2024 Retiree Choice Medical Plan
for pre-age-65 retirees

The following is a brief overview of covered benefits under the medical plan options offered to Retiree Choice retirees, surviving spouses and their eligible dependents under the FCA US LLC ("FCA") Health Care Benefits Plan (the "Plan") administered through your basic medical carrier.

FCA-provided health care coverage ends on the first day of the month in which you or your spouse turns age 65. Medicare will be the primary medical coverage for the age 65 enrollee. Anyone (you or your eligible dependents) who is under age 65 may continue to have coverage under the Plan.

Refer to the Summary Plan Description (SPD) and Summaries of Material Modifications (SMM), available on Benefit Connect, for coverage guidelines, limitations and restrictions including dosage and frequency criteria.

Your doctor may not know whether a recommended procedure or service is covered by the Plan administered by your medical plan carrier. Before services are performed, ask your doctor for the procedure code, then contact your carrier to verify that the procedure or service is a covered benefit. This will give you the opportunity to determine if you will incur additional out-of-pocket expenses. Certain procedures such as MRIs and CAT scans require precertification.

Maximum Approved Payment (MAP): MAP is the maximum amount that your carrier will pay for a covered benefit, sometimes referred to as reasonable and customary. To avoid higher out-of-pocket expenses, always ask providers if they participate in your carrier's network of providers. Further, some services are not covered outside of the PPO network, such as office visits, physical exams, well-baby care and immunizations. Consult your carrier for specific benefit information.

Copayment (Copay): Is the fixed-dollar amount you pay for certain health care services. Copays do not apply to the deductible or out-of-pocket maximums.

Covered Services: Covered services are paid up to the MAP amount allowed by your carrier, not the amount charged. Services received out-of-network, except for emergency care, are subject to the out-of-network deductible and coinsurance. Out-of-network providers generally will bill you for the difference between their charges and the MAP. This difference may be significant and is your responsibility to pay.

IMPORTANT: If you receive services from a **non-participating** general acute care hospital, which does not have a contract with your medical carrier, the Plan will only allow the carrier to pay a maximum benefit of: $500 per day toward room, board, and other charges billed by the hospital/facility; $50 per day for ancillary services, such as drugs and dressings received at that hospital/facility; and $50 per condition, for services received on an outpatient basis, **not per service**. You are responsible for the out-of-network cost share plus any difference between the allowed amount and the provider's charges. Your out-of-pocket payment does not accrue toward the OOP maximum.

		PPO/POS		HDHP+HSA I		HDHP+HSA II
Annual Deductible						
Applies to all covered services, unless otherwise noted.	**In-Network**	**$1,100**	Individual	**$1,600**	Individual	**$2,100**
		$2,200	Family	**$3,200**	Family	**$4,200**
	Out-of-Network	**$2,200**	Individual	**$1,600**	Individual	**$2,100**
		$4,400	Family	**$3,200**	Family	**$4,200**
Annual Out-of-Pocket (OOP) Maximum						
	In-Network:	**$3,675**	Individual	**$3,500**	Individual	**$4,000**
		$7,350	Family	**$7,000**	Family	**$8,000**
	Out-of-Network:	**$7,350**	Individual	**$6,250**	Individual	**$6,750**
		$14,700	Family	**$12,500**	Family	**$13,500**
Coinsurance						
	In-Network:	**30%**		**20%**		
	Out-of-Network:	**50%**		**40%**		

BENEFITS	PPO/POS	HDHP+HSA
PLAN COVERAGE		
	Once the OOP maximum is reached, all covered services—Hospital, Surgical, Medical, DME and P&O**,** Mental Health & Substance Abuse and Foot & Ankle Care, but excluding hearing benefits, **are paid at 100%.** **Note:** Prescription Drug and Durable Medical Equipment coverage are separate plans, not provided by your carrier and not subject to the PPO/POS deductible or OOP maximums.	Once the OOP maximum is reached, all covered services—Hospital, Surgical, Medical, Prescription Drug, Mental Health & Substance Abuse, Durable Medical Equipment and Foot & Ankle Care, but excluding hearing benefits, **are paid at 100%.**
HOSPITAL SERVICES		
Lab, X-Ray, Drugs **Maternity Benefits** **Physician Services** **Semi-Private Room & Board** **Surgery**	**In-Network:** Covered subject to applicable deductible and coinsurance up to OOP maximum. **Out-of-Network:** Hospital services are subject to plan limits per day as outlined under Covered Services.	

