UAW Retirees of the
Dana Corporation Health & Welfare Trust

Benefits for Retiree Flex Plan

SUMMARY PLAN DESCRIPTION

JANUARY 1, 2021

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Introduction

The UAW Retirees of the Dana Corporation Health & Welfare Trust (Trust) provides long term disability income, medical and prescription drug benefits to eligible participants. This Summary Plan Description (SPD) describes the benefits available as of January 1, 2021 under the Retiree Flex program. The Trust has separate medical and prescription drug benefit programs for Disabled Employees, Medicare-eligible and non-Medicare eligible participants, which are described in other SPDs.

The Retiree Flex program provides you with benefit dollars that may be used to help pay for health coverage or other eligible health care expenses. Your benefit dollars are based on your accrued service at retirement. You can use your benefit dollars to:

- Purchase your own health coverage; or
- Pay for IRS approved health care expenses.

This Summary Plan Description (SPD) describes the Retiree Flex program available through the Trust as of January 1, 2021 for eligible participants.

The Trust, which was established February 1, 2008 as part of a bankruptcy settlement between the UAW and Dana Corporation, is sponsored and administered by a Committee of seven members. Four of the Committee members are independent members and three of the Committee members are appointed by the UAW. The Committee manages the Trust, designs, and administers the benefit Plan and serves as the legal Plan Administrator and named fiduciary. The Trust is independent from both the Dana Corporation and the UAW.

The Committee reserves the right, at any time, to modify, amend or terminate any existing or future benefit or condition of eligibility or self-payment or any other term or condition of the Plan.

The Committee hired BeneSys, Inc. (BeneSys) as the Trust Administrator. BeneSys handles general Plan administration, including eligibility, recordkeeping, participant contributions and inquiries.

Please take time to read this SPD and familiarize yourself with your health care benefits. By reading each section carefully, you will understand your benefits and know how to use them wisely. You'll also learn about any out-of-pocket expenses that are your responsibility. When you come across a word you don’t understand, look in the Glossary at the back of the SPD. It contains the definitions of many health care terms that may be unfamiliar to you.

This SPD is only a summary of your benefits. Full details of the Plan’s benefits are set forth in the official Plan documents – which are the certificates, policies and schedules of the insurance carriers and benefit providers, the policies of the Committee and other documents that govern the Plan. In case of conflict between this SPD and the official Plan documents, those official Plan documents and not this SPD will govern, unless this SPD specifically states to the contrary. The Committee is the legal Plan Administrator. No one has the authority to speak for the Committee in explaining the eligibility rules or benefits of the Plan, except the full Committee or the Trust Administrator to whom such authority has been delegated. The Committee has the right to interpret the Plan, and to change or eliminate benefits or amend or terminate the Plan at any time. The Committee’s interpretation of the Plan is final and binding on all persons dealing with the Plan

or claiming a benefit from the Plan. If a decision of the Committee, or its delegate, is challenged in court, that decision will be upheld under current law unless it is determined by the court to have been arbitrary and capricious.

As a reminder, the Participant Website is available to all eligible participants. The website will provide key contact information, forms and documents that will help you get the most out of your benefits.

The address is www.ourbenefitoffice.com/uawdanaretirees

Please take some time to familiarize yourself with all it has to offer.

Each year, you will receive a Summary of Material Modifications, which includes a statement of significant changes in the Plan after the date of this SPD if any material changes are made to the Plan. Like this SPD, it is intended as a general statement of the changes and is not a substitute for other formal documents governing the terms of the Fund's coverage and eligibility rules.

If you have specific questions or need any assistance, contact the Trust Administrator. Contact information for the Plan Administrator can be found below, and in the Plan Administrative Information Section. When calling the Trust or any provider's customer service, please remember to document the date, time, name, and department of the representative you speak with. This could help locate your call should there be any discrepancies or questions in the future.

Your Responsibilities

The Plan is designed to reimburse you for eligible health care expenses. It is your responsibility to know what expenses are eligible for reimbursement and how to request reimbursement. Be sure to:

- **Follow Plan Procedures.** Review the information in this SPD so that you are familiar with how the Plan works to ensure you make the most of your benefits.
- **Enroll in Medicare as Soon as You are Eligible** due to age, disability, or end stage renal disease (ESRD). If you are not yet 65 or otherwise disabled but, have ESRD you will become entitled to/eligible for Medicare on the first day of the third month following the month when you first started dialysis. If you receive a transplant, your entitlement/eligibility for Medicare will start two months before the transplant. If you perform self-dialysis, your entitlement/eligibility for Medicare starts the month that you begin your dialysis. Be sure to enroll in Medicare Parts A and B or you will not be covered under this Plan.
- **Keep the Trust Administrator Informed of Changes.** You should notify BeneSys of any change in your address or family status (such as marriage, birth, adoption, death, divorce, legal separation, or a child losing dependent status).
- **Identify Yourself.** If you need to contact BeneSys, be sure to include your name and your member ID number or the last four digits of your Social Security number in your letter. To protect against identity theft, do not include your complete Social Security number in your letter. If you call, please be sure to have your complete member ID number or Social Security number handy.

- **Keep Copies of Bills, Receipts and Explanations of Benefits (EOBs).** These copies can help you when filing a Claim or appeal.
- **Keep Notices You Receive from the Trust.** Keep any notices of Plan changes or information you receive with this booklet. As a Plan participant, you have certain responsibilities to protect your eligibility for coverage and to receive your benefits.
- **Read this Booklet.** Take the time to read this SPD and share it with your family. The information contained in this SPD supersedes any earlier SPD you may have received.
- **Defined Terms:** Terms that have specific meanings relating to this Plan are capitalized throughout this booklet and are defined in the Glossary, which begins on page 41.

If you have specific questions or need any assistance, contact BeneSys:

- **Street Address:** 700 Tower Drive, Suite 300, Troy, Michigan
- **Mailing Address:** P.O. Box 1708 Troy, Michigan 48099-1708
- **Phone:** (866) 626-2070 or (248) 641-4903
- **Fax:** (248) 813-9898
- **Office Hours:** Monday through Friday, 7:30 a.m. to 4:30 p.m.

This SPD describes how the Plan works, what benefits it provides and how to obtain those benefits. This SPD is only a summary of your benefits; full details of the Plan are included in the legal documents that govern this Plan. The UAW Retirees of the Dana Corporation Health & Welfare Trust and the Plan are governed by the Committee. The Committee is the legal Plan Administrator. No one has the authority to speak for the Committee in explaining the eligibility rules or benefits of the Plan, except the full Committee or the Trust Administrator to whom such authority has been delegated. The Committee has the right to interpret the Plan, change or eliminate benefits, or amend or terminate the Plan at any time.

Eligibility and Participation

This section describes the eligibility requirements for individuals eligible for the Retiree Flex Program under the UAW Retirees of the Dana Corporation Health & Welfare Trust. Descriptions of the Trusts other programs are described in other separate SPDs.

Employee Eligibility

Retired Employee

You are eligible for coverage under the Retiree Flex Program as a Retired Employee if you meet **one** of the following two conditions:

1. **Retired Auburn Hills Employee:** You were an Employee (as defined by the Plan, refer to the Glossary, page 42) hired before January 1, 2004 who terminated employment after January 31, 2008 from the Auburn Hills, MI Dana facility with eligibility for Retired Employee benefits under the Retiree Flex Program, you retired directly from active service without a break ***and*** you are:
   - Age 65 or older with any amount of credited service; ***or***
   - Age 50 or older with 10 or more years of credited service and have 70 or more combined years of age and credited service.

