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INSURANCE AGREEMENT

between

MASSEY-FERGUSON INC.

AND

INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW,

and its Locals 174, 244, 256 and 1446

March 10, 1980 through October 31, 1982

NCE AGREEMENT

GREEMENT, made this March 10, 1980 between Massey-Ferguson Inc., nafter referred to as the "company") and the INTERNATIONAL UNION, AUTOMOBILE, AEROSPACE AND AGRICULTURAL IMPLEMENT WORKERS OF A, UAW, and its Locals 174, 244, 256, 1446, (hereinafter referred the "union") shall constitute the entire agreement between the with respect to the insurance program for employees and pensioners. as otherwise provided herein, this agreement shall, effective the following ratification, amend and supersede the plans of insurance s set forth in any and all agreements or supplemental agreements the company and the union with respect to the North American Plant, the Engineering Experimental Shop, the Engineering Lab-, all located at 12601 Southfield Road, Detroit, Michigan; the nerican Parts Operation Warehouse, Racine, Wisconsin; the Gear ft Plant located at 13881 W. Chicago, Detroit, Michigan; the nerican Implement Plant, located at 1901 Bell Avenue, Des Moines ne Transmission and Axle Plant located at 32500 Van Born Road, Michigan.

I - ELIGIBILITY REQUIREMENTS

nitial Eligibility

a) New Coverages

(1) An employee who is actively at work shall be eligible for the benefits coverages under Article II, Article III, (Dental), Article IV (Vision), the Prescription Drug Agreement, and the Hearing Aid Agreement, as of the later of: (1) March 10, 1980 or (2) the first day of the third month. If such employee is not then actively at work, on the date of his return to active work.

(2) However, for employees hired on or after July 1, 1980, an employee shall be eligible for the benefits coverages under Article II, the Prescription Drug Agreement and the Hearing Aid Agreement as of the first day of the fourth month following the month of hire. If such employee is not then actively at work, on the date of his return to active work.

(3.) Coverage for benefits under Article III and Article IV (Dental and Vision) will become effective on the first of the month after the employee has attained a year of seniority for employees hired on or after July 1, 1980.

(b) Transitional Coverages. An employee who is not eligible for the Health Care Coverages in accordance with Section 1.01 and who was eligible for insurance coverages under the predecessor benefit program agreed to between the company and the union, shall continue to be eligible for coverages under such predecessor program for the periods of time provided thereunder prior to attaining eligibility for the coverages under the Health Care Coverages of this agreement.

1.02 Laid Off Employees

(a) An employee laid off shall be eligible for life and limb insurance, health and disability benefit coverage at no cost to him until the end of the calendar month following the month in which the layoff commences. Thereafter either paragraph (b) or (c) of this Section 1.02 shall apply.

(b) On SUB Extension. If such employee meets the requirements of Section 1.01 of the Supplemental Unemployment Benefit Plan, he shall be eligible for life and limb insurance, health and disability benefit coverage at no

units whould entitle him under Section 3.04 of the Supplemental Unemployment

Benefit Plan as outlined in the following table, commencing with the month following the last month for which the company has paid premiums:

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Maximum number of full weekly SUBenefits which employee's credit units as of last day worked prior to layoff would entitle him*	Maximum number of months for which insurance coverage will be continued without cost to employee
Less than 4	0
4 - 7	1
8 - 11	2
12 - 15	3
16 - 19	4
20 - 23	5
24 - 27	6
28 - 31	7
32 - 35	8
36 - 39	9
40 - 43	10
44 - 47	11
48 - 52	12

In applying the above table, the maximum number of full weekly SUBenefits to which employee's credit units as of last day worked prior to layoff would entitle him shall be determined by dividing the number of the employee's credit units under the Supplemental Unemployment Benefit Plan by the number of credit units to be cancelled for one SUBenefit in accordance with the credit unit cancellation base

and the employee's seniority as of the last day worked prior to layoff.

*If an employee after his last day worked prior to layoff is initially credited with credit units under the SUB Plan, the date on which he is entitled to be credited with credit units shall be used.

For an employee laid off on or after March 1, 1977, continuation will be based on the higher of the above table or the number of months of coverage, up to a maximum of twelve (12), for which he would be eligible on the basis of his years of seniority on the date layoff begins in accordance with the following table:

Year(s) of Seniority on Date Layoff Begins	Maximum Months Continuation w/o Contribution
Less than 1	0
1 but less than 2	2
2 but less than 3	4
3 but less than 4	6
4 but less than 5	8
5 but less than 6	10
6 and over	12

Thereafter he may continue life and limb and health Benefit coverage for a further period of twelve (12) months, but not longer than the period during which he retains seniority under the master agreement, by paying the full monthly group premium for the health Benefit coverage and by paying a monthly premium of fifty cents (50¢) per one thousand dollars ($1,000) of life insurance in force on the day of layoff.

(c) Not on SUB Extension. If such employee does not meet the requirements of Section 1.01 of the Supplemental Unemployment Benefit Plan, he may continue the life and limb and health benefit coverage for a period of twelve (12) months, but not longer than the period during which he retains seniority under the master agreement, by paying the full monthly group premium for the health coverage and by paying a monthly premium of fifty cents (50¢) per one thousand dollars ($1,000) of life insurance in force on the day of layoff. Such months of coverage shall be for months following the last month of employee's coverage for which contributions were made by the company.

(d) Recall

(1) An employee recalled from layoff shall be eligible for all benefit plan coverage to include life and limb insurance, accident and sickness insurance, long-term disability insurance, health insurance, dental, vision, and hearing which he is lacking under Article II upon his return to active work, if otherwise eligible in accordance with Section 1.01.

(2) An employee with seniority who is recalled from layoff or is scheduled to return from leave of absence but is not employed because he fails to pass a company medical examination shall, for purposes of benefit plan coverage, be deemed to be actively at work on the day on which the medical examination took place, and shall thereafter be eligible for life

and limb and health benefit coverages on the same basis as provided in Section 1.04 and any accident and sickness benefits for which he may qualify under Section 2.03, but shall have included in the maximum period for which benefits are payable any period of time during which he received disability benefits while on layoff.

(3) An employee who is recalled from layoff before the fifteenth of the month shall have refunded to him any benefit plan premiums which he may have paid for that month.

1.03 Leave of Absence. An employee on approved leave of absence under the master agreement shall be eligible for life and limb insurance and health benefits on the same basis as provided in Sections 1.02 (a) and (c); except that if such employee is on approved leave of absence for local union business, he shall have the option of continuing such coverages for the full duration of such leave by paying the required premiums. This section shall not apply to absence due to disability nor to leave of absence to assume a position with the International Union.

1.04 Disability. An employee who has become totally and continuously disabled while actively at work or who has physical limitations which temporarily prevent him from working due to disability shall be eligible for life and limb insurance

duration of his absence, for such reason or a period equal to his seniority, whichever is less, but in no event for less than six (6) months or until he is retired under the pension agreement, whichever occurs earlier.

1.05 Loss of Seniority or Suspension. A employee who is seeking reinstatement through the grievance procedure under the master agreement following loss of seniority as provided in Section 7.04 of the master agreement, or an employee on disciplinary layoff, shall have the option of continuing life and limb insurance and health benefit coverage while his grievance is pending through the grievance procedure for up to twenty-four (24) months following the date of loss of seniority or commencement of the disciplinary layoff, as the case may be by paying a monthly premium of fifty cents (50¢) per one thousand dollars ($1,000) of life insurance coverage and the full monthly group premium for health benefit coverage. If the employee is reinstated following such loss of seniority, or if the disciplinary layoff is reduced, the company shall reimburse the employee for all contributions made by him for coverage under this section for any period for which he is reinstated with back pay.

1.06 Termination between 60-65. An employee who is covered on his sixtieth (60th) birthday and who terminates his employment relationship for reasons other than discharge, but who is not eligible for a pension under the pension agreement and who has five (5) or more years of credited service under the pension agreement, shall have the option of continuing his life and limb insurance (excluding

fifty cents (50¢) per one thousand dollars ($1,000) of life insurance in force on the day of termination.