BENEFITS	PPO/POS	HDHP+HSA
PREVENTIVE SERVICES		
The FCA US LLC Retiree Health Care Plan (the Plan) has exempt status under the Affordable Care Act (ACA) and preventive health services mandated by ACA do not apply to the Plan. However, certain preventive health services are covered benefits under the PPO/POS and HDHP+HSA plan options, as described below. If a medical condition is diagnosed or considered probable, during the annual physical exam or other preventive screening, any supplemental tests ordered by your physician will be coded as diagnostic services and subject to applicable deductible and coinsurance.		
Annual Physical Exam The following preventive screenings may be performed as part of the annual physical exam based on age and physician recommendation: height and weight, standard blood work (complete blood count, cholesterol, blood sugar), urinalysis, blood pressure.	**In-Network:** Covered 100% **Out-of-Network:** Not covered	**In-Network:** Covered 100% **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
	Based on your family history, additional biometrics may be ordered by your physician and covered as part of the annual physical exam.	
Early Detection Screenings Fecal Occult Blood—one annually beginning at age 45. **One of the following starting at age 45:** Cologuard—every 3 years Sigmoidscopy—every 5 years Colonoscopy—every 10 years Barium Enema X-Ray—every 5–10 years	**In-Network:** Covered subject to applicable deductible and coinsurance up to OOP max **Out-of-Network:** Not covered	**In-Network:** Covered 100%, includes high risk **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
	Note: Members with high risk for colorectal cancer can begin screening prior to age 45, once per calendar year, covered with applicable member cost share, when submitted with high risk, medically necessary procedure and diagnostic codes. Subsequent colonoscopy testing within the same year will be covered with applicable member cost share.	
Immunizations—Measles, Mumps, Rubella, Polio, Diphtheria, Pertussis and Tetanus (Td/Tdap combo)*, Haemophilus Influenzae B, Varicella, Hepatitis A and B**,** Pneumococcal Conjugate Vaccine (PCV)*, RSV (Respiratory Syncytial Virus)*, Pneumococcal (Polysaccharide)(PPV)*, Flu Shot*, Meningococcal (MCV4 or MPSV4)*, Rotavirus (Rota) and Human Papillomavirus (HPV), COVID-19*. **Certain age and dose restrictions apply.** *See **Prescription Drug** section for additional benefit.	**In-Network:** Covered subject to applicable deductible and 30% coinsurance up to OOP max **Out-of-Network:** Not covered	**In-Network:** Covered 100% **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
Mammography Screening—1 baseline between ages 35–39; an additional for ages 36–39 w/family history of breast cancer or other evidence of high risk; 1 mammogram annually at age 40 and older	**In-Network:** Covered subject to applicable deductible and 30% coinsurance up to OOP max **Out-of-Network:** Covered subject to applicable deductible and 50% coinsurance up to OOP max	**In-Network:** Covered 100% **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max