Or

2. **Retired Elizabethtown Employee:** You were an Employee (as defined by the Plan, refer to the Glossary, page 42) hired before January 1, 2004 who terminated employment after January 31, 2008, from the Elizabethtown, KY facility, you retired directly from active service without a break ***and*** you are:
   - Age 65 or older with any amount of credited service; ***or***
   - Age 50 or older with 10 or more years of credited service and have 70 or more combined years of age and credited service.

Disabled Employee

You are eligible for coverage under this Plan as a Disabled Employee if you are eligible for Medicare due to age or disability and, upon cessation of your long-term disability benefits, you immediately begin your retirement benefits and meet **one** of the following:

1. **Disabled Employee Eligibility:** You were listed by Dana and the UAW as being on long-term disability status as of January 31, 2008 and have been continuously disabled and eligible since that date.

2. **Disabled Employee Eligibility:** You were an Employee (as defined by the Plan, refer to the Glossary, page 41) who began a Continuous Period of Disability on or before January 31, 2008, but are no longer entitled to receive short-term disability benefits ***and***:
   - You were a full-time hourly Employee employed as of the date you became disabled at a Dana facility located in Auburn Hills, MI or Elizabethtown, KY;
   - You meet the definition of disability because you are:
     - Wholly and continuously disabled because of an Illness or Injury; *and*
     - Under the care of a licensed Physician;
     - Completely prevented by your disability from engaging in any gainful occupation for which you are reasonably qualified by education, training or experience and you cannot earn a living through any other means; and
     - You are not regularly employed elsewhere.

If you are a Disabled Employee who retires directly from disability status, you will continue to be covered under the Plan, subject to meeting all other eligibility requirements

Surviving Spouse Eligibility

If you die before using your entire Retiree Flex account balance, your Surviving Spouse may be eligible to continue using your Retiree Flex account for reimbursement of Eligible Expenses if:

- You were continuously married to your Spouse from the date of your retirement or disability (for a Disabled Employee) through the date of your death; or
- You were continuously married to your Spouse through the date of your death, and you would have been eligible for coverage under the Plan as a Retired Employee if you had terminated employment at that time.

For your Surviving Spouse to continue coverage, he or she must submit a complete and accurate enrollment application to BeneSys no later than 30 days after the date of your death.

Dependents

The Retiree Flex Program allows you to request reimbursement of Eligible Expenses for yourself and your eligible dependents. To request reimbursement of Eligible Expenses for dependents, the individual must have been your dependent either at the time the services were provided or at the

time you paid the expenses. Your eligible dependents include the individuals described in this section.

Eligible Spouses

Your Spouse's Eligible Expenses may be reimbursed if you are a:

- Retired Employee and you have been continuously married to your Spouse since the date of your retirement; or
- Disabled Employee and you have been continuously married to your Spouse since the date your Continuous Period of Disability (entitling you to benefits) began.

Eligible Dependent Children

Your Dependent Child(ren)'s Eligible Expenses may be reimbursed if he or she is:

- Not married; and
- Under age 19 or age 25 if a full-time student.

As long as a Dependent Child is not married, coverage will continue until the last day of the Calendar Year in which the Dependent Child reaches age 19. However, coverage for an unmarried Dependent Child may be extended until the last day of the Calendar Year in which the Dependent Child reaches age 25 if the Dependent Child:

- Is enrolled as a full-time student at an accredited high school, college, university or vocational training school;
- Lives with you; and
- Can be claimed by you as a dependent for federal tax purposes.

In addition, coverage may be continued beyond the above age limits if the Dependent Child is disabled, and adequate annual proof of disability is provided.

Disabled Dependents

A Dependent Child may continue to receive benefits after the Dependent Child reaches the maximum age (19 or 25 if a full-time student) if the Dependent Child is incapable of self-sustaining employment because of physical or mental incapacity or disability developed before the Dependent Child reaches age 19 (or 25 if a full-time student). Proof of incapacity or disability acceptable to the Committee (or its designee) must be provided within 31 days of the date on which the Dependent Child's status as a dependent would otherwise end. In addition, proof of continued incapacity or disability must be provided on an annual basis. So long as annual proof of continued eligibility is provided and the Dependent Child otherwise meets eligibility requirements, coverage may continue until the Dependent Child dies or the Committee determines that the child is no longer disabled or incapacitated.

Qualified Medical Child Support Orders

As required by federal law, the Plan recognizes Qualified Medical Child Support Orders (QMCSOs). A QMCSO is a court order that recognizes the right of an alternate recipient (Dependent Child) to receive Plan benefits. A QMCSO is usually issued in a divorce where an individual is ordered by the court to continue to provide medical support for their child(ren); it may also be in the form of a National Medical Support Notice (NMSN) issued by the Friend of the Court. A QMCSO may not require the Plan to provide a type or form of benefit not otherwise provided to eligible Dependent Children.

When BeneSys receives an order that may be a QMCSO, BeneSys or Trust legal counsel will determine if it is a QMCSO. If the document is determined to be a QMCSO, the Trust will notify the eligible Covered Person and the possible alternate recipient (or custodial parent or issuing agency, as appropriate). If the document is determined not to be a QMCSO, the Trust will send a letter describing the reason for that determination. Payment of benefits made by the Plan pursuant to a QMCSO may be made to the alternate recipient's custodial parent or legal guardian, and notices and explanations of benefits relating to the alternate recipient will be sent to the custodian parent or legal guardian. Plan coverage of a Dependent Child under a QMCSO will be provided for as long as the child satisfies the definition of a Dependent Child for the applicable benefits, the required monthly contributions are made to the Trust for the period of coverage indicated in the QMCSO and the QMCSO remains in effect.

Enrolling for Coverage and When Coverage Begins

When you first become eligible for the Plan, you must complete an enrollment application for yourself, including information relating to your Spouse and dependents, and file it with BeneSys. For a:

- Retired or Disabled Employee, you must submit your application no later than the first day of the month before the month your retirement begins; or
- A Surviving Spouse who becomes eligible for coverage because of the death of an Employee, you must submit your application no later than 30 days after the date of the Employee's death.

A Retired or Disabled Employee, but not a Surviving Spouse, may request reimbursement of Eligible Expenses for a newly eligible Dependent Child. Written notice must be provided to BeneSys with all required documentation (such as birth certificates, proof of guardianship, adoption papers, marriage certificates, etc.) within 30 days of becoming eligible. Coverage for expenses of new dependents will not begin before the notice and the documentation are received, so it is to your benefit to provide the notice and the documentation to BeneSys as quickly as possible.

Your coverage under this Plan begins on the first day after you notify BeneSys that you want to enroll in the Plan within 30 days of when you are eligible.

Contact BeneSys with any questions about enrollment.

When Coverage Ends

Retired Employee, Disabled Employee or Surviving Spouse

As a Retired Employee, Disabled Employee or Surviving Spouse, you are no longer covered under this program on the earliest of the:

- Date you no longer have a Retiree Flex account balance;
- Date of your death;
- Date the Plan terminates.

While coverage for a Surviving Spouse does not end if the Surviving Spouse remarries, the Surviving Spouse cannot receive reimbursement for expenses of any new dependents. The expenses of a new spouse of a Surviving Spouse and any newly acquired dependents are not eligible for Plan coverage.

Spouse

As a Spouse of a Retired or Disabled Employee, you are no longer covered under the Plan on the earliest of the:

- Date there is no longer a balance in the Retired or Disabled Employee's Retiree Flex account;
- Date of your death;
- Date of your divorce or legal separation from a Retired or Disabled Employee; or
- Date the Plan terminates.

Dependent Children

A Dependent Child's expenses are no longer covered under the Plan on the earliest of the:

- Date there is no longer a balance in the Retired or Disabled Employee's Retiree Flex account;
- Date of the dependent's death;
- Date on which the child no longer meets the Plan's definition of a Dependent Child;
- Date on which the Retired or Disabled Employee or Surviving Spouse with whom the dependent is covered is no longer covered by the Plan; or
- Date the Plan terminates.