1.07 Surviving Spouse of Deceased Employee or Pensioner. A surviving spouse:

(a) of an employee who dies before retirement and on or after January 1, 1976, and whose surviving spouse is elibible for a survivor benefit under Section 3.05 of the pension agreement (including for this purpose a surviving spouse who would receive such benefits except for receipt of transition or bridge benefits);

(b) of a pensioner retired on or after January 1, 1965, under any pension agreement between the parties; (not including a former employee entitled to or receiving a deferred vested pension) whether or not the pensioner elected a survivor option;

(c) of an employee whose employment terminated after age sixty-five (65) and on or after January 1, 1965, (except if discharged for cause) with insufficient credited service to entitle him to a pension under the pension agreement;

shall effective August 1, 1968, have the option of continuing company paid health benefit coverage, including dental, prescription drug expense coverage, vision and hearing aid coverage, by electing such coverage for herself and any eligible dependents not later than three (3) months after the death of the employee or pensioner. The company shall notify the surviving spouse of the availability of such coverage following

receipt of proof of death of the employee or pensioner by the company. Commencing with the month in which the spouse becomes eligible for Medicare under the Federal Social Security Act, the company will continue premium contribution only for months in which the spouse has the voluntary coverage that is available under the Federal Social Security Act.

A surviving spouse not covered above who is receiving the transition or bridge benefit under Section 2.01 (b),(c),(d),(e),(f), or (g) or who is not receiving a bridge benefit only, because the widow is eligible for mother's insurance benefits under the Federal Social Security Act, shall have the option of continuing health benefit coverage by paying the full monthly group premium. The company shall notify the surviving spouse of the availability of such coverage and such coverage must be elected by the spouse in writing no later than three (3) months after the death of the employee or pensioner. Where the surviving spouse has elected this option the company shall have the option of deducting the required premium from the transition or bridge benefit.

ARTICLE II. INSURANCE BENEFITS FOR ACTIVE EMPLOYEES

2.01 Life and Limb Insurance. An employee eligible under the applicable sections of Article I shall be entitled to the following coverages:

(a) Life Insurance. Life insurance for an eligible

of twelve thousand dollars ($12,000) and a maximum of twenty-five thousand dollars ($25,000).

(b) Survivor Income Benefit Insurance effective December 1, 1964:

(1) Transition Benefit - one hundred dollars ($100) per month for twenty-four (24) months following death of employee; payable to the employee's eligible surviving spouse, dependent children or dependent parents.

(2) Bridge Benefit - one hundred dollars ($100) per month to employee's eligible surviving spouse if she is at least fifty (50) years of age at the time of death of the employee, payable after transition benefit is exhausted until she attains age sixty-two (62), remarries or becomes eligible for full Widow's or Widower's Insurance Benefit or Old Age Insurance Benefit under the Federal Social Security Act (as now in effect or hereafter amended), whichever occurs earliest, provided that no bridge benefit shall be payable to a widow for any month for which she is eligible to receive Mother's Insurance Benefits (nor to a widower eligible to receive a comparable benefit for a father whether or not called a Father's Insurance Benefit) under such Act.

(c) Survivor Income Benefit Insurance effective November 1, 1968:

(1) Transition Benefit - one hundred and fifty dollars ($150 per month, providing an otherwise eligible employee was actively at work on or after November 1, 1968, payable for any month for which an eligible survivor of the deceased employee is ineligible for an unreduced old age survivors or disability benefit under the Federal Social Security Act as now in effect or as hereafter amended, otherwise such benefit shall be one hundred dollars ($1(but in any event the benefit shall be payable for a maximum period of twenty-four (24) months following the death of the employee.

(2) Bridge Benefit - one hundred and fifty dollars ($150) per month providing an otherwise eligible employee was actively at work on or after November 1, 1968, payable to the employee's eligible surviving spouse in accordance with eligibility requirements defined in Section 2.01 (b)

(d) Survivor Income Benefit Insurance effective November 1, 1971:

(1) Transition Benefit - one hundred and seventy-five dollars ($175) per month providing an otherwise eligible employee was actively at work on or after November 1, 197 and payable for any month for which an eligible survivor is not eligible for full old age, survivors, or disabilit benefit under the Federal Social Security Act as now in effect or as hereafter amended, otherwise such benefit shall be one hundred dollars ($100) but in any event shall be payable for a maximum period of twenty-four months following the death of the employee.

(2) Bridge Benefit - one hundred and seventy-five dollars ($175) per month providing an otherwise eligible employee was actively at work on or after November 1, 1971 payable to the employee's eligible surviving spouse, if she is at lease forty-eight (48) years of age at the time of death of the employee, in accordance with the eligibility requirements defined in Section 2.01 (b) (2).

(e) Survivor Income Benefit Insurance effective November 1, 1975:

(1) Transition Benefit - two hundred dollars ($200) per month providing an otherwise eligible employee was actively at work on or after November 1, 1975, and payable for any month for which an eligible survivor is not eligible for full old age, survivors or disability benefit under Federal Social Security Act as now in effect or as hereafter amended, otherwise such benefit shall be one hundr dollars ($100) but in any event shall be payable for a maximum period of twenty-four (24) months following the

(2) Bridge Benefit - two hundred dollars ($200) per month providing an otherwise eligible employee was actively at work on or after November 1, 1975 payable to the employee's eligible surviving spouse, if she is at least forty-five (45) years of age at the time of death of the employee, in accordance with the eligibility requirements defined in Section 2.01 (b) (2).

(f) Survivor Income Benefit Insurance effective March 1, 1977:

(1) Transition Benefit: two hundred and fifty dollars ($250) per month providing an otherwise eligible employee was actively at work on or after March 1, 1977, and payable for any month for which an eligible survivor is not eligible for full old age, survivor's or disability benefit under the Federal Social Security Act as now in effect or as hereafter amended, otherwise such benefit shall be one hundred and fifty dollars ($150) but in any event shall be payable for a maximum period of twenty-four (24) months following the death of the employee.

(2) Bridge Benefit - two hundred and fifty dollars ($250) per month providing an otherwise eligible employee was actively at work on or after March 1, 1977 payable to the employee's eligible surviving spouse, if she is at least forth-five (45) years of age at the time of death of the employee, in accordance with the eligibility requirements defined in Section 2.01 (b) (2).

(g) Survivor Income Benefit Insurance effective March 1, 1980:

(1) Transition Benefit - three hundred dollars ($300) per month providing an otherwise eligible employee was activ at work on or after March 1, 1980, and payable for any

Federal Social Security Act as now in effect or as hereafter amended, otherwise such benefit shall be one hundred and seventy-five dollars ($175) but in any event shall be payable for a maximum period of twenty-four (24) months following the death of the employee.

(2) Bridge Benefit - three hundred dollars ($300) per month providing an otherwise eligible employee was actively at work on or after March 1, 1980, payable to the employee's eligible surviving spouse, if she is at least forty-five (45) years of age at the time of death of the employee, or, if the surviving spouse is less than forty-five (45) years of age, if her a when combined with the employee's years of credited service under the Pension Plan, both of which to be determined as of the date of the employee's death totals 55 or more.

in accordance with the eligibility requirements defined in Section 2.01 (b) (2). A surviving spouse that is eligible for Bridge Benefit and who is not otherwise eligible for such Company paid coverage will have fully paid coverage for all hospital, surgical, medical, Section 2.08, 2.10, Dental, Vision and Hearing Aid coverages for a six (6) month period after the spouse's death.

(h) Sharing of Transition Benefit. For months in which two or more survivors share a benefit, such benefit shall be computed as a share of the amount that would be payable to each survivor in accordance with his own eligibility for Social Security Benefits.

(i) If the survivor pension payable to a surviving spouse is greater than the transition and bridge benefits payable under this section, Article III Pension Agreement will be effective immediately and any obligation to pay benefits under this Section will terminate.