BENEFITS	PPO/POS	HDHP+HSA
PREVENTIVE SERVICES cont'd		
PAP Smear—One per calendar year	**In-Network:** Covered subject to applicable deductible and 30% coinsurance up to OOP max **Out-of-Network:** Covered subject to applicable deductible and 50% coinsurance up to OOP max	**In-Network:** Covered 100% **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
Proctoscopic Exam—With biopsy is a covered benefit. Proctoscopic examination without biopsy is a covered benefit once every three (3) calendar years age 40+	**In-Network:** Covered subject to applicable deductible and 30% coinsurance up to OOP max **Out-of-Network:** Covered subject to applicable deductible and 50% coinsurance up to OOP max	**In-Network:** Covered 100% **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
PSA—One per calendar yr. at age 40; 2nd follow-up test annually at age 30 for those with PSA levels of > 20 ng/ml	**In-Network:** Covered subject to applicable deductible and coinsurance up to OOP max **Out-of-Network:** Not covered	**In-Network:** Covered 100% **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
Well-Baby Care—Covered up to age 24 months	**In-Network:** Covered subject to applicable deductible and coinsurance up to OOP max **Out-of-Network:** Not covered	**In-Network:** Covered 100% **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
OUTPATIENT SERVICES		
Allergy Tests, Injections	**In-Network:** Covered subject to applicable deductible and 30% coinsurance up to OOP max **Out-of-Network:** Covered subject to applicable deductible and 50% coinsurance up to OOP max **Note:** Serum reimbursements can be submitted to Caremark.	**In-Network:** Covered subject to deductible and 20% coinsurance up to OOP max **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
Ambulatory Surgical Centers	**Covered**—when center is approved by the Plan. **In-Network:** Covered subject to applicable deductible and 30% coinsurance up to OOP max **Out-of-Network:** Covered subject to applicable deductible and 50% coinsurance up to OOP max **Note:** In some cases, facility charges at ambulatory surgical centers may not be covered.	**In-Network:** Covered subject to deductible and 20% coinsurance up to OOP max **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
Ancillary Services includes lab, pathology and certain X-rays	**In-Network:** Covered subject to applicable deductible and coinsurance up to OOP max **Out-of-Network:** Covered subject to applicable deductible and coinsurance up to OOP max	

BENEFITS	PPO/POS	HDHP+HSA
OUTPATIENT SERVICES cont'd		
Bone Marrow Screening—One per lifetime	**In-Network:** Covered subject to applicable deductible and 30% coinsurance up to OOP max **Out-of-Network:** Covered subject to applicable deductible and 50% coinsurance up to OOP max	**In-Network:** Covered subject to deductible and 20% coinsurance up to OOP max **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
HEP C Screening—If enrollee is at risk or when signs or symptoms may indicate a Hepatitis C infection	**In-Network:** Covered subject to applicable deductible and 30% coinsurance up to OOP max **Out-of-Network:** Covered subject to applicable deductible and 50% coinsurance up to OOP max	**In-Network:** Covered subject to deductible and 20% coinsurance up to OOP max **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
Shingrix-Zoster—One immunization for shingles for individuals 50 years of age and older (See **Prescription Drugs** for additional benefit)	**In-Network:** Covered subject to applicable deductible and 30% coinsurance up to OOP max **Out-of-Network:** Covered subject to applicable deductible and 50% coinsurance up to OOP max	**In-Network:** Covered subject to deductible and 20% coinsurance up to OOP max **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
Office Visits (See page 11 for Telemedicine) **Primary Care Physician**	**In-Network:** Covered subject to $35 copay **Out-of-Network:** Not covered	**In-Network:** Covered subject to deductible and 20% coinsurance up to OOP max **Out-of-Network:** Covered subject to deductible and 40% coinsurance up to OOP max
Specialist	**In-Network:** Covered subject to $55 copay **Out-of-Network:** Not covered	
Urgent Care Center Visit	**In-Network:** Covered subject to $60 copay **Out-of-Network:** Not covered	
Outpatient Physical, Speech and Occupational Therapy	Covered (**In-Network only for PPO/POS**) subject to applicable deductible and coinsurance up to OOP max, when medically necessary and approved by the Plan; Diagnostic restrictions apply. Unlimited sessions. **Exception:** Children **under the age of 6** receiving speech therapy for typical childhood speech abnormalities limited to 60 speech therapy sessions per calendar year.	
Outpatient Surgery	**In-Network:** Covered subject to applicable deductible and coinsurance up to OOP max. For PPO/POS, $50 copay also applies **Out-of-Network:** Covered subject to applicable deductible and coinsurance up to OOP max	