Your Retiree Flex Account

The Retiree Flex Program provides you with benefit dollars from an individual Retiree Flex account that you may use to help pay for retiree health coverage or other eligible medical expenses.

The initial amount in your Retiree Flex account was based on your accrued service at retirement. No additional contributions are made to your account after your retirement or termination of service. You may claim reimbursement for eligible medical expenses from your Retiree Flex account until your account is exhausted. Once your Retiree Flex account is exhausted, no additional claims will be reimbursed from this Plan.

After a claim is reimbursed, you will receive a statement that includes your account balance. If you are not sure of your account balance, contact Benesys.

Retiree Flex Account Eligible Expenses

Eligible Expenses are those that would generally qualify for a tax deduction for medical and dental expenses. Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and for the purpose of affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes. They don't include expenses that are merely beneficial to general health, such as vitamins or a vacation. These are explained in IRS *Publication 502, Medical and Dental Expenses*. Following is a summary of some specific expenses eligible for reimbursement from your Retiree Flex account, as listed in Publication 502:

- Acupuncture.
- Alcoholism inpatient treatment at a therapeutic center, including meals and lodging provided by the center during treatment and transportation expenses to and from Alcoholics Anonymous meetings in your community if the attendance is pursuant to medical advice that membership in Alcoholics Anonymous is necessary for the treatment of a disease involving the alcoholism.
- Ambulance.
- Artificial limbs.
- Artificial teeth.
- Birth control pills prescribed by a doctor.
- Braille books and magazines for use by a visually impaired person, limited to the cost that is more than the cost of regular printed editions.
- Breast pumps and supplies that assist lactation.
- Breast reconstruction surgery following a mastectomy for cancer.
- Capital expenses paid for special equipment installed in a home, or for improvements, if the main purpose is medical care for you, your Spouse or your dependent. See *IRS Publication 502* for more detailed information.
- Car improvements, such as special hand controls and other special equipment installed in a car for the use of a person with a disability.
- Chiropractor medical care.
- Christian Science Practitioner medical care.
- Contact lenses needed for medical reasons, including the cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner.
- Crutches, including purchase or rental.
- Dental treatment for the prevention and alleviation of dental disease.
    - Preventive treatment includes services of a dental hygienist or dentist for procedures such as teeth cleaning, application of sealants and fluoride treatments to prevent tooth decay.
    - Treatment to alleviate dental disease include services of a dentist for procedures such as X-rays, fillings, braces, extractions, dentures, and other dental ailments.

- Diagnostic devices used in diagnosing and treating illness and disease.
- Disabled dependent care expenses. However, these expenses may qualify as medical expenses and work-related expenses for a credit for dependent care; you cannot apply for a credit if you are reimbursed for these costs as a medical expense.
- Eye or vision correction surgery to treat defective vision, such as laser eye surgery or radial keratotomy.
- Eyeglasses needed for medical reasons, including fees paid for eye examinations, such as optometrist fees.
- Fertility enhancement procedures to overcome an inability to have children, including:
    - Procedures such as in vitro fertilization, temporary storage of eggs or sperm; and
    - Surgery, including an operation to reverse prior surgery that prevented the person from having children.
- Guide dog or other service animal costs related to buying, training, and maintaining a guide dog or other service animal to assist a visually impaired person, hearing-impaired person, or a person with other physical disabilities.
- Health institute fees you pay for treatment if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving the treatment.
- Health Maintenance Organization (HMO) amounts to entitle you, your Spouse or a dependent to receive medical care from the HMO.
- Hearing aids and batteries to operate them.
- Home care.
- Hospital services when receiving inpatient care at a hospital or similar institution if the main reason for being there is to receive medical care, this includes meals and lodging.
- Insurance premiums for policies that cover medical care; certain restrictions apply (see *IRS Publication 502*). These premiums may include:
    - Employer-sponsored health insurance plan premiums that are included in box 1 of your Form W-2, Wage and Tax Statement.
    - Medicare A premiums if you are not covered under Social Security (or were not a government employee who paid Medicare tax) and you voluntarily enroll in Medicare A.
    - Medicare B premiums.
    - Prepaid insurance premiums, under specific circumstances.
- Intellectually and developmentally disabled individual special home costs; certain restrictions apply (see *IRS Publication 502*).
- Laboratory fees.
- Lactation expenses.
- Lead-based paint removal costs to prevent a child who has or had lead poisoning from eating the paint; certain restrictions apply (see *IRS Publication 502*).

- Long-term care services and premiums for qualified long-term care insurance contracts; certain restrictions apply (see *IRS Publication 502*).
- Meals at a hospital or similar institution if a principal reason for being there is to get medical care.
- Medical conference expenses for admission and transportation to a medical conference if the medical conference concerns the chronic illness of yourself, your Spouse or your dependent; certain restrictions apply (see *IRS Publication 502*).
- Medical information plan expenses relating to a plan that keeps medical information in a computer data bank and retrieves and furnishes the information upon request to an attending physician.
- Medical supplies, such as bandages.
- Nursing home, home for the aged or similar institution expenses for yourself, your Spouse or your dependents, including meals and lodging in the home if a principal reason for being there is to get medical care.
- Nursing services, such as giving medication or changing dressings, as well as bathing and grooming the patient. These services can be provided in your home or another care facility. Certain restrictions apply (see *IRS Publication 502*).
- Physical examination (annual) and diagnostic tests by a physician. You do not have to be ill at the time of the examination.
- Pregnancy test kit.
- Prescribed medicines and drugs.
- Prosthesis.
- Psychiatric care, including the cost of supporting a mentally ill dependent at a specially equipped medical center where the dependent receives medical care.
- Psychoanalysis.
- Psychologist medical care.
- Special education, learning disabilities and tuition paid on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities caused by mental or physical impairments, including nervous system disorders. Certain restrictions apply (see *IRS Publication 502*).
- Sterilization (a legally performed operation to make a person unable to have children).
- Stop-smoking programs, not including drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.
- Substance abuse inpatient's treatment at a therapeutic center, including meals and lodging at the center during treatment.
- Surgery or operations that are legal and not for unnecessary cosmetic surgery.
- Telephone special equipment that lets a hearing-impaired person communicate over a regular telephone, including teletypewriter (TTY) and telecommunications device for the deaf (TDD) equipment as well as the cost of repairing the equipment.

- Television equipment that displays the audio part of television programs as subtitles for hearing-impaired persons. This may be the cost of an adapter that attaches to a regular set. It also may be the part of the cost of a specially equipped television that exceeds the cost of the same model regular television set.
- Therapy received as medical treatment.
- Transplants when you are a donor or a possible donor of a kidney or other organ, including transportation and expenses you pay for the medical care of a donor in connection with the donating of an organ.
- Transportation primarily for, and essential to, medical care; certain restrictions apply (see *IRS Publication 502*).
- Vasectomy.
- Weight-loss programs to lose weight if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). This may include membership fees in a weight reduction group as well as fees for attendance at periodic meetings. In general, this does not include diet food or beverages; however, some exceptions may apply. See *IRS Publication 502* for more detailed information.
- Wheelchairs or autoettes used mainly for the relief of sickness or disability, and not just to provide transportation to and from work. The cost of operating and maintaining the autoette or wheelchair is also an Eligible Expense.
- Wig costs purchased on the advice of a physician when hair is lost from disease.
- X-rays for medical reasons.

