Person	$387	$447
Family	$504	$629
Mixed Contract		
One Medicare/One Pre-Medicare	$303	$333
One Medicare/Two or more Person Pre-Medicare	$489	$549
Two Medicare/One or more Person Pre-Medicare	$539	$569

MEDICARE PARTICIPANTS

Coverage Status: On Medicare	Current 2010 Premium Amount	New 2011 Premium Amount
Single	$102	$102
Two Person	$203	$203
Mixed Contract		
One Medicare/One Pre-Medicare	$303	$333
One Medicare/Two or more Person Pre-Medicare	$489	$549
Two Medicare/One or more Person Pre-Medicare	$539	$569

Your method of payment will continue. If you have not already arranged for direct withdrawal, contact the Fund Office and you can avoid the monthly $5 service charge when paying by check. Please make these payments timely as your coverage is contingent upon receipt of payment each month.

Section 6. Questions Regarding the Changes?

Several informational meetings have been established at the dates, times and locations listed below to answer any of your questions:

Date:	Location:
December 06, 2008, 9:00am - 11:00am	Holiday Inn Richmond 5501 National Road East Richmond, Indiana 47374
December 08, 2010, 9:00am - 11:00am	UAW Region 1A 9650 South Telegraph Road Taylor, Michigan 48180
December 09, 2010, 9:00am - 11:00am	UAW Local 602 2510 W. Michigan Ave. Lansing, MI 48917
December 10, 2010, 9:00am – 11:00am	USW Hall 2228 Lakeview Drive Ft. Wayne, IN 46818
December 13, 2010, 9:00am - 11:00am	UAW Local 1765 1440 Bellefontaine Avenue Lima, Ohio 45804
December 14, 2010, 9:00am - 11:00am	UAW Local 12 2300 Ashland Ave. Toledo, OH 43609
December 16, 2010, 9:00am - 11:00am	UAW Local 879 2191 Ford Parkway St. Paul, MN 55116

If you have any questions regarding the changes listed above, please contact the UAW Retirees of the Dana Corporation Benefit Office at (866) 626-2070 Monday through Friday from 7:30 a.m. until 4:30 p.m., Eastern Standard Time.

Section 6. Questions Regarding the Changes? (cont.)

Important Phone Numbers

If You Have a Question About.	You Should Contact.
Eligibility	BeneSys: (866) 626-2070 Hours: 7:30 a.m. - 4:30 p.m. ET
Pre-Medicare Eligible Participant Medical Coverage	Anthem BlueCross BlueShield/CMSi: (800) 305-0406
Medicare Medical Coverage	Medicare Advantage BlueCross BlueShield of MI: (866) 684-8216 TTY - (800) 579-0235
Locating a Provider that Participates in the Blue Cross Blue Shield PPO Network	Blue Cross Blue Shield: (800) 810-Blue (2583)
Medical Premiums	BeneSys: (866) 626-2070
Prescription Drug Coverage	CVS Caremark: (888) 865-6592
Long-Term Disability Coverage	BeneSys: (866) 626-2070

Final Note

The Committee recognizes that your retiree benefits provide important protection for you and your dependents. Accordingly, the Committee seeks to make available to eligible UAW retirees comprehensive and cost effective retiree benefit programs with the funds that it manages. From time to time, the Committee may change the programs that it makes available and reserves the right to do so and to terminate such programs as it determines in its sole discretion. The rates described in this letter are valid through December 31, 2011. The Committee encourages you to attend an Informational Meeting in your area in order to understand your options, premium rates and enrollment procedures. As will be described in future communications, there will be very limited rights to waive coverage initially and still retain an opportunity to participate in the Trust's plan of benefits in the future. Accordingly, it is important that you make an informed decision about the continuation of your coverage in the next several weeks.

Sincerely,

The Committee of the UAW Retirees of the Dana Corporation Health Care Trust

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor **UAW Retirees of the Dana Corporation Health and Welfare Trust** may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses, to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.