<table>
<tr><th>BENEFITS</th><th>PPO/POS</th><th>HDHP+HSA</th></tr>
<tr><td colspan="3">EMERGENCY CARE</td></tr>
<tr><td>Rabies Immunization—A series of 6 post-exposure passive immunizations</td><td>In-Network: Covered subject to applicable deductible and 30% coinsurance up to OOP max Out-of-Network: Covered subject to applicable deductible and 50% coinsurance up to OOP max</td><td>In-Network: Covered subject to deductible and 20% coinsurance up to OOP max
Out-of-Network: Covered subject to deductible and 40% coinsurance up to OOP max</td></tr>
<tr><td>Ambulance—Ground/Air/Water</td><td>Covered under certain conditions including transport from scene of emergency incident or home to nearest facility subject to applicable deductible and coinsurance up to OOP max</td><td rowspan="2">In-Network: Covered subject to deductible and 20% coinsurance up to OOP max
Out-of-Network: Covered subject to deductible and 40% coinsurance up to OOP max</td></tr>
<tr><td>Emergency Room Visit</td><td>Covered for life-threatening medical conditions and accidental injuries, subject to $175 copay which is waived if admitted</td></tr>
<tr><td colspan="3">EXTENDED CARE & HOME HEALTH</td></tr>
<tr><td>Coordinated Home Care</td><td colspan="2">Covered—Subject to applicable deductible and coinsurance for 3 coordinated home care visits for each unused hospital day, whichever is less, when medically necessary</td></tr>
<tr><td>Home Health Aides</td><td colspan="2">Covered—Under certain conditions, subject to applicable deductible and coinsurance up to OOP max</td></tr>
<tr><td>Skilled Nursing Facility</td><td colspan="2">Covered—Unlimited days, must meet medical criteria, subject to applicable deductible and coinsurance up to OOP max</td></tr>
<tr><td colspan="3">MENTAL HEALTH AND SUBSTANCE ABUSE (MHSA)</td></tr>
<tr><td>Hospital Services, Outpatient Services, Psychological Testing</td><td colspan="2">Mental Health and Substance Abuse services are provided by Beacon Health Options (formerly Value Options) through the HELP-LINE MANAGED CARE PROGRAM. 1-800-346-7651.

Subject to deductible and coinsurance % up to OOP max. Prior authorization is required.</td></tr>
<tr><td>Telemedicine Services
Confidential therapy by phone or online video conference with a counselor via smartphone, tablet, computer or MDLIVE app

Visit www.mdlive.com/FCAUS or call 888-430-4827</td><td colspan="2">PPO/POS: In-Network: $0 co-pay, 5 visits per member per calendar year, $10 co-pay begins with 6th visit, no visit limit Out-of-Network: Not Covered

HDHP: In-Network: Covered subject to deductible & 20% coinsurance up to OOP Max, no visit limit
Out-of Network: Not covered</td></tr>
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BENEFITS	PPO/POS	HDHP+HSA
PRESCRIPTION DRUG		
Pharmacy Benefit Manager (PBM)	**CVS Caremark, P.O. Box 94467, Palatine, IL 60094-4467 1-866-329-4448 www.caremark.com**	
	Out-of-pocket costs are not subject to the PPO/POS Medical Plan deductible or OOP max	Out-of-pocket costs are subject to the HDHP+HSA deductible and OOP max
In-Network Retail Pharmacies*		
Generic Brands *** Member must fill prescriptions at CVS retail pharmacies only, if there is a CVS retail pharmacy within 5 miles of their home zip code (based on a geographic radius of 5 miles from the zip code center)** **For members where there is no CVS retail pharmacy within 5 miles of their home zip code (based on a geographic radius of 5 miles from the zip code center), prescriptions can be filled at any pharmacy in the CVS/Caremark broad-based network (e.g., Walgreens, Rite Aid, Duane Reade, etc.)**	**$10 copay** for generic drugs up to a 34-day supply	Preventive generic drugs in the classes listed below will be covered at 100% by the HDHP+HSA plan and will not count toward the deductible or OOP maximum. New generic drugs in these classes may be added by the PBM as they become available. Check with the PBM's customer service or member website (see above for contact information) to confirm availability of a specific generic drug. **PREVENTIVE GENERIC DRUGS:** • Asthma • Blood clotting disorders (blood thinners) • Cardiovascular • Diabetes • High blood pressure (Antihypertensive) • Lipid disorders (reduce cholesterol and triglycerides) • Anti-obesity agents • Smoking & chemical dependency agents • Mental Health • Anti-convulsants See a complete list of preventive generic drugs at **https://www.caremark.com/portal/asset/Generics_Only_Preventive_DL.pdf** For all other generic drugs, pay the full discounted cost until the deductible is met; then pay 20% coinsurance up to the OOP maximum. After that, drugs are covered at 100%.