(j) Accidental Death and Dismemberment Insurance. In addition to any life insurance for which an employee may be eligible under Section 2.01 (a) one hundred percent (100%) of the employee's life insurance shall be payable in the event of accidental death or double dismemberment or fifty percent (50%) of his life insurance shall be payable in the event of single dismemberment. No benefit shall be payable for losses unless they occurred within two (2) years of the date of the injuries.

2.02 Total and Permanent Disability Benefit. An employee eligible for life insurance coverage under Section 2.01 (a) who becomes totally and permanently disabled as defined in Section 7.01 (k), shall be entitled to such life insurance on the following basis:

(a) Continuation of Benefits. His life insurance under Section 2.01 (a) and accidental death and dismemberment insurance under 2.01 (j) will continue at no cost to him in accordance with the table in 2.06 (b) (2).

(b) Installment Payments. In lieu of the continuation of benefits provision in Section 2.02 (a) such an employee who becomes so disabled and prior to age seventy (70) who has ten (10) years or more of credited service under the pension agreement, may elect to forego his accidental death and dismemberment insurance provided under Section 2.01 (j) and receive his life insurance provided under Section 2.01 (a) in fifty (50) monthly installments of twenty dollars ($20) for each one thousand dollars ($1,000) of such insurance, subject to the following:

(1) if the employee dies while monthly installments are being paid, the remaining installments shall be paid to his beneficiary in a lump sum, provided that a minimum of five hundred dollars ($500) shall be paid to such beneficiary regardless of the amount of remaining unpaid installments;

(2) after the total amount of his life insurance has been paid out under Section 2.02 (b) five hundred dollars ($500) of group life insurance coverage shall be provided during the remainder of the employee's disability;

(3) if such employee recovers from such disability,

(i) and returns to work, he shall be entitled to the full life insurance coverage provided in Section 2.01 (a); but if he again becomes eligible for installment payments under this Section 2.02 (b) such installments shall cease when their total, plus the total of the installments for any prior disability equals the amount of his life insurance in force at the time of his latest disability;

(ii) and does not return to work, he may convert the amount of unpaid installments, but not less than five hundred dollars ($500) into an individual policy, provided that if he is then over age sixty (60) but not age seventy (70), he may continue life insurance equal to the unpaid installments to age seventy (70) by paying a premium of fifty cents (50c) per one thousand dollars ($1,000)

(4) no installment payments shall be made as long as the employee is eligible to receive disability insurance benefits, nor shall any installment payments be made for any month following the month in which the employee attains age seventy (70).

2.03 Accident and Sickness Benefits.

(a) Benefits shall be payable to employees eligible in accordance with Section 1.01. The maximum period during which accident and sickness benefits are payable to employees eligible in accordance with Section 1.01 for accident and sickness shall be limited by the lesser of:

(1) The number of full weeks of the employee's seniority at the time his disability began, unless the employee is hospital confined or in receipt of worker's compensation benefits in that event the benefits will continue for the duration of the confinement, but in no event for a period greater than fifty-two (52) weeks commencing with the first day of benefit; or

(2) fifty-two (52) weeks including any period of time the employee received layoff disability benefits during a period of layoff.

Successive periods of disability separated by less than two weeks of active work on full time shall be considered one period of disability unless the subsequent disability is due to an injury or disease entirely unrelated to the causes of the previous disability and commences after the employee has returned to active work on full time.

(b) Determination of Amount. Effective March 1, 1980, sixty-five percent (65%) of forty (40) times his base hourly rate at the time his disability began, subject to a maximum of two hundred sixty dollars ($260). The base hourly rate for determination of Accident and Sickness benefits shall be defined as the regular day work rate as defined in paragraph 11.08 of the Master Agreement, excluding the cost-of-living allowance and shift premium. Effective March 1, 1981 the maximum shall become two hundred eighty dollars ($280) and on March 1, 1982 the maximum amount will be three hundred dollars ($300).

(c) Such benefits shall start on the earliest of:

(1) first day of accident on which employee was unable to work;

(2) first day of hospitalization on which the employee was unable to work;

(3) the day following a surgical operation not performed on an in-patient basis for which the surgical schedule provides benefits of twenty-five dollars ($25) or more;

(4) the eighth (8th) day of sickness.

(d) Such benefits shall be payable for non-occupational and occupational disability, but shall be reduced by the amount of any worker's compensation benefits for which the employee is eligible. Effective November 1, 1971, in the case of a disability incurred with another employer, benefits under this plan shall be payable in an amount determined in accordance with Section 2.03 (b) less the amount of any worker's compensation benefits and the amount of disability benefits paid by the other employer, if any, except that no reduction from this benefit shall be made for any payments specifically for hospitalization or medical expense, or specific allowances for loss, or 100% loss of use, of a body member or disfigurements.

(e) No benefits shall be payable for any period for which the employee is eligible for unemployment compensation.

(f) Payment of benefits are subject to the following provisions:

(1) For other than a whole work week, benefits will be paid on the basis of one-fifth (1/5) of the weekly benefit for each day the employee is disabled in his regular five-day work week;

(2) Benefits will not paid for any day for which holiday pay is received from the Company.

(g) The amount payable to an employee who becomes disabled prior to attaining one year of seniority shall be 75% of the amount determined above. The full amount shall become payable as of the date such an employee attains one year of seniority.

2.04 Recovery of Benefit Overpayments. If it is determined that any benefits paid to an employee under the program should not have been paid or should have been paid in a lesser amount, written notice thereof shall be given to such employee and he shall repay the amount of the overpayment to the company. If the employee fails to repay such amount of overpayment promptly, the Plan Administrator may arrange to recover the amount of the overpayment by making an appropriate deduction or deductions from any future benefit payment or payments payable to the employee; or the company, at the Plan Administrator's request, may make an appropriate deduction or deductions from future compensation payable by the company to the employee.

However, no repayment shall be required unless notice is given to the employee by the company within 60 days from the date the company has knowledge of the overpayment. The amount deducted from each pay check or benefit check shall be limited

to $30.00 or the amount permitted by law, whichever is less, except that no such time limitation shall be applicable in cases of fraud or willful misrepresentation.

2.05 Layoff Disability Benefits.

(a) Effective August 1, 1968, layoff disability benefits shall be payable in accordance with the amounts and effective dates as defined in Section 2.03 (b).

The general provisions of the accident and sickness benefits program shall govern the administration of the layoff disability benefit program subject to the provisions detailed in this Section 2.05.

(b) Eligibility Requirements. In order to qualify for layoff disability benefits the employee must:

(1) become totally and continuously disabled while on a qualifying layoff as defined in Section 1.03 of the SUB Plan and must be insured for life insurance under the agreement;

(2) have been eligible for a regular benefit under the SUB Plan or have been employed by another employer immediately prior to the commencement of his disability;

(3) have to his credit at least one (1) credit unit under the SUB Plan;

(4) apply for the benefit and otherwise meet the disability requirements outlined in the Plan document.

(c) Payment of benefits shall become payable commencing with the first day following the last day for which a regular benefit was payable to the employee if he was receiving regular benefits under the SUB Plan immediately prior to becoming disabled, otherwise on the first day of a qualifying disability.

(d) Reduction and Suspension of Benefits. Benefits shall be reduced in accordance with the provisions of Section 2.03 (d) as well as by the amount of any disability benefits the employee receives for the same week under a plan financed in whole or in part by another employer, providing further, that no benefits shall be payable for any week in which:

(1) the employee receives an accident and sickness or long term disability benefit under the agreement;

(2) the employee is eligible for unemployment compensation;

(3) the Credit Unit Cancellation Base under the SUB Plan is below eighteen dollars ($18).

(e) The number of credit units under the SUB Plan to be cancelled for each full layoff disability benefit shall be determined in accordance with Section 3.04 of the SUB Plan.

2.06 Long Term Disability Income. An employee eligible in accordance with Section 2.03 (a) who exhausts his eligibility for Accident and Sickness benefits and/or layoff disability benefits and is still totally disabled and unable to engage in any work in the bargaining unit, shall receive Long Term Disability Insurance Benefits as follows:

(a) Commencing with the day following the last day of eligibility under the Accident and Sickness and layoff disability programs, monthly Long Term Disability Benefits shall be payable on the basis of fifty percent (50%) of one hundred and seventy-three (173) times the employee's base hourly rate.