Expenses Not Eligible for Reimbursement

Following are some items that are not eligible for reimbursement:

- Babysitting, childcare, and nursing services for a normal, healthy baby, even if the expenses enable you, your Spouse or your dependent to get medical or dental treatment. Also, any expense allowed as a childcare credit cannot be treated as an expense paid for medical care.
- Controlled substances that are in violation of federal law (even if legalized by state law).
- Cosmetic surgery or procedures that are not necessary, including any procedure that is directed at improving appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease, such as face lifts, hair transplants, hair removal (electrolysis), teeth whitening and liposuction. (Medical expenses for cosmetic surgery necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease may be eligible).
- Dancing lessons, swimming lessons, etc., even if recommended by a doctor or for improvement of general health.
- Diaper service or diapers (unless needed to relieve the effects of a particular disease).
- Funeral expenses.
- Future medical care (including medical insurance) to be provided substantially beyond the end of the year (unless future care is purchased in connection with obtaining covered lifetime care or long-term care.
- Health club dues, amounts paid to improve one's general health or relieve physical or mental discomfort not related to a particular medical condition or membership costs for any club organized for business, pleasure, recreation, or other social purpose.
- Household help costs, even if recommended by a doctor. (Certain expenses paid to a person providing nursing-type services or certain maintenance or personal care services provided for qualified long-term care may be reimbursable.)
- Illegal operations, treatments, or controlled substances, whether provided or prescribed by licensed or unlicensed practitioners.
- Insurance premiums, except as specifically provided otherwise as reimbursable.
- Maternity clothes.
- Medicines and drugs brought in (or ordered shipped) from another country, unless imported legally. (A prescribed drug purchased or consumed in another country may be reimbursable if the drug is legal in both the other country and the United States.)
- Non-prescription drugs and medicines, except insulin (while prescription copayments are eligible expenses, non-prescription, over-the-counter medications are not eligible for reimbursement).
- Nutritional supplements, vitamins, herbal supplements, natural medicines, etc. unless recommended and prescribed by a medical practitioner as treatment for a specific medical condition diagnosed.

- Personal use items ordinarily used for personal, living or family purposes unless it is primarily to prevent or alleviate a physical or mental defect or illness.
- Veterinary fees.
- Weight loss programs to improve appearance, general health, or sense of well-being; this includes diet food or beverages that substitute for what is normally consumed to satisfy nutritional needs. (Weight loss treatment for a specific disease diagnosed by a physician, such as obesity, hypertension, or heart disease, may be reimbursable).
- Expenses reimbursable from other sources. You cannot be reimbursed for amounts that are reimbursable from other sources, such as:
    - Amounts that are fully reimbursed by a flexible spending account if you contribute a part of your income on a pre-tax basis to pay for the qualified benefit;
    - Any payment or distribution for medical expenses out of a health savings account (contributions to health savings accounts may be deducted separately);
    - Expenses paid for with a tax-free distribution from an Archer Medical Spending Account (MSA) to which you contribute; and
    - Amounts paid for health insurance used to figure any Health Coverage Tax Credit.

Claims and Appeals

As a Participant in the Plan, you have the right to appeal decisions to deny or limit Plan benefits. You may also file an appeal to address concerns regarding eligibility (your or a dependent's right to participate in the Trust).

The type of Claim determines the way you appeal or ask for review of a denied or partially denied claim under the Plan.

If your Claim involves eligibility to participate in the Plan or the application of other Plan rules, these claims and appeals procedures are explained in the section titled "Eligibility Claims and Appeals." You must submit these claims to the Plan's Trust Administrator. Final review of appeals from these Claim denials is conducted by the Committee (or the designated subcommittee).

Examples of Claims and appeals that must be submitted to the Trust Administrator or the Committee (or the designated subcommittee) would be an eligibility issue that resulted in a denial of a Claim – for example, because a participant's spouse or child no longer meets the definition of dependent under the Plan.

If the Claim concerns health care benefits, the claims procedures, and appeal rights are explained in the sections titled "Medical Claims and Appeals" or "Prescription Drug Claims and Appeals".

Examples of appeals of health benefit decisions would be situations where the Plan denies your Claim in whole or in part because the expense is for a gym membership. Other examples might be a situation where the Plan denies part of a Claim because a portion of the amount claimed is greater than the remaining balance in your Retiree Flex account.

If you want to make a Claim or appeal a Claim denial and you have a question as to whether your claim involves health benefits or another type of Claim, contact the Trust Administrator.

Eligibility Claims and Appeals

BeneSys makes initial determinations regarding the eligibility, continued eligibility, and termination of eligibility. If BeneSys determines that you or a covered dependent are not eligible, you will receive written notice of the determination within 10 days of receipt of a complete Claim for eligibility. The notice will include:

- The specific reason or reasons for the denial;
- Specific references to pertinent Plan provisions on which the denial is based; and
- Information on any new or additional evidence considered, relied on, or generated by the review process.

If you disagree with an eligibility determination, you or your authorized representative may appeal in writing to the Committee within 180 days after you receive notification of the determination.

The Committee's decision on appeal is final; there are no further appeals for the Committee's (or the designated subcommittee's) decision.

Benefit Claims and Appeals

You are responsible for submitting Claims for reimbursement for Eligible Expenses. Payment is made directly to you, and you are responsible for paying your provider.

Filing a Claim

When you need to file a Claim, contact BeneSys for the appropriate form.

If the Eligible Expense is covered under another plan and the benefit is subject to coordination of benefits, you may need to submit a copy of the other plan's Explanation of Benefits with your Claim. You can do this either when the Claim is initially submitted or as soon as possible afterward.

Time Limit for Filing a Claim

You must file your Claim within six months after the date of service or treatment or receipt of supplies. Your Claim will not be invalidated or reduced if it is not reasonably possible to provide written proof of the Claim within this period. However, no Claim is eligible for payment if it is filed more than 12 months from the date the Claim was incurred.

Notwithstanding the above, all Claims must be received no later than March 31 following the year in which they were incurred.

Claim Determinations

You will be notified of a decision within a reasonable period, but not later than 30 days after receipt of the complete Claim.

The 30-day period may be extended for an additional 15 days due to circumstances beyond the Plan's control. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which a decision is expected.

Appeal Procedures

If your Claim is denied, in whole or in part, you will be provided with a written or electronic notification, which will include all legally required information.

You, or your authorized representative, have the right to appeal an adverse benefit determination. You must file any appeal within 180 days after you received notice of a denial on your Claim. To file an appeal, you can call BeneSys for information on filing an appeal, or you can submit an appeal in writing to:

BeneSys
P.O. Box 1708 Troy
Michigan 48099-1708

There are many protections for you in the Plan's appeal procedure. The appeal procedure:

- Provides you or your authorized representative the opportunity to submit written comments, documents, records, and other information relating to your Claim.
- Allows you or your authorized representative to be given, upon request and free of charge, reasonable access to or copies of all documents, records, and other information relevant to your Claim.
- Requires that all relevant comments, documents, records, and other information submitted in the appeal, regardless of whether such information was submitted or considered in the initial benefit determination, be taken, into account.
- Gives you 180 days following receipt of a notification of an adverse benefit determination to appeal the initial adverse determination and 180 days following receipt of the first appeal determination to request a final appeal.
- Requires that no deference will be given to the initial adverse benefit determination and requires that the review on appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor the subordinate of such individual.
- Requires that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment (for example, a determination with, regard to whether a particular treatment, drug or other item is Experimental, Investigational or not Medically Necessary or appropriate), the person(s) deciding the appeal consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- Identifies any medical or vocational experts whom the Plan consulted in connection with the denial of your Claim (even if their advice was not relied upon in denying the Claim),and requires that they have not been consulted in connection with the initial Claim denial.

Appeal Determinations

You will be notified of the decision within a reasonable time, but no later than 30 days after receipt of your appeal.