BENEFITS	PPO/POS	HDHP+HSA
PRESCRIPTION DRUG cont'd		
Brand Name Drugs	Prescriptions for brand-name drugs at an in-network retail pharmacy will be limited to a 34-day supply.	You pay the full discounted cost of the drug until the deductible is met. Then you pay 20% coinsurance up to the OOP maximum. After that, drugs are covered at 100%.
	25% coinsurance ($25 minimum/$40 maximum) up to a 34-day supply of preferred brand name drug (formulary) when no generic is available. If generic is available, pay $10 copay plus the cost difference between the brand and generic drug.	If you or your doctor requests a brand-name drug when a generic is available, you pay the difference in cost between the generic and brand. This difference will not be applied toward your deductible, coinsurance or OOP max.
	30% coinsurance ($65 minimum/$95 maximum) for up to a 34-day supply of non-preferred brand name drug (non-formulary) when no generic is available.	Insulin and needles are covered under the Prescription Drug Program, subject to applicable HSA deductibles and coinsurance up to OOP max.
	Mandatory generics: If you or your doctor requests a brand-name drug when a generic is available, you pay the generic $10 copay plus the difference in cost between the generic and the brand.	Lancets, strips, monitors and other diabetic supplies are covered under the Durable Medical Equipment (DME) program. (See below for DME program details.)
	Your doctor may establish medical necessity for a brand-name drug. If approved through the "Review Process," the additional amount paid will be refunded less the applicable brand-name copay.	
Vaccines: COVID-19; Shingrix-Zoster (shingles) for individuals 50 years of age and older; Influenza; Diphtheria, tetanus and pertussis (DTP); Meningococcal; Pneumococcal conjugate (PCV); RSV (Respiratory Syncytial Virus) **Administered by a certified pharmacist**	Present your CVS Caremark Prescription ID card. Subject to applicable copay. Not covered if received from an out-of-network pharmacy.	Present your BCBS or SuperMed MMO medical ID card. **In-Network Pharmacy:** subject to applicable deductible and 20% coinsurance **Out-of-Network pharmacy**: Covered, subject to applicable deductible and 40% coinsurance

Maintenance Drug List (MDL) **(Not applicable to the HDHP+HSA)**	Mandatory mail order. The first three fills of the same MDL medication are covered at retail with the applicable copay for up to a 34-day supply. By the fourth fill, the prescription must be filled by mail order (or by 90-day supply from a retail CVS pharmacy at the applicable mail-order copay). Otherwise, you will be responsible for the full cost of the drug.	Not applicable

BENEFITS	PPO/POS	HDHP+HSA
PRESCRIPTION DRUG cont'd		
Out-of-Network Retail Pharmacies	Prescriptions filled at out-of-network pharmacies are not covered and are not eligible for reimbursement through the manual claim form process.	Prescriptions filled at out-of-network pharmacies are not covered and are not eligible for reimbursement through the manual claim form process. Any cost share incurred will not be applied toward your out-of-network deductible or OOP max.
Mail Order	Not subject to the deductible or OOP max. **$20 copay** for up to a 90-day supply of generic drugs. **25%** coinsurance ($50 minimum/$80 maximum) up to a 90-day supply of preferred brand-name drug (formulary) when no generic is available. **30%** coinsurance **($130 minimum/$190 maximum)** for up to a 90-day supply of a non-preferred brand drug (non-formulary) when no generic is available. If generic is available, you pay the generic copay, plus the difference in cost between the brand drug and generic.	Covered subject to deductible and 20% coinsurance up to OOP max. • Lancets, strips and diabetic supplies covered under DME program. • Insulin and needles covered under the prescription drug program. • Preventive generic drugs are **covered at 100%**. If you or your doctor requests a brand-name drug when a generic is available, you pay the difference in cost between the generic and brand. The difference will not be applied toward your deductible, coinsurance or OOP max.
Prescription Drug Coverage Rules: Refer to your Pharmacy Benefit Manager for additional information regarding the prescription drug coverage rules and specific drugs impacted by these rules. Certain drugs may be subject to step therapy, prior authorization, quantity limits or preferred coverage. Specialty drugs limited to a 30-day supply.		
Non-Sedating Antihistamines	Not covered. Examples include Allegra, Claritin, Clarinex, Zyrtec and their generic equivalent.	
Sexual Dysfunction drugs	Not covered, except in prior authorized cases of Benign Prostatic Hyperplasia (BPH). Examples include Viagra, Cialis and Levitra.	
Proton Pump Inhibitor (PPI) drug class	Not covered, except in prior authorized cases of Barrett's Esophagitis and Zollinger-Ellison Syndrome. Examples include omeprazole, Prilosec, Zegerid, Nexium, Aciphex, Prevacid and Protonix.	
Vitamins and Essential Minerals	Limited coverage	
Cosmetic Drugs	Limited coverage	
Specialty Drugs	**PPO/POS:** Administered by PrudentRx Copay Program Call **1-800-578-4403** to confirm enrollment Cost share if enrolled: $0	**HDHP+HSA:** Administered by PrudentRx Copay Program Call **1-800-578-4403** to confirm enrollment Cost share if enrolled: $0