(b) The maximum period during which Long Term Disability Benefits are payable shall be limited by the earlier of:

(1) the greater of twelve (12) months or the number of months by which the employee's seniority exceeds twelve (12) at the time his disability began;

(2) or based on following Table depending on age at disablement.

Age at Disablement	Duration of Benefits
61 or younger	Up to age 65
62	3.5 Years
63	3.0 Years
64	2.5 Years
65	2.0 Years
66	1.75 Years
67	1.5 Years
68	1.25 Years
69	To age 70

(3) the day the employee no longer satisfies the disability requirements;

(4) the date the employee dies.

(c) The amount of Long Term Disability Benefits payable shall be reduced by any or all of the following for which the employee becomes eligible:

(1) pension benefits under any retirement plan of the company;

(2) Worker's compensation benefits except specific allowances for loss or one hundred percent (100%) loss of use, of a body member;

(3) primary insurance amount of disability or old age insurance benefits under the Federal Social Security Act or future legislation providing similar benefits; except for old age benefits reduced because of the age at which they are received. For an employee who worked on or after November 1, 1971, and subsequently becomes eligible for long term disability benefits, the primary insurance amount of disability or old age insurance benefits under the Federal Social Security Act or future legislation

providing similar benefits shall be frozen to the amount applicable at the time such benefits are initially deducted.

(4) any benefits under any state or federal law providing benefits for periods of unemployment or disability.

(5) the amount of such benefit under 2.06 (c) (1) (2) (3) and (4) above shall not be increased subsequent to the first day for which Long Term Disability Benefits are payable, except that the amount of such increase shall not be disregarded if it represents an adjustment in the original determination of the amount of such benefit.

Applicable deduction for retirement benefits and Social Security Disability benefits shall be made as soon as the employee becomes eligible for such benefits unless the employee submits satisfactory evidence that these benefits were applied for and denied for reasons other than denial to accept vocational rehabilitation services.

(d) The amount of Long Term Disability Benefits shall be reduced by the monthly equivalent of other benefits as applicable by:

(1) multiplying, the weekly benefits rate by four and thirty-three hundredths (4.33);

(2) dividing lump sum settlements into the monthly equivalent of the amount of benefits which the employee would have received in the absence of such lump sum settlement, not to exceed the amount of the settlement.

(e) Benefits and reductions applicable to periods other than a full month, shall be pro-rated on the basis of the ratio of calendar days for the period in question to the total number of calendar days in the month.

2.07 Health Benefit Plan.

(a) Health benefits shall be provided for eligible employees and dependents as follows:

(1) Hospital Board and Room: Semi-private accomodation to a maximum of three hundred and sixty-five (365) days per confinement;

(2) Hospital Supplementary Benefits: (including special charges, anesthesia and necessary ambulance service) maximum unlimited while board and room benefits are payable;

(3) Preadmission Hospital Tests:
Effective March 1, 1977, benefits will be paid for charges by a hospital for required tests prior to a scheduled admission to the hospital in an amount equal to the actual expense to the employee up to the reasonable and customary charges for such tests. Such required test must be:

(i) related to the patient's condition or diagnosis or required by the hospital, and

(ii) ordered by the physician in charge, and

(iii) performed within 72 hours of the date of the scheduled admission to the hospital.

In the event the scheduled admission to the hospital is canceled by the physician in charge, benefits will be paid. However, if the scheduled admission is canceled by the employee or the employee's dependent, then no benefits are payable.

(4) Free Standing Surgical Facility:
Benefits will be paid for charges in connection with a surgical procedure performed in a free-standing surgical

facility for those procedures which would otherwise require the service of the out-patient department of a hospital or be performed on an in-patient basis.

(5) Surgical Schedule: benefits payable in accordance with a reasonable and customary fee schedule;

(6) Medical Visits in Hospital: benefits payable at a reasonable and customary level of a daily visit times the number of days confined, with a maximum of three hundred and sixty-five (365) days;

(7) Diagnostic X-ray, Laboratory Examinations and Radiation Therapy: Benefits payable at a reasonable and customary level. Effective November 1, 1975, this benefit will include routine pap smears and pregnancy tests, i.e. medical costs including physician's services at the UCR rate in addition to laboratory analysis fees.

(8) Supplemental Accident Benefits: to a maximum of one hundred and fifty dollars ($150) per accident per individual;

(9) Maternity benefits for employees and eligible spouse:

(i) Hospital board and room and hospital supplementary benefits; as in (1) and (2) of this Section 2.07 (a);

(ii) Surgical benefits (including pre-natal and post-natal care benefits) payable at a reasonable and customary level.

(10) Convalescent Care: Seven hundred and thirty (730) days in an approved facility. Hospital benefit duration will not be reduced because of prior confinement in an approved convalescent or long stay facility; however, convalescent care will continue to be reduced by prior hospital confinement.

(11) Psychiatric and Related Psychotherapeutic Service: as provided in the Plan document. Effective November 1, 1975:

(i) For each visit after the first five visits under the out-patient Psychiatric Care Benefit, the deductible applied to the maximum allowable expense shall be ten percent (10%)

(ii) The annual maximum shall be increased from four hundred dollars ($400) to one thousand dollars ($1,000) maximum.

(12) Prescription Drug Plan: Benefits payable at a reasonable and customary level subject to a two dollar ($2.00) deductible for each separate prescription order and refill not exceeding one month's supply. The supply limitation for certain maintenance legend drugs, as outlined in Section J of the Agreement on Prescription Drug Benefits, to be limited to a thirty-four (34) day supply or 100-unit doses, whichever is greater, or to be limited to a thirty-four (34) day supply or 200 unit doses, whichever is greater; whichever is applicable in Section J of the Agreement on Prescription Drug Benefits.

(13) Intensive Care Coverage: Intensive care in-hospital accommodation to a maximum of three hundred and sixty-five (365) days per confinement.

(14) In-hospital Consultation Medical visits: Benefits payable at a reasonable and customary level;

(15) Hemodialysis Benefits: Benefits provided for hospital billed services in connection with an approved program of hemodialysis in an approved hospital out-patient department and in the home (except charges for blood). Reasonable and necessary expenses for installation, maintenance and repair of equipment and supplies used in the home are also covered.

(16) Effective November 1, 1975, out-patient physical therapy benefits will be payable for services performed for a period of sixty (60) treatment days when prescribed by a physician (M.D. or D.O.) for a specified condition resulting from disease or injury or prescribed immediately following surgery related to the condition and when the physical therapy is performed in the out-patient department of a hospital, in an Approved Convalescent Facility or other facilities such as Rehabilitation Centers having comprehensive physical therapy facilities and approved by the Plan Administrator or the company. Such services must be performed by a physician (M.D. or D.O.) or a qualified physical therapist according to a prescription from a physician concerning the nature, frequency and duration of treatment. Consultation services of a physician who is a

specialist in rehabilitation or physical medicine when requested by the physician in charge of the case where special skill or knowledge for proper diagnosis and treatment is required, will be provided once during or preceeding a course of physical therapy treatment whether charged by the physician or charged by the institution where the service is rendered. The sixty (60) treatment day limit will be renewed in the event of surgery and the condition is such as to require physical therapy, in the event of an unrelated condition requiring physical therapy, or annually from the last date of course of physical therapy treatment commenced. A "qualified physical therapist" is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in Collaboration with the American Physical Therapy Association or its equivalent, and, where applicable, is licensed by the State.

(17) Emergency Medical Benefit: A benefit payable at reasonable and customary level payable to the physician for each non-accidental emergency medical treatment including

administration of a series of rabies immunizations. Effective November 1, 1975, this benefit will be paid on reasonable and customary level, for both physician and hospital services. "Medical emergencies" are defined as sudden and unexpected onset of conditions requiring medical care, but not surgical care which the employee or dependent receives from the physician immediately after the onset and would include heart attacks, cardiovascular accidents, poisonings, loss of consciousness, or respiration and such other acute conditions as may be determined to be medical emergencies.