Final Committee Appeal

If your Claim is denied on appeal, in whole or in part, you or your authorized representative may submit a final appeal, in writing, to the Committee within 180 days after you receive notification of the denial. The final written appeal should be directed to the Trust Administrator at:

BeneSys, Inc. (Appeals)
P.O. Box 1708
Troy, Michigan 48099-1708
Fax: (248) 813-9898

The Committee (or a subcommittee of Committee members) will process and decide the appeal and notify you or your authorized representative of the decision in writing in accordance with the requirements of all applicable and effective laws and regulations. The Committee's decision is the final level of appeal under the Plan and there are no further appeals from the Committee's (or the designated subcommittee's) decision.

Physical Examination

The Plan has the right to have you examined, at the Plan's expense, for evaluation and verification of an illness or injury as often as required while a Claim for benefits is pending.

Plan's Right to Recover Overpayments or Improper Payments

The Plan has the right to recover payments made that exceed the maximum amount required under the Plan. You may be asked to reimburse the Plan for any Plan benefit payment that is later determined to be in, excess of the amount required to be paid by the terms of the Plan. In addition, the Plan may reduce future benefits to recover these amounts. The Plan's right of recovery applies against any person to whom, for whom or with respect to whom such payments were made, or against any insurance companies or other organizations, which according to these provisions, provide benefits for the same Allowable Expense under any other plan.

If you make a material misrepresentation on your application for coverage, the Plan has the right to rescind (retroactively terminate) coverage. A material misrepresentation is an untrue statement that leads the Plan to cover the person or to cover a medical condition of the person when it would not have done so if it had known the truth. For example, if it is determined that an individual has enrolled an ineligible dependent in the Plan, that would constitute an intentional misrepresentation of a material fact and could result in a retroactive termination of that ineligible dependent's coverage. Rescinding coverage means the Plan can cancel coverage effective on the date coverage was granted in reliance on the material misrepresentation. The Plan will provide at least 30 days advance written notice to each participant who would be affected before coverage is rescinded. A retroactive termination is not a rescission to the extent it is attributable to a failure to timely pay required premiums or contributions for the cost of coverage. The Plan will refund all contributions paid for any coverage rescinded; however, Claims paid will be offset from this amount. The Plan reserves the right to recover from the Covered Person or provider the amount paid on Claims incurred during the period for which coverage is rescinded.

Claims Administrator and Committee Discretion

The Claims Administrator has the sole and exclusive authority and discretion to interpret and to apply the rules of the Plan and the Committee has sole and exclusive authority and discretion to interpret and apply the rules of the Trust and other rules and regulations of the Trust. Under the law, this authority means that the Claims Administrator's and/or Committee's decision, or that of their designee, will be upheld unless the court finds that it was arbitrary and capricious. No action at law or equity may be brought for benefits until all mandatory appeal rights have been fully exhausted. Under the terms of the Plan, any lawsuit brought against the Trust, the Committee, any of the Committee members individually, or any agent of any of these under or relating to the Plan, including the Trust Administrator and Claims Administrators, is barred unless the complaint is filed within three years after the first date you receive a determination of your rights and/or benefits under the Plan, unless a shorter period is established by applicable statute, regulation or case law. You should seek legal advice with respect to these requirements.

Notice of Trust's Privacy Practices

This section describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully and contact the Plan's Privacy Officer if you have any questions.

The Plan is required by the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 to make sure that health information that identifies you is kept private to the extent required by law (PHI). This notice gives you information regarding the uses and disclosures of PHI that may be made by the Plan and your rights and the Plan's legal duties with respect to such information. This notice and its contents are intended to conform to the requirements of HIPAA. Please be advised, carriers associated with this Plan may issue separate Notices regarding disclosure of PHI that they maintain on the Plan's behalf.

The Plan Privacy Officer can be contacted at:

UAW Retirees of the Dana Corporation Health & Welfare Trust
P.O. Box 1708
Troy, Michigan 48099-1708

How the Plan May Use and Disclose PHI

The following categories describe different ways that the Plan uses and discloses PHI. Not every use or disclosure in a category will be listed. However, all of the ways permitted to use and disclose information will fall within one of the categories.

- **For Payment.** The Plan may use and disclose PHI to determine eligibility for Plan benefits, facilitate payment for the treatment and services received from health care Providers, determine benefit responsibility under the Plan or coordinate Plan coverage. For example, the Plan may tell a health care Provider about eligibility for benefits to confirm whether payment will be made for a particular service. The Plan may also share PHI with a utilization review or pre-certification service Provider. Likewise, the Plan may share PHI with another entity to assist with the coordination of benefit payments.
- **For Health Care Operations.** The Plan may use and disclose PHI for Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use PHI in connection with:
    - Conducting quality assessment and improvement activities;
    - Underwriting, premium rating and other activities relating to Plan coverage;
    - Reviewing and responding to appeals;
    - Conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs; and
    - General Plan administrative activities.
- **To Inform You of Treatment Alternatives or Other Health Related Benefits.** The Plan may use PHI to identify if you may benefit from communications from the Plan regarding:

- Available Provider networks or available Plan products or services;
- Your treatment;
- Case management or care coordination; or
- Recommended alternative treatments, therapies, health care Providers or settings of care. For instance, the Plan may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.

- **Use by the Trust Committee.** The Committee may use PHI for plan administration functions, including but not limited to reviewing appeals; however, every effort is made to minimize the disclosure of personal medical information. Summary PHI may be used for soliciting premium bids from health insurers or for consideration in decisions whether to modify, amend or terminate the Plan. The Committee also may have access to information on whether you are participating in the Trust.
- **To Business Associates.** The Plan may disclose our PHI to its business associates that perform functions on the Plan's behalf or provide the Plan with services if the information is necessary for such functions or services. For example, the Plan may use another company to perform billing services on its behalf. All the Plan's business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in their agreement with the Plan.
- **When Legally Required.** The Plan will disclose PHI when it is required to do so by any federal, state, or local law.
- **For Public Health Activities.** The Plan may disclose PHI for public health activities such as the reporting of vital events, such as birth or death or the tracking of products regulated by the Food and Drug Administration.
- **For Reporting Abuse, Neglect or Domestic Violence.** The Plan may disclose your PHI when required by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose, of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
- **To Conduct Health Oversight Activities.** The Plan may disclose PHI to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure, or disciplinary action. However, we may not disclose PHI if you are the subject of an investigation, and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

- **In Connection with Judicial and Administrative Proceedings.** As permitted or required by state law, the Plan may disclose PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan receives satisfactory assurance from the party seeking the information that reasonable efforts have been made to notify you of the request or, if such assurance is not forthcoming, if the Plan has made a reasonable effort to notify you about the request or to obtain an order protecting your PHI.
- **For Law Enforcement Purposes.** As permitted or required by state law, the Plan may disclose PHI to a law enforcement official for certain law enforcement purposes, including, in an emergency, to report a crime.
- **To Coroners, Medical Examiners and Funeral Directors.** The Plan may release PHI to coroners or medical examiners for duties authorized by law or to funeral directors consistent with applicable law.
- **Organ and Tissue Donation.** If you are an organ donor, the Plan may release PHI to organizations that handle organ procurement or transplantation.
- **For Research.** The Plan may disclose your PHI for research subject to certain conditions regarding the manner which the research is conducted.
- **In the Event of a Serious Threat to Health or Safety.** The Plan may disclose PHI if necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public or another person.
- **For Specified Government Functions.** In certain circumstances, federal regulations may require the Plan to use or disclose PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others and correctional institutions and inmates.
- **For Workers' Compensation.** The Plan may release PHI to the extent necessary to comply with laws related to workers' compensation or similar programs.
- **For Other Purposes.** Other uses and disclosures of PHI not covered by this Notice or the laws that apply to the Plan will be made only if you provide a written authorization. If you provide the Plan with written authorization to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that we have already made with your permission. The Plan may use or disclose your PHI for other purposes not set forth in this Notice when the Plan is permitted to do so without your written authorization or consent.
- **Minimum Necessary Standard.** When using, disclosing, or requesting PHI, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose. However, the minimum necessary standard will not apply in the following situations:
    - disclosures to or requests by a health care provider for treatment;

- uses or disclosures made to the individual or pursuant to an authorization;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

- The Plan will not (1) supply confidential information to another entity for its marketing purposes in violation of the privacy regulations, or (2) sell your confidential information in violation of the privacy regulations.