	Cost share if not enrolled: 30% co-insurance	Cost share if not enrolled: 30% co-insurance

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<tr><th>BENEFITS</th><th>PPO/POS</th><th>HDHP+HSA</th></tr>
<tr><td colspan="3">DURABLE MEDICAL EQUIPMENT AND PROSTHETIC AND ORTHOTIC APPLIANCES (DME/P&O)</td></tr>
<tr><td>DME/P&O</td><td colspan="2">PPO and HDHP: Call the customer service number on the back of your ID card to locate an in-network provider.
POS (MI): (DME and P&O)-To locate Northwood providers near you call 1-800-667-8496. 8:30am-5:00pm, Monday-Friday
POS (MI): (Diabetic Supplies) To locate J&B Medical Supply providers near you call 1-888-896-6233 from 8:00am-6:00pm, Monday- Friday</td></tr>
<tr><td>Program Administrator</td><td colspan="2">To order diabetic, ostomy and urological supplies and all other DME and P&O supplies, call the customer service number on the back of your ID card to locate an in-network provider.</td></tr>
<tr><td></td><td>In-Network: Not subject to deductible or OOP max. Covered at 100% of maximum allowable payment (MAP)
Out-of-Network: You are responsible for 20% coinsurance (of MAP) up to annual out-of-pocket maximum of $500 plus the difference between the actual amount billed and the MAP.</td><td>In-Network: Covered—subject to deductible and 20% coinsurance up to OOP max
Out-of-Network: Covered—subject to deductible and 40% coinsurance up to OOP max</td></tr>
<tr><td>Lab Services</td><td>PPO In-Network: Covered— Subject to deductible coinsurance POS: Covered by JVHL, for lab services near you call 1-800-445-4979 you call 1-800-445-4979
Out-of-Network PPO/POS: Not Covered</td><td>In-Network: Covered—Subject to deductible and 20% coinsurance up to OOP max
Out-of-Network: Covered subject to deductible and 40% coinsurance up to OOP max</td></tr>
<tr><td colspan="3">HEARING CARE Provided by AudioNet America 586-782-6435 www.audionetamerica.com</td></tr>
<tr><td colspan="3">● Covered benefits include audiometric examination, hearing aid evaluation test, conformity evaluation and mid-level standard digital hearing aids, covered in full. Coverage period is every 36 months. All services require preauthorization and received from in-network providers. Advanced and Flagship level hearing aids are covered with additional co-payment.
Hearing benefits not subject to deductible or coinsurance for PPO/POS or HDHP +HSA plans.</td></tr>
</table>

This comparison is intended as a brief description of benefits and is subject to the terms and conditions of the documents that govern the FCA US LLC Health Care Benefit Program. FCA reserves the right to terminate, suspend or amend all or part of its employee and retiree benefit plans or programs. Upon termination or partial termination of the program, coverage will cease as of the effective date of the termination or partial termination.