(18) Psychiatric and Related Psychotherapeutic Service: A maximum annual benefit per person of seventy-five dollars ($75) for outpatient psychological testing.

(19) Prosthetic Devices: On or after November 1, 1975, with respect to expenses incurred for any of the following services or medical supplies, benefits will be paid as follows: If a prosthetic device is received as a result of an injury or sickness on the order of a Physician (M.D. or D.O.) when payment for such device is not otherwise covered under the Plan, pay-

ment will be made for the actual amount charged for such device to the extent such charge does not exceed the usual charge by the physician, group or other entity furnishing the device and is not in excess of the general level of charges made by others providing similar devices within the area. Payment may be made directly to the supplier of such device.

"Prosthetic Device" means a device which replaces all or part of a body organ (including contiguous tissue) or a diseased, malformed, or injured portion of the body or replaces all or part of the function of a permanently inoperative or malfunctioning body organ, or portion of the body, including, but not limited to, leg, arm, back and neck braces, trusses and artificial legs, arms, and eyes, and terminal devices such as hand hooks furnished on the order of a physician (M.D. or D.O.). Replacement of unusable prosthetic devices or repairs of these devices when furnished on a physician's order, and supplies and equipment not having any use other than in connection with the use of the prosthetic device and which are necessary for the effective use of the prosthetic device will also be covered.

The term "Prosthetic Device" includes post-surgical lenses customarily used during convalescence from eye surgery in which the lens of the eye was removed, or used to replace a congenitally absent lens of the eye. In addition, combinations of prosthetic lenses are covered when determined to be medically necessary by a physician to restore essentially the vision provided by the crystalline lens of the eye. Dentures, other dental appliances, hearing aids, and glasses and contact lenses prescribed to correct visual defects are excluded except as provided elsewhere in this agreement. Also excluded are non-durable items such as support garments, special shoes, (unless an integral part of a leg brace), and elastic support bandages.

(20) Durable Medical Equipment: If Durable Medical Equipment is received by an employee or dependent after November 1, 1975, on the order of a physician (M.D. or D.O.) for use when not confined as an in-patient in a hospital, convalescent facility, or any other institution for the treatment of injury or sickness or to improve the functioning of a malformed body member when payment for such equipment is not otherwise provided for under this Plan, payment will be made of the actual amounts charged for the rental of such equipment to the extent such charges do

not exceed the usual charge by the physician, group or other entity furnishing the equipment, and is not in excess of the general level of charges made by others providing similar equipment within the area. Payment may be made directly to the supplier of the equipment. The Plan Administrator or company may approve the purchase of such equipment if it can reasonably be assumed that the duration of need is such that the rental price would exceed the purchase price, or said item cannot be made available on a rental basis.

"Durable Medical Equipment" means medical equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purposes, (3) generally is not useful to a person in the absence of illness or injury, and (4) is appropriate for medical treatment in the home and includes, but is not limited to, such items used for treatment as an iron lung, oxygen tents, hospital-type beds and equipment, wheelchairs, crutches, canes, walkers, inhalators, traction equipment, nebulizers and suction machines, toilet aids, circulatory aids and neuromuscular stimulants. Benefits will not be paid for special features or equipment such as motor drive beds and wheelchairs requested by the

patient for personal comfort or convenience unless medically necessary.

"Durable Medical Equipment" does not include dentures; hearing aids; eyeglasses; contact lenses or equipment which is primarily and customarily used for non-medical purposes, such as heat lamps; air conditioners and other devices and equipment used for environmental control

or to enhance the environmental setting in which the patient is placed such as room heaters, humidifiers, dehumidifiers and other equipment which basically serve comfort or convenience; special pad or mattress to prevent decubitus ulcers, (except in case of advanced neurological disorders) and bed bath types of equipment which basically are utilized for hygienic purposes; prosthetic devices; any other item or device which does not stand repeated use such as elastic stockings, face mask, irrigating kits, ace bandages, orthopedic shoes, or other devices that do not serve a meaningful and necessary therapeutic purpose in the care and treatment of the patient.

(21) Chemotherapy: If an employee or dependent undergoes treatment by a physician for

malignancies using medically accepted chemotherapy on or after November 1, 1975, and payment for such treatment is not otherwise provided for under this Plan, payment will be made for such treatment administered and charged for by a physician or administered in the out-patient department of a hospital and charged for by the hospital. The actual amount charged will be paid to the extent such charge does not exceed the usual charge of the physician or hospital and is not in excess of the general level of charges made by others providing chemotherapy treatment in the area. Payment may be made directly to the physician or hospital and will include the chemicals or other substances used in the treatment.

(22) Employees and their dependents who are eligible for health benefit coverage under this agreement and who are eligible for and enrolled in Medicare Part "B" shall be reimbursed $8.70 per month effective March 1, 1980; $9.20 effective December 1, 1980; and $9.70 effective December 1, 1981.

(23) Effective March 10, 1980 reconstructive surgery of deformities from disease or medically necessary surgery; eg. breast reconstruction, post surgical scars when previous surgery was medically necessary will be a covered benefit.

(24) Effective March 10, 1980, brain and body CAT SCANS is a covered benefit in accordance with the same requirements as used for Medicare coverage.

(25) Effective March 10, 1980, ambulance transport between hospital and CAT SCAN facilities will be a covered benefit.

2.08 Effective November 1, 1975, sterilization of either sex will be considered a covered surgical expense. In addition, benefits will be paid when the surgical service is performed in any facility licensed by the State for the performance of such services provided, however, the charges of a facility not licensed as a hospital shall not exceed such facility's usual charges, nor shall such charges exceed the usual charges of hospitals in the area for the same services.

2.09 Sponsored Dependents. Effective November 1, 1968, employees who are actively employed on or after such date, may make application to the company for enrollment of a sponsored dependent for the health insurance coverage (excluding maternity benefits and prescription drug coverage) under Section 2.07 (a):

(a) application for enrollment must be received by the company the earlier of:

(1) the day the employee becomes insured;

(2) or if the employee is already insured within thirty (30) days of acquiring such sponsored dependents.

(b) The employee will be required to pay the full premium for such coverage prior to the first day of the month for which such coverage is in effect. The premium may be deducted from the employee's pay; if the employee has no pay in the appropriate pay period he will be required to submit such premium in accordance with the foregoing.

(c) Coverage for sponsored dependents shall terminate on the earlier of:

(1) the end of the month in which the employee files a request to cancel such coverage;

(2) the first of the month for which no contribution was paid;

(3) the date the employee's benefit plan coverage terminates;

(4) the date the sponsored dependent ceases to meet the dependency requirement;

(5) the first of the month in which the sponsored dependent becomes eligible for coverage under "Medicare."

(d) In the event of the death or retirement of any employee and notwithstanding the provision outlined in Section 2.09 (c) (3), the pensioner or the surviving spouse of

the employee, whichever is the case, may continue such sponsored dependent coverage by paying the applicable premium.

2.10 Catastrophic Medical Expense Benefits.

Benefits for catastrophic medical events are provided after the exhaustion of 365 days of hospitalization on the basis of the following:

(a) Hospital charges as provided in the primary provisions of the Plan but without regard to the limitation of 365 days;

(b) Nonsurgical Physician charges as provided in the primary provisions of the Plan but without regard to the Indemnity Limits normally applicable.

Charges for necessary private duty, registered nursing care services in excess of a $100.00 deductible per calendar year.

Payment of the above charges will be made on the basis of 80% of the first $10,000 and 100% for charges in excess of $10,000 with a maximum of $50,000 for any person for his or her lifetime.

ARTICLE III. DENTAL EXPENSE BENEFITS

3.01 Description of Benefit.

Dental expense benefits will be payable, subject to the conditions herein, if an employee, and their dependents, while dental expense coverage is in effect with respect to such employee or dependent, incurs covered dental expenses.