Your Rights Regarding the Privacy of Personal PHI

Any of the rights described below that you may exercise may also be exercised by your personal representative. The Plan will require an appointment of the representative that you have signed. You have the following rights:

- The right to request restrictions or limitations on the PHI the Plan uses or discloses about you for treatment, payment, or health care operations. However, the Plan is not required to agree to your request, with the exception, of a request for a restriction of a disclosure of PHI pertaining solely to a health care item or service, for which the health care provider involved has been paid out of pocket, that is for purposes of carrying out payment or health care operations (and not for the purposes of carrying out treatment). To request restrictions, you must make your request in writing to the Plan's Privacy Officer. In your request, you must state:
  - What information you want to limit;
  - If you want to limit the Plan's use, disclosure, or both; and
  - To whom the limits apply.
- **The right to request to receive confidential communication of your PHI by an alternative means or at an alternative location if a disclosure of your PHI could endanger you.** The request must be made in writing to the Plan's Privacy Officer and must specify the alternative location or other method of communication that you prefer (for example, using an alternate address). Your request must include a statement that the restriction is necessary to prevent a disclosure that could endanger you. The Plan does not refuse to accommodate such a request unless the request imposes an unreasonable administrative burden. If the request is granted, the documentation of your request will be placed in your record.

- **The right to access documents regarding your eligibility, payment of Claims, appeals or other similar documents for inspection and/or copying.** If the information you request is in an electronic health record, you may request that these records be transmitted electronically. Your request for access to documents with your PHI must be in writing to the Plan's Privacy Officer. When a request for access is accepted (in whole or in part), you will be notified of the decisions and you may then inspect the PHI, copy it, or both, in the form or format requested at a time and place that is mutually convenient. If you would like, you may receive a summary of the requested PHI instead of your entire record, for a reasonable fee. You may also receive a copy of your PHI by mail if you prefer. (The Plan charges a reasonable, cost-based fee for copying, including labor and supplies, for instance, paper, computer disks and for postage if you request that the information be mailed. No fee is charged for retrieving or handling the PHI or for processing your request for access.) When a request for access is denied in part, the Plan will grant access to the PHI for which there is no grounds to deny access. The Plan will also inform you why your request for access was denied, how to appeal the denial (if the denial is reviewable) and how to file complaints with us and/or the U.S. Department of Health and Human Services. If you request a review and the denial is reviewable, the Plan will designate a licensed health care professional, not involved in the original denial decision, to serve as a reviewing official, and you will be notified in writing of the reviewing official's determination.
- **The right to request that your PHI be amended if it is inaccurate or incomplete.** You may request that your PHI be amended. That request must be in writing to the Plan's Privacy Officer and include a reason why your PHI should be amended. If you do not include a reason, the Plan will not act on the request. When a request for amendment is accepted (in whole or in part), the Plan will inform you that your request for amendment has been accepted. The Plan will request from you permission to contact other individuals or health care entities that you identify that need to be informed of the amendment(s), and the Plan will inform them and other entities with whom the Plan does business who may rely on the disputed PHI to your detriment. The Plan will identify the record(s) that are the subject of the amendment request and will append the amendment to the record. When a request for amendment is denied, you will be notified why the request was denied (e.g., the information requested was not created by the Plan, is accurate and complete, is not part of the record or may not legally be changed, such as information compiled in anticipation of a civil, criminal or administrative proceeding), how to file a statement of disagreement or a request that the Plan provide the request for amendment and the denial in any future release of the disputed PHI and how to file a complaint with us or the U.S. Department of Health and Human Services. If you choose to write a statement of disagreement with the denial decision, the Plan may write a rebuttal statement and will provide a copy to you, and the Plan will include the request for amendment, denial letter, statement of disagreement and rebuttal (if any), with any future disclosures of the disputed PHI. If you do not choose to write a statement of disagreement with the denial decision, the Plan is not required to include the request for amendment and denial decision letter with future disclosures of the disputed PHI unless you request the Plan do so. When the Plan is notified that your PHI has been amended, it will ensure that the amendment is appended to your records and will inform entities with whom it does business that may use or rely on your PHI of the amendment and require them to make the necessary corrections.

- **The right to obtain an accounting of disclosures of your PHI.** You have the right to request the Plan to provide you with an accounting of its disclosure of your PHI. The right to an accounting extends to disclosures, other than disclosures made:
  - For treatment, payment or health care operations, including those made to business associates;
  - To individuals about their own PHI;
  - Incident to an otherwise permitted use or disclosure;
  - Pursuant to an authorization;
  - To persons involved in the patient's care or other notification purposes;
  - As part of a limited data set;
  - For national security or intelligence purposes;
  - To correctional institutions or law enforcement officials; and
  - Those made before April 14, 2003.

  To request an accounting of disclosures, you must submit your request in writing to the Plan's Privacy Officer. Your request must specify a period, which may not be longer than six years. You may request and receive an accounting of disclosures once during any 12-month period for no charge. If you request more than one accounting within the same 12-month period, a reasonable, cost-based fee may be charged. The Trust will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

  You also have the right to an accounting of disclosures of electronic health records for purposes of payment, treatment, and health care operations. The right to such an accounting depends on whether the Plan maintains such electronic health records and, if so, when the electronic health records were acquired by the Plan and when the disclosure occurred.
- **The right to receive a paper copy of this Notice and any revisions to this Notice.** You may request a copy of this Notice in writing to the Plan's Privacy Officer at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Legal Effect of this Notice

The Plan is required by law to maintain the privacy of your PHI as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. If your PHI is improperly accessed, acquired, used, or disclosed, the Plan will notify you, as required by law. That notification may include a description of what happened, the information involved, and the steps you can take to protect yourself.

The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI we have about you as well as any information we receive in the future. If the Plan changes its policies and procedures, it will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services (HHS) if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to the Plan's Privacy Officer. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Trust Privacy Officer

For questions about this Notice, to exercise your privacy rights or to file a complaint, contact:

Trust Privacy Officer
UAW Retirees of the Dana Corporation Health & Welfare Trust
P.O. Box 1708
Troy, Michigan 48099-1708

Subrogation and Reimbursement

Any reference in this section to "you" also includes your covered dependent or you or your dependent's assignee or representative.

If the Plan pays benefits for any Illness, Injury, expense or loss caused by a third party, the Plan is subrogated (acting as a substitute) to all rights you may have against any person, firm, corporation or other entity for any Claim related to the Illness, Injury, expense, or loss, including any occupationally related Claim or cause of action covered by the any state or federal act, for the full amount of benefits paid by the Plan. All recoveries you receive from a third party (whether by lawsuit, settlement or otherwise) must be used to reimburse the Plan for benefits paid. In addition, the Plan itself may pursue a third party for recovery in the amount, of benefits it has paid as a result, of Illness, Injury, expense, or loss caused by that third party.

By accepting benefits provided by this Plan, you (and your dependents, heirs or estate) agree to reimburse the Plan for any benefits you may receive from a third party due to a judgment, settlement or otherwise, regardless of any offset for expenses, including legal fees, that you may owe, and before you pay any other individual, organization or entity out of that full or partial recovery. In other words, this Plan has first priority with respect to its rights under this subrogation rule. Any money you recover will be, considered to be held in a constructive trust for the benefit of the Plan, regardless of who, holds the money.