Save Time, Save Money: Choosing the right place for care

If it's not an emergency, why go to the emergency room? You pay more out of pocket ($175 PPO/POS copay applies) and wait longer. Save yourself time and money by using these choices for care.

24-Hour Nurse Line $0	Online Visit $0*	Retail Health Clinic $15	Primary Care Doctor** $35	Urgent Care Center $60
Average time for care 12 minutes	**Average time for care** 10 minutes	**Average time for care** 45 minutes	**Average time for care** 60 minutes	**Average time for care** 60–90 minutes
Appointment required No	**Appointment required** No	**Appointment required** No	**Appointment required** Yes	**Appointment required** No
Treatment When you have questions about an illness or injury, anytime of day or night	**Treatment** When you're short on time and want to talk to a doctor face to face from the comfort of your home or on the go	**Treatment** For a quick, in-person evaluation to get minor health care and a prescription at one location	**Treatment** When you want to talk to a doctor you know and trust face-to-face	**Treatment** When your symptoms are a little more complicated and you need convenient, in-person care
• No cost • Available by phone anytime, anywhere in the U.S. • Service provided by a registered nurse	• Available any time your doctor isn't available, nearly anywhere in the U.S. • Option to call or video chat • Send a visit summary to your primary doctor • Care provided by U.S. board-certified doctors through smartphone, tablet or computer	• Evening and weekend hours • Convenient locations • Care provided by physician assistants and certified nurse practitioners, overseen by a U.S. board- certified doctor	• High-quality, comprehensive care • Knows you and your medical history and coordinates all of your care • May be open late or on weekends • May offer additional services, such as labs	• Evening and weekend hours • Convenient locations • Lab and X-rays • Care provided by U.S. board-certified doctors, nurses and nurse practitioners, depending on severity of symptoms
Talk to a registered nurse for free. **BCBSM:1-800-775-2583** **MMO: 1-888-912-0636**	**BCBSM**: Download the app at **bcbsmonlinevisits.com** or call **1-844-606-1608**. Add service key **BLUE.** **MMO:** download the Express Care app or visit **ClevelandClinic.org/ECO**	Find a retail health clinic in select drug store chains **BCBSM:** Visit **bcbsm.com** and click *Find a Doctor* **MMO:** Visit **MedMutual.com/FCAOptions** and click Find a Provider tool	Choose a primary care doctor **BCBSM:** Visit **bcbsm.com** and click *Find a Doctor* **MMO:** Visit **MedMutual.com/FCAOptions** and click Find a Provider tool	Find an urgent care center **BCBSM:** Visit **bcbsm.com** and click *Find a Doctor* **MMO:** Visit **MedMutual.com/FCAOptions** and click Find a Provider tool .

* PPO/POS members: $0 copay for 5 visits per member per calendar year, visit 6 and beyond $10 copay. HDHP members: visits subject to deductible and co-insurance up to out of pocket maximum.

** 50% co-insurance for PPO/POS members

2024 Retiree Choice Dental Plan

BENEFITS	DELTA DENTAL			GREEN SHIELD CANADA
	Delta /POS Provider [1, 2]	Delta Premier Provider [1, 2]	Non-Participating Dentist (Out-of-Network)[2]	
Annual Deductible				
One Person	$50*	$50*	$50*	$50*
Two Persons	$100*	$100*	$100*	N/A
Family	$150*	$150*	$150*	$150*
Annual Plan Maximum				
Per Person	$1,850	$1,850	$1,850	$1,850
Diagnostic/Preventive				
Oral Exam	100%	90%	80%**	100%
Cleaning	100%	90%	80%**	100%
Fluoride Treatment (*covered for enrollees through age 14*)	100%	90%	80%**	100%
X-Rays (*bitewing X-rays covered once every 12 months for under age 15 and every 24 months for age 15 or older*)	100%	90%	80%**	100%
Sealants for children up to age 14	100%	90%	80%**	100%
Restorative				
Fillings***	90%	80%	70%**	90%
Root Canal	90%	80%	70%**	90%
Gum Treatments/Surgery	90%	80%	70%**	90%
Oral Surgery				
Extractions	90%	80%	70%**	90%
3rd Molars (Wisdom Teeth)	50%	50%	50%**	50%