3.02 Maximum Benefit.

The maximum benefit payable for all covered dental expenses incurred in any one calendar year (except those for orthodontic treatment and procedures listed in Section 3.03 (b)) will be $1,000. This maximum will apply separately to each insured employee and to each insured dependent.

For covered dental expenses in connection with orthodontic treatment the maximum benefit will be $800 for all such expenses incurred during the lifetime of the insured family member. This lifetime maximum will apply separately to each insured employee and to each insured dependent.

3.03 Covered Dental Expenses

Covered dental expenses are the reasonable and customary charges of a dentist which an employee is required to pay for the following dental services and supplies received, while insurance is in force for the necessary dental treatment. The amount of payment for dental expenses shall be governed by professional consideration of the procedures, services, or courses of treatment that are customarily provided by the dental profession consistent with sound professional standards of dental practice for the dental condition concerned.

(a) The charges of a dentist, but only for the following services. The rate of payment for items (b)(1) through (c)(11) shall be 100% of the reasonable and customary charge, except that the following procedures (b)(1) through (b)(8) shall not be included in the $1,000 annual maximum and the following procedures (c)(1) through (c)(11) shall be included in the $1,000 annual maximum.

(b) 100% of Reasonable and Customary but NOT charged against the $1,000 yearly maximum;

(1) The excision of partially or completely unerupted or impacted teeth.

(2) The excision of the tooth root without the extraction of the entire tooth.

(3) Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction of or repair of teeth, but not treatment of periodontal and other diseases of the gums and tissues of the mouth covered by (c) (6) below.

(4) Multiple extractions for bed patients in hospitals when a concurrent hazardous medical condition exists.

(5) Gingivectomy procedures, if performed in connection with the treatment of diseased gums.

(6) Topical application of fluoride.

(7) Space maintainers that replace prematurely lost teeth for children under 19 years of age.

(8) Emergency palliative treatment.

(c) 100% of Reasonable and Customary charged against the $1,000 annual maximum;

(1) Dental x-rays, but not more than one full mouth x-ray in any period of thirty-six (36) consecutive months; and supplementary bitewing x-rays but not more than once in any 150 consecutive day period; and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment.

(2) Extractions.

(3) Oral surgery.

(4) Fillings.

(5) General anesthetics administered in connection with oral surgery or other covered dental services.

(6) Treatment of periodontal and other diseases of the gums and tissues of the mouth but not surgical procedures covered in (b) (3) above. (Bridgework requir in connection with such treatment is subject to 50% rate of payment.)

(7) Oral examinations including prophylaxis (scaling and cleaning of teeth), but not more than one (1) examination in any 150 consecutive day period.

(8) Endodontic treatment, including root canal therapy.

(9) Injection of antibiotic drugs by the attending dentist.

(10) Repair or recementing of crowns, inlays, bridgework or dentures, or relining of dentures.

(11) Inlays; gold fillings; crowns (including precision attachments for dentures.)

The rate of payment for items (12) through (15) shall be 50% of the reasonable and customary charge.

(12) Initial installation of fixed bridgework (including inlays and crowns to form abutments).

(13) Initial installation (including adjustments during the six (6) month period following installation) of partial or full removable dentures.

(14) Replacement of existing partial or full removable denture or fixed bridgework by a new denture by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

(i) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or

(ii) the existing denture or bridgework was installed at least five (5) years prior to its replacement (however, this five (5) year rule applies to dentures or bridgework benefits paid under this Plan only) and the existing denture or bridgework cannot be made serviceable; or

(iii) the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within twelve (12) months from the date of installation of the immediate temporary denture.

Normally dentures will be replaced by dentures but if achieving a professionally acceptable course of treatment requires bridgework, such bridgework will be a covered dental expense.

(15) Orthodontic treatment consisting of surgical therapy, appliance therapy, and functional/myo-functional

(d) Hospital board and room expenses, and the charges of a hospital for necessary hospital services and supplies, in connection with injuries or diseases of a dental nature, are included under hospital expense benefits and not under dental expense benefits.

(e) Those covered individuals, otherwise eligible, commencing treatment prior to age 19 and continuing treatment beyond age 19 will continue to receive benefits until the earlier of completion of treatment or reaching the appropriate maximum benefit.

3.04 Pre-Determination of Benefits.

If a course of treatment which commences on or after March 10, 1980, can reasonably be expected to involve covered dental expenses of more than $250.00, a description of the procedures to be performed and an estimate of the dentist's charges must be filed with the insurance company prior to the commencement of the course of treatment. The insurance company will notify the employee and the dentist in advance of the benefits payable based upon completion of such course of treatment and of the expenses not covered. The expenses to be paid will be certified by the insurance company as payable under this Article III.

In determining the amount of benefits payable professional consideration will be given to procedures, services, or courses of treatment that are customarily provided by the dental profession consistent with sound professional standards of dental practice for the dental condition concerned. The amount included as certified covered dental expenses will be the reasonable and customary charge determined in accordance with the limitations set forth below. In the event alternate procedures

(2) Reconstruction. Appropriate payment will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion will be considered optional and their cost will remain the responsibility of the patient.

(b) Prosthodontics:

(1) Partial dentures. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, dental expense benefits will cover the applicable percentage of the cost of such procedure toward a more elaborate or precision appliance that patient and dentist may choose to use, and the balance of the cost will remain the responsibility of the patient.

(2) Complete dentures. If, in the provision of complete denture services, the patient and dentist decide on personalized restorations or specialized techniques as opposed to standard procedures, dental expense benefits will be allowed for the appropriate amount for the standard denture service toward such treatment and the balance of the cost will remain the responsibility of the patient.

(3) Replacement of existing dentures. An existing

denture will be replaced only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to render such appliances satisfactory will be provided in accordance with the agreement. Prosthodontic appliances will be replaced only after five (5) years have elapsed following any prior provision of such appliances under this Group program. (This five year limitation applies to appliances provided under this Group Plan only.)

(c) Orthodontics:

(1) If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination.

(2) The monthly benefit payment obligation under the orthodontic benefits provision shall cease on the termination date of this agreement unless renewed or extended.

3.06 Exclusions.

Covered dental expenses do not include and no benefits are payable for:

(a) Charges for which benefits are otherwise provided under this Health-Benefits Agreement.

(b) Charges for treatment by other than a dentist except that scaling or cleaning of teeth may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist.

(c) Charges for services and supplies that are solely cosmetic in nature, including charges for personalization or characterization of dentures.

(d) Charges for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while the individual was not insured for dental expense benefits or which were ordered while the individual was insured for dental expense benefits but are finally installed or delivered to such individual more than sixty days after termination of insurance.

(e) Charges for the replacement of a lost, missing or stolen prosthetic device.

(f) Charges set forth in "Exclusions" applicable to all Articles.

(g) Charges for failure to keep a scheduled visit with the dentist.

(h) Charges for replacement or repair of a broken orthodontic appliance.

(i) Charges for services or supplies related to periodontal splinting unless preceded by appropriate periodontal surgery performed to control the periodontal disease.

3.07 Definitions.

The term "dentist" means a legally licensed dentist practicing within the scope of his license. For the purposes of this Article, the term "dentist" also includes a legally licensed physician authorized by his license to perform the particular dental service he has rendered.

The term "Reasonable and Customary Charge" means the actual charge of a dentist for services rendered or supplies furnished to the extent the fee is reasonable and does not exceed his usual charge for such service or supply, and does not exceed the customary fee for comparable services and supplies charged by dentists in the area with training, experience and professional standing similar to that of the dentist who renders the services or furnishes the supplies.

The term "Area" as it would apply to any particular service or supply means a county or such greater area as is necessary to obtain a representative cross section of dentists rendering such services or furnishing such supplies.

The term "Orthodontic Treatment" means the preventative and corrective treatment of all those dental irregularities which result from the anomalous growth and development of dentition and its related anatomic structures or as result of accidental injury and which require repositioning of teeth to establish normal occlusion.