You may not take any action that would prejudice the Plan's rights, and you are required to take any action, provide any information and assistance, and sign any papers required by the Plan for the Plan to be able to enforce its subrogation rights.

The Plan (and/or any of the Plan's designees) is not responsible for attorney's fees or costs you may incur or pay unless the Plan agrees in writing to pay these fees or costs in full or in part. If for any reason any of the Plan's subrogation rights are compromised or diminished in any way, the Plan may treat the benefit amounts you received as a debt you have to the Plan and the Plan may pursue recovery of that amount from you and/or reduce or eliminate any future benefits that may be payable on your behalf until this debt is paid.

The Plan will have a first priority lien on any recovery from a third party. This lien is binding on any attorney, insurance company, or other party who agrees or is obligated to make payment to you or your dependents as compensation for any damages. The lien exists at the time the Plan pays medical benefits. If you or your dependent files a petition for bankruptcy, you or your dependent agrees that the Plan's lien existed in time prior to the creation of the bankruptcy estate.

If you have hired an attorney, and you and your attorney agree to honor the Plan's first priority lien during any court proceedings, negotiations, or similar procedures, the Plan will consider reducing the amount of its recovery to allow for your attorney's fees or court costs. To take advantage of this, you must have an express written authorization from the Plan or its representative.

Before the Plan's payment of benefits for any Illness, Injury, expense, or loss caused by a third party, you may be asked to sign a written assignment to the Plan of your rights, Claims, interests or causes of action up to the full amount of Plan benefits. In addition, you may be asked to authorize the Plan, at the Plan's expense, to sue, compromise or settle, in your name or otherwise, all rights, Claims, interests, or causes of action to the full extent of the benefits paid and to do nothing to prejudice the Plan's subrogation rights. You may be asked to assure the Plan that you have not discharged or released any rights, Claims, interests, or causes of action. However, the Plan's failure to request or obtain any such document before payment of benefits does not in any way diminish the Plan's subrogation and reimbursement rights.

You are expected to assist or cooperate with the Plan, including, if requested, by bringing legal proceedings against any appropriate persons, firms corporations or other entities. The Plan may withhold benefits if you do not assist or cooperate or if you fail to repay the Plan, the Plan may offset future payments for medical services you receive by withholding payments until the entire amount due is reimbursed.

Plan Administrative Information

This section contains important information about the Plan that is described in this SPD. In this section you will find information about the Plan and your legal rights.

Trust Name

UAW Retirees of the Dana Corporation Health and Welfare Trust

Plan Name

UAW Retirees of the Dana Corporation Health and Welfare Trust. The benefits described in this SPD are limited to the Retiree Flex program.

Plan Sponsor and Plan Administrator

The Plan is sponsored and administered by the Committee. The Committee has seven members, four of whom are independent members and three of whom are appointed by the UAW. The Committee manages the Trust, designs, and administers the benefit Plan and serves as the legal Plan Administrator and named Plan fiduciary under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. However, the Committee has delegated administrative responsibility to BeneSys, as the Trust Administrator.

The Committee is comprised of four independent members and three members appointed by the UAW. The Committee members are as follows:

Suzanne Daniels, Ph.D., Committee Chair
Jack Martin, Committee Member
Francine Parker, Committee Member
Gary Petroni, Committee Member
George Hardy, Committee Member
Richard Lein, Committee Member
Rick Isaacson, Committee Member

The principal place of business for each of the Committee Members is

UAW Retirees of the Dana Corporation Health and Welfare Trust
700 Tower Dr., Suite 300
Troy, MI 48098

Mailing Address:
UAW Retirees of the Dana Corporation Health and Welfare Trust
P.O. Box 1708
Troy, Michigan 48099-1708

Trust Administrator

The Committee hired BeneSys, Inc. as the Trust Administrator. BeneSys handles general Plan administration, including eligibility, recordkeeping, participant contributions and inquiries. To contact BeneSys:

BeneSys
700 Tower Dr., Suite 300
P.O. Box 1708
Troy, Michigan 48099-1708
(248) 641-4903 or (866) 626-2070
Fax: (248) 813-9898

Plan Sponsor Employer Identification Number (EIN)

26-1851652

Plan Number

501

Plan Year

The Plan Year is January 1 and ending December 31.

Plan Type

This Plan is a welfare plan providing reimbursement for eligible medical and prescription drug expenses for eligible participants.

Plan Funding

Your Retiree Flex program benefits are funded solely from your Retiree Flex account which is funded out of Trust assets. No insurance company or other state licensed entity is responsible for the financing of the Plan. Benefits under the Plan are not guaranteed by a policy of insurance.

Agents for Service of Legal Process

If legal disputes involving the Plan arise, any legal documents may be served on:

UAW Retirees of the Dana Corporation Health and Welfare Trust
c/o Derek L. Watkins
Watkins, Pawlick, Calati & Prifti, PC
1423 E. Twelve Mile Road
Madison Heights, MI 48071

Legal process also may be served on the Trust Administrator or on any Committee member at the office of the Trust Administrator.

Legal Actions

No action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under Plan terms, any lawsuit brought against the Trust, Committee, any of the Committee members individually or any agent of any of these under or relating to the Plan, including the Trust Administrator and Claims Administrators, is barred unless the complaint is filed within three years after the first date you receive a determination of your rights and/or benefits under the Plan, unless a shorter period is established by applicable statute, regulation, or case law.

Plan Documents

This Summary Plan Description (SPD) is as accurate and up to date as possible. However, this SPD is only a summary of your benefits; full details of the Plan are included in the legal documents that govern the Plan.

In the case of any uncertainty regarding the meaning or intent of any section in the Plan, the interpretation of the Plan Administrator or the Plan Administrator's designee will be final.

Plan Interpretation

Only the full Committee is authorized to interpret the Plan and decide eligibility for the benefits described in this booklet. The Committee's interpretation is final and binding on all persons dealing with the Trust or claiming a benefit from the Trust. If a decision of the Committee is challenged in court, that decision will be upheld, under current law, unless it is determined by the court to have been arbitrary and capricious. No agent, representative, officer or other person from Dana Corporation or the UAW has the authority to speak for the Committee or to act contrary to the written terms of the governing Plan Documents.

Plan Changes

The Committee may change the eligibility rules and/or benefit provisions of the Plan at any time. The benefits provided by the Trust are limited to the assets of the Trust that are available to pay benefits. No Employee, Retired Employee, Disabled Employee, Surviving Spouse, or any other Covered Person has any vested rights to any benefit provided under the Plan, now or at any time in the future. The right to change or eliminate any, and all aspects of benefits under the Plan is a right specifically reserved to the Committee.

Plan Discontinuation or Termination

The Trust and the Plan may be discontinued or terminated under certain circumstances, for example if there are insufficient assets in the Trust to continue payment of benefits or administration of the Plan. In this event, benefits for covered expenses incurred on or before the termination date will be paid as, long as the Trust's assets are more than its liabilities. Full benefits may not be paid if the Trust's liabilities are more than its assets, and benefit payments will be limited to the funds available. The Committee will not be liable for the adequacy or inadequacy of funds. If the Trust is terminated by action of the Committee, any assets remaining after payment of Trust liabilities will be used for purposes determined by the Committee according to the Trust Agreement.

Notice of Nondiscrimination

The UAW Retirees of the Dana Corporation Health and Welfare Trust ("Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The UAW Retirees of the Dana Corporation Health and Welfare Trust cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-626-2070.

The UAW Retirees of the Dana Corporation Health and Welfare Trust **遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視任何人。**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-626-2070

بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو
The UAW Retirees of the Dana Corporation Health and Welfare Trust يلتزم الأصل الوطني أو السن أو الإعاقة أو الجنس.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-626-2070

The UAW Retirees of the Dana Corporation Health and Welfare Trust erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-626-2070.