Retiree Choice Dental Plan

January 1, 2024

BENEFITS	DELTA DENTAL Delta PPO Provider [1, 2]	DELTA DENTAL Delta Premier Provider [1, 2]	DELTA DENTAL Non-Participating Dentist (Out-of-Network)[2]	GREEN SHIELD CANADA
Prosthetics* **				
Crowns****	70%	60%	50%**	70%
Single Tooth Implant****	50%	50%	50%**	50%
Bridgework	50%	50%	40%**	50%
Dentures and partials	50%	50%	40%**	50%
Orthodontics (up to age 19)				
Full Course of Treatment	50%	50%	40%**	50%
Lifetime Maximum	$2,200	$2,200	$2,200	$2,200
Accidental Injury (to the Natural Teeth)	Covered $1,200 per accident			Covered $1,400 per accident under medical plan
Emergency (Out-of-Area)	Covered at applicable percentage for palliative treatment only (i.e., relief of pain, swelling and bleeding)			

Delta Dental 1-800-524-0149 www.deltadentalmi.com Green Shield Canada 1-888-711-1119 www.greenshield.ca

* Deductible does not apply to Diagnostic/Preventive or Orthodontic benefits.

** Out-of-network provider payment is based on the maximum approved payment amount. Enrollees are subject to balance billing.

*** Coverage is for amalgam and composite fillings. If precious metal is used, a copayment may be required.

**** Cast restorations (including jackets, crowns, onlays), associated procedures (such as cores and post substructures) and single tooth implants on the same tooth are payable once in any five-year period regardless of reason for replacement.

[1] Member is encouraged to seek predetermination for procedures expected to be $200 or more.

[2] Delta Dental will use a carve-out method of coordinating benefits. If the patient has other coverage and that coverage has a higher priority than this plan, this plan's payment for covered services will equal the amount payable under this plan minus the amount paid by the primary carrier. This plan's payment will not exceed the amount that would have been paid in the absence of any other plan.

This chart is intended as a brief description of benefits and is subject to the terms and conditions of the plan documents that govern the FCA US LLC Health Care Benefit Plan for Salaried Non-Represented Retirees. FCA reserves the right to terminate, suspend or amend the benefits stated in its employee and retiree benefit plans. If material changes are made, you will be notified. Upon termination or partial termination of the plan, coverage will cease as of the effective date of termination or partial termination. Benefit levels for Delta Dental enrollees will depend upon the provider's network affiliation.

2024 Retiree Choice Vision Plan

Vision coverage is a separate plan and benefit election and is not subject to basic medical plan deductibles or coinsurance.

The following is a brief overview of covered benefits under the Vision Benefit Plan offered to salaried non-represented retirees (U.S. residents only). Vision services for retirees who reside in Canada are provided by Green Shield (**1-888-711-1119** or visit **www.greenshield.ca**).

Vision Care Benefits	
From a Participating Provider	**VSP** **3333 Quality Drive** **Rancho Cordova, CA 95607** **Phone: 1-800-877-7195** **https://www.vsp.com**
Frequency Limitations	Eye examinations every calendar year. All other services once every 2 calendar years.
Examination **Lenses and Frames** **Contact Lenses**	Examinations covered with $5 copay; lenses and frames with $7.50 copay, **or** contact lenses covered in full if medically necessary, up to $90 for voluntary purchase (includes fitting). Claim forms are not required. To use this program, call your VSP participating provider to make an appointment. Ask your provider to verify eligibility and to obtain authorization for services and materials. If you use a non-participating provider, you may request reimbursement by mailing an itemized paid receipt to VSP. You will be reimbursed according to the non-panel provider reimbursement schedule and are responsible for costs exceeding that schedule.
Insulin Dependent **(Type 1 Diabetics)**	Insulin dependent (Type 1 Diabetics) eligible for annual vision exam. Appropriate corrective spectacle lenses covered for prescription changes of .50 diopter and/or 10 degrees of axis. Must present a letter from your physician.

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