3.08 Coordination With Other Dental Expense Benefits.

The insurance company shall follow the same procedures with respect to the dental expense benefits concerning coordination of benefits as is set forth for hospital, surgical and

medical benefits except that only other dental expense benefits provided either by a group dental benefit plan to which an employer contributes at lease 50% of the cost, or a comprehensive medical plan providing dental benefits which meets the same qualifications will be considered.

ARTICLE IV. VISION EXPENSE BENEFITS PROGRAM

4.01 Effective Date.

The following Vision Expense benefits will be provided to employees with seniority who are eligible for coverage under the provision of 1.01 of the Insurance Agreement.

4.02 Coverage.

Vision Expense Benefits will be payable, subject to the conditions herein, if an employee or his dependent, while Vision Expense Coverage is in effect with respect to such employee or dependent, incurs Covered Vision Expenses.

4.03 Covered Expenses.

"Covered Vision Expense" means the charges (as defined in 4.04 incurred for vision testing examinations, lenses and frames as described below.

(a) Vision testing examination, performed by a physician or optometrist, including a determination as to the need for correction of visual acuity, prescribing lenses, if needed, and confirming the appropriateness of eye glasses obtained under the prescription. It shall include: history, testing visual acuity, external examination of the eye; binocular measure, ophthalmoscopic examination and may include tonometry when indicated; medication for dilating the pupils and desensitizing the eyes for tonometry, if applicable; and summary and findings.

(b) Lenses of a quality equal to the first quality lens series manufactured by American Optical, Bausch and Lomb, Orthodon, Tillier or Univis, and which meet Z80.1 or Z80.2 standards of the American National Standards Institute, including, when prescribed, equivalent plastic lenses or tints equal to Rose Tints #1 or #2.

(c) Contact lenses as prescribed by a physician or optometrist.

(d) Dispensing service performed by the physician, optometrist or optician who, based on prescription, prepares or orders the eyeglasses or contact lenses selected, verifies the accuracy of the lenses and assures that the eyeglasses or contact lenses fit properly.

(e) Frames adequate to hold lenses which are Covered Vision Expense within the limits described in 4.04.

(f) Referrals from an optometrist to an ophthalmologist when executed within 60 days from the date of the optometrist examination.

4.04 Benefit Payment.

(a) Effective April 1, 1980, benefit payment will be made for the services rendered by a physician or optometrist for services rendered as outlined in 4.03 (a) or (f) of this pro Such benefit payment will be the actual charge but in no event more than $30. for the services rendered by a physician and $24. when rendered by an optometrist.

(b) The maximum benefit payable for services and materials as described in 4.03 (b), (c) and (d) of this program

shall be the actual charge for one (1) or two (2) lenses or contact lenses but not more than:

(1) $12.00 per lens - single vision
(2) $18.00 per lens - bifocal
(3) $24.00 per lens - trifocal
(4) $30.00 per lens - lenticular
(5) $18.00 per lens - contact lens

(c) Benefit payment will be made for frames as provided in 4.03 (e) of this program for the actual charge but not more than $17.00.

(d) Effective November 1, 1980, the benefit payments for services rendered on or after November 1, 1980, in 4.04 (a), (b), and (c) will be in accordance with the Table below.

(e) Effective on or after November 1, 1981, for services rendered on or after November 1, 1981, the benefit payments in 4.04 (a), (b), and (c) will be in accordance with the Table below.

Table of Benefits

Exams 1st Year		November 1, 1980	November 1, 1981
Ophth.	$30.00	$33.00	$36.30
Optomet.	24.00	26.40	29.00
Per Lens			
Single	12.00	13.20	14.50
Bifocal	18.00	19.80	21.75

Trifocal	24.00	26.40	29.00
Lenticular	30.00	33.00	36.30
Contacts	18.00	19.80	21.75
Frames	17.00	18.70	20.60

4.05 Contract Providers.

The Company will attempt to establish contracts with suppl of the materials and services provided in 4.03 (b), (c), (and (e) of this Program in certain areas where the Company employees. Such contracts will provide a predetermined se tion of prescription lenses and frames to be provided with cost to the employee except for the cost of contact lenses excess of $18.00 per lens effective April 1, 1980, $19.80 effective November 1, 1980, and $21.75 effective November 1981. If lenses, contact lenses, or frames are selected which are not included in the predetermined selection or a tional services are ordered, the employee will be respons: for the additional cost in excess of the amounts shown in 4.04 of this Program.

4.06 Limitations.

Frequency. If a covered person has received a vision tes examination, lenses or frames for which benefits were pay under the Plan, or under the Company's safety eyeglass pr gram, benefits will be payable for each subsequent vision testing examination, lenses or frames only if received mo than 24 months after receipt of the most recent previous vision testing examination (except as provided in 4.03 f) lenses or frames, respectively, for which benefits were p under the Plan, provided, however, that lenses and frames received under the Company prescription safety glasses pr gram for which no benefits were received under this Plan not be considered lenses

and frames received under this Plan. An employee may utilize duplicate copies of the prescription for which a benefit is paid under this Plan to obtain lenses and frames under both the Plan and the Company's prescription safety glasses program if he is otherwise eligible under both and complies with the procedures of each.

4.07 Exclusions

Covered Vision Expense does not include and no benefits are payable for:

(a) Charges for which benefits are otherwise provided under this Health-Benefits Agreement and charges set forth in "Exclusions" applicable to all Articles;

(b) Sunglasses to the extent the charge for such lenses exceeds the benefit amount for regular lenses as provided in 4.04 (tinted lenses with a tint other than the equivalent of Rose Tints #1 or #2 are considered to be sunglasses for the purpose of this exclusion);

(c) Photosensitive or anti-reflective lenses to the extent the charge for such lenses exceeds the benefit amount for regular lenses as provided in 4.04;

(d) Drugs or any other medication not administered for the purpose of a vision testing examination;

(e) Procedures determined by the insurance company to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids aniseikonic lenses and tonography;

(f) Services rendered and materials ordered:
(1) before the employee became eligible for this benefit
(2) for which the employee is not charged or is not obligated to pay.

(g) Charges for vision testing examinations, lenses or frames which are not necessary, according to accepted standards of ophthalmic practice, or which are not ordered or prescribed by the attending physician or optometrist;

(h) Charges for vision testing examinations, lenses or frames which do not meet accepted standards of ophthalmic practice, including charges for any such services or supplies which are experimental in nature;

(i) Replacement of lenses or frames which are lost or broken unless at the time of such replacement the covered person is otherwise eligible under the frequency limitations set forth in 4.06;

(j) Charges for the completion of any claim forms.

(k) Charges for failure to keep a scheduled visit with the Ophthalmologist, Optometrist or Optician.

(l) Vision examinations or materials furnished for any condition, disease, ailment, or injury arising out of and in the course of employment.

4.08 Coordination of Benefits.

Coordination of benefits will be administered under the same provisions applicable to hospital-surgical-medical-drug expense coverage.

4.09 Definitions

As used herein:

(a) "Physician" means any licensed doctor of medicine or osteopathy legally qualified to practice medicine and who within the scope of his license performs vision testing examinations and prescribes lenses to improve visual acuity;

(b) "Optometrist" means any person licensed to practice optometry in the state in which the service is rendered;

(c) "Optician" means any person licensed in the state in which the service is rendered to supply eyeglasses prescribed by a physician or optometrist to improve visual acuity, to grind or mold the lenses or have them ground or molded according to prescription, to fit them into frames and to adjust the frames to fit the face.

(d) "Lenses" means ophthalmic corrective lenses, either glass or plastic, ground or molded as prescribed by a physician or optometrist to be fitted into frames;

(e) "Contact lenses" means ophthalmic corrective lenses, either glass or plastic, ground or molded as prescribed by a physician or optometrist to be fitted directly to the patient's eyes; these are subject to limitations

and exclusions applicable to lenses generally;

(f) "Frames" means standard eyeglass frames into which two lenses are fitted.

ARTICLE V. INSURANCE BENEFITS FOR PENSIONERS

5.01 Life Insurance - Normal Retirement.

(a) Pensioners retired before December 1, 1964, under a predecessor pension agreement shall be entitled to two thousand dollars ($2000) of life insurance.