Whistleblower Policy

General

The Committee of the UAW Retirees of the Dana Corporation Health and Welfare Trust ("Trust") requires the Committee, the Trustee and service providers to observe high standards of business and personal ethics in the conduct of their duties and responsibilities in relation to the Trust.

This Whistleblower Policy is intended to encourage and enable individuals to raise serious concerns within the Trust prior to seeking resolution outside the Trust.

Reporting Responsibility

It is the responsibility of all Committee members, the Trustee and service providers to report ethics violations or suspected violations in accordance with this Whistleblower Policy. Participants will be encouraged to report suspected ethics violations.

No Retaliation

The Committee shall employ its best efforts to ensure that no person who in good faith reports an ethics violation shall suffer harassment, retaliation, or adverse employment consequence. An individual who retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment.

Reporting Violations

The Trust has an open-door policy and suggests that Committee members, the Trustee, service providers share their questions, concerns, suggestions, or complaints with someone who can address them properly. In most cases, the Trust's Committee (the Plan Administrator) is in the best position to address an area of concern. However, if you are not comfortable speaking with the Committee, or are not satisfied with the response of the Committee, you are encouraged to speak with the Trust's Compliance Office, Trust Legal Counsel, or any one of the Committee members whom you are comfortable in approaching.

The Committee, individual Committee members or Legal Counsel shall report all suspected ethics violations to the Trust's Compliance Officer, who has specific and exclusive responsibility to investigate all reported violations. For suspected fraud, or when you are not satisfied or are uncomfortable with following the Trust's open-door policy, you should contact the Trust's Compliance Officer directly.

Compliance Officer

The Committee shall appoint a Compliance Officer. The Trust's Compliance Officer is responsible for investigating and resolving all reported complaints and allegations concerning violations and, at his/her discretion, shall advise the Committee. The Compliance Officer has direct access to the Committee and is required to report to the Committee at least annually on compliance activity.

Accounting and Auditing Matters

The Committee shall address all reported concerns or complaints regarding accounting practices, internal controls, or auditing. The Compliance Officer shall immediately notify the Committee of any such complaint and work with the Committee until the matter is resolved.

Acting in Good Faith

Anyone filing a complaint concerning a violation or suspected violation should be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.

Confidentiality

Suspected violations may be reported on a confidential basis or anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

Handling of Reported Violations

The Compliance Officer will notify the sender and acknowledge receipt of the reported violation or suspected violation within five business days. All reports will be promptly investigated, and appropriate corrective action will be taken if warranted by the investigation.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. ERISA provides that you are entitled to the rights described in this section.

Receive Information about Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan. These include insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator's office, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. A reasonable charge may be required for the copies.
- Receive a summary of the Plans' annual financial report (summary annual report), which is required by law to be provided to each participant.

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 Plan. The people who operate the Plan, called Plan fiduciaries, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including an employer, union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your Claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision (without charge) and to appeal any denial, all within certain time schedules. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's Claim and appeal procedures.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the 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 Plan Administrator's control.

If you have a Claim that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been 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.

Assistance with Questions

If you have any questions about the 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 Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) or the national office at:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
(866) 444-3272

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their website at www.dol.gov/ebsa.

Other Legal Protections

Newborns' and Mothers' Health Protection Act

Under federal law, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. The mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). You are not required to obtain authorization from the Plan for prescribing a length of stay, not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. 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 lymphedemas. These benefits are provided the same as other benefits under the Plan.

Children's Health Insurance Program (CHIP) (if available in your state).

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer sponsored health coverage but need assistance in paying the health premiums.

Important Notice

The Committee has all powers necessary to administer and enforce Plan provisions. The Committee's decisions are final as to all questions arising in the administration, interpretation, and application of the Plan. Any interpretation, determination, rule, regulation or similar action or decision issued by the Committee, or any person acting at the Committee's direction, will be conclusive and binding on all persons, except as otherwise provided, and any such determination, rule, regulation, or similar decision may not be set aside unless it is determined by a court of competent jurisdiction that the Committee acted in an arbitrary and capricious manner. Plan benefits are paid only if the Committee or its designee decides, in its discretion, that the applicant is entitled to them.

Glossary

Calendar Year

The period from January 1 through December 31 of the same year.

Claim

A request for reimbursement of Eligible Expenses.

Claims Administrator

The Claims Administrator is BeneSys.

Committee

The committee that sponsors and administers the Plan.

Continuous Period of Disability

Any two or more periods of disability caused by the same or related illness or injury that are not separated by more than three months.

Covered Person

You or your eligible dependent if you meet the Plan's eligibility requirements for coverage, satisfy any applicable waiting period and properly enrolled in the Plan.

Dependent Child

Any biological child, stepchild or legally adopted child, including a child placed for adoption or legal guardianship, dependent on an Employee or Retired Employee for support.

Eligible Expense

Expenses eligible for reimbursement from a flexible spending account, as defined by the Internal Revenue Service Code Section 213(d).

Employee

You are considered an Employee if you were:

- An active employee of Dana Corporation on or before January 31, 2008;
- Covered by a collective bargaining agreement and/or plant closing agreement between Dana and UAW as of the date that you retired; and
- Employed as of the date you terminated employment with Dana at the Dana facility located in either Auburn Hills, MI or Elizabethtown, KY.

Experimental or Investigational

Any treatments, procedures, devices, drugs, or medicines that:

- Cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished;
- Reliable evidence shows is the subject of ongoing phase I, II or III clinical trial(s) or under study to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis;
- Are educational or provided primarily for research;
- Relate to transplants of non-human organs, tissues, or cells; or
- Reliable evidence shows that the consensus, of opinion, among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug, or medicine.

Trust Administrator

BeneSys, Inc.
P.O. Box 1708
Troy, Michigan 48099-1708
(248) 641-4903 or (866) 626-2070
Fax: (248) 813-9898

Medically Necessary

A service, treatment, procedure, equipment, drug, device, or supply provided by a hospital, physician or other health care provider required to diagnose or treat an illness or injury and that is, as determined by the Claims Administrator and/or Plan Administrator:

- Consistent with the symptoms or diagnosis and treatment of the illness or injury;
- Appropriate under the standards of acceptable medical practice to treat that illness or injury;
- Not solely for the convenience of the patient, physician, hospital, or other health care provider; and
- The most appropriate service, treatment, procedure, equipment, drug, device, or supply that can be safely provided and that accomplishes the desired end-result in the most economical manner.

The fact that a provider may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make that treatment, service, or supply Medically Necessary.

Medicare

The program for health benefits under Title XVIII of the Social Security Act, as amended.

Spouse

The person to whom you are legally married as of the date you become eligible to receive benefits as a Retired Employee or Disabled Employee on or before January 31, 2008.

Surviving Spouse

The surviving Spouse of a deceased Employee or Retired Employee that meets the Plan's eligibility requirements for coverage.

Trust

The UAW Retirees of the Dana Corporation Health & Welfare Trust.

Important Phone Numbers

If You Have a Question About:	You Should Contact:
Medical Premiums	Trust Office: (866) 626-2070 Hours: 7:30 AM – 4:30 PM EST
Pre-Medicare Eligible Participant Medical Coverage	Anthem Blue Cross Blue Shield/CMSi: (800) 305-0406
Medicare Medical Coverage	Medicare Advantage Blue Cross Blue Shield of MI: (866) 684-8216 TTY - (800) 579-0235
Locating a participating provider in the Blue Cross Blue Shield PPO Network	Blue Cross Blue Shield: (800) 810-Blue (2583)
Eligibility and Claims	BeneSys: (866) 626-2070
Prescription Drug Coverage	CVS Caremark: (888) 865-6592
Long-Term Disability Coverage	BeneSys: (866) 626-2070

Notes

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