(b) Pensioners retired on or after December 1, 1964, under their respective pension agreement, shall be entitled to life insurance benefits as follows:

(1) Employees retired under the normal retirement provisions of the pension agreement for Detroit units dated December 30, 1964 - the greater of two thousand dollars ($2000) or one hundred percent (100%) of the pensioner's annual rate of pension;

(2) Employees retired under the normal retirement provisions of the pension agreement for Racine Warehouse employees dated January 18, 1965, - two thousand dollars ($2000).

(c) For a pensioner retired on or after January 24, 1977, the minimum benefit outlined in 5.01 (b) above shall be increased to three thousand dollars ($3000).

5.02 Life Insurance. Total and Permanent Disability Retirement. A disability pensioner retired on or after December 1, 1964, under the pension agreement:

(a) Who is covered by the continuation of benefits provisions of 2.02 (a) until age sixty-five (65) will thereafter be eligible for coverage as applicable under 5.01 (b) or (c);

(b) Who has elected installment payments under 2.02 (b) shall have no life insurance provided under this section.

5.03 Life Insurance - Early Retirement. A pensioner retired prior to age sixty-five (65) (other than a disability pensioner covered under 5.02) and on or after December 1, 1964, shall have his life and limb and accidental death and dismemberment insurance coverage (excluding survivor income benefit insurance) continued until the end of the month in which he attains age sixty-five (65) for the amount in effect at the time of retirement at no cost to the pensioner.

Pensioners retired prior to June 1, 1968, who have not continued their life insurance coverage will be covered commencing with the first of the month following the month in which their application for such coverage is received by the company at no cost to the employee.

5.04 Survivor Income Benefit Insurance.

(a) A disability pensioner retired on or after December 1, 1964, who has not attained the age at which he may elect the survivor option under 3.04 (b) of the pension

agreement shall be eligible for survivor income benefit insurance in accordance with 2.01 (b), (c), (d), (e), (f), or (g).

5.05 Health Benefits.

(a) Effective March 1, 1980, pensioners, surviving spouses and their dependents, excluding pensioners who are receiving a deferred vested pension shall be eligible for the dental expense benefits coverage set forth in Article III, the vision expense benefits coverage set forth in Article IV, the hearing aid benefits as set forth in the agreement on Hearing Aid Program and Benefits and the health benefits coverage set forth in 2.07, 2.08, and 2.10.

Effective with the first day of the month following the month in which a pensioner or dependent who is eligible for health benefits under 5.05 becomes eligible for hospital, surgical and medical benefits, under the Federal Social Security Act, such benefits shall be coordinated with the health benefits plan provided by the company with the company considered secondary carrier. Pensioners and their dependents, survivors of pensioners or survivors of active employees receiving the special age sixty-five (65) benefit in accordance with 2.05 of the pension agreement shall be deemed to be enrolled in Part "B" of Medicare for purposes of coordinating their company provided health benefits.

ARTICLE VI GENERAL

6.01 Benefit Plan Administrator and Benefit Plan Agreement with Benefit Plan Administrator. Benefits shall be provided by means of an agreement with a Benefit Plan Administrator selected by the company, and the company shall have the right to change Benefit Plan Administrators. This agreement establishes eligibility and contains a summary of benefits, but the Benefit Plan Agreement between the company and the Benefit Plan Administrator shall be controlling as to all matters not covered herein. The union shall have an opportunity to review and approve those provisions of the Benefit Plan Agreement between the company and the Benefit Plan Administrator which relate to employees, pensioners and dependents, and survivors of employees or pensioners all as set forth in the Benefit Plan document. In the event of any conflict between the Benefit Plan document and this agreement, the Benefit Plan document shall be revised to conform to this agreement. The failure of the Administrator to provide for any of the benefits for which it has contracted shall result in no liability to the company or the union, nor shall such failure be considered a breach by the company or the the union of any of the obligations which they may have undertaken herein. Nothing herein contained, however, shall be construed to relieve said Administrator from any liability which it may have to the company or any claimant.

6.02 Cost of Coverage. Except as otherwise provided in this agreement, the company shall pay the full cost (including any increases in cost) of Benefit coverage for eligible employees, pensioners and dependents, and survivors of employees or pensioners, and any refunds, dividends or payments of a like nature paid by the Benefit Plan Administrator shall

be returnable to the company. The company may, from time to time, request that employees, pensioners or survivors of employees or pensioners attest to the eligibility status of their dependents towards whose coverage the company contributes. If such person fails to comply with such request, the company may reduce his coverage to that of "self only," unless it can be demonstrated that he has an eligible dependent.

6.03 Optional Contributions. Where this agreement calls for payment of Benefit Plan contributions by an employee or other person, such contributions shall be paid to the company before the first (1st) day of the calendar month for which coverage is to be provided.

6.04 Integration of Benefit Program with Statutory Benefits. In the event that any state or federal law provides benefits of the same general type as provided by this agreement, compliance by the company with such law shall be deemed full compliance with the applicable provisions of this agreement, and thereafter such provisions of this agreement shall not be applicable. Where such benefits under such law are on a generally lower level than the corresponding benefits under this agreement, the company shall, to the extent it finds it practicable, provide benefits supplementary to those provided under law to the extent necessary to make the total benefits as nearly comparable as practical to the benefits under this agreement. If such benefits exceed the benefits provided under this agreement, the company may require from employees, pensioners and survivors of employees or pensioners such contributions as it may deem appropriate for such excess benefits.

6.05 Coordination of Benefits. Health benefits for eligible employees and their dependents, retired employees and their dependents and survivors of employees or pensioners shall be subject to the following provisions:

In the event any covered employee, pensioner, dependent, or survivor of an employee or pensioner is entitled to benefits for medical expenses under any other plan (except individual policies) at least a portion of which is under at least one of the plans covering the person for whom claim is made, health benefits payable under this plan shall be reduced by the amount necessary, if any, so that the sum of benefits payable under all plans in a calendar year shall not exceed the total necessary, reasonable and customary charges for such medical expenses.

If said other plan contains a similar provision for non-duplication of benefits, benefits will be paid in the following order of determination:

1. The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent;

2. The benefits of a plan which covers the person on whose expenses claim is based as a dependent of a male person shall be determined before the benefits of a Plan which covers such person as a dependent of female person; except that in the case of a person for whom claim is made on a dependent child,

   (a) when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody;

   (b) when the parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

Notwithstanding (a) and (b) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

3. When rules (1) and (2) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time; but in no event shall the sum of all benefits payable under all plans in a calendar year exceed the total necessary, reasonable and customary charges for such medical expenses.

6.06 Non-Duplication of Benefits. An employee whose benefit coverage is continued during a period of layoff provided he is entitled to benefits as a covered employee of another employer shall be subject to the following provision: If any benefit shall be provided under any other group benefit policy, issued by any other administrator or any other group plan by whatever name called, on account of hospital, surgical and medical expenses covered by this agreement and in connection with any injury, sickness or pregnancy, an amount equal to the sum of (1) the total benefits provided through such policy or plan and (2) the total cash value computed on an equiable basis of all services and supplies furnished through such policy or plan under provisions thereof which provide for the furnishing of services and supplies rather than payment in cash, shall be deducted from the amount which otherwise would be payable under this agreement on account of such injury, sickness, or pregnanc

6.07 Board of Appeal. During the term of this agreement, an appeal board (hereinafter referred to as the board) shall be established for the purpose of resolving disputes concerning the interpretation of the provisions of this agreement.

(a) Board Composition. The board shall consist of six (6) members as follows:

(1) three (3) members appointed by the company at least one (1) of which shall represent the location on whose behalf the appeal is made;

(2) two (2) members from the International Union plus one (1) member representing the location on whose behalf an appeal is made.

The company and the union shall appoint and remove their own members from the board but shall be required to notify the other party of such action.

(b) Board Powers. The board shall be empowered to interpret the language of the insurance agreement and settle disputes referred to the board but the board shall have no authority to waive, alter or fail to apply any eligibility requirements set forth in the insurance agreement, nor shall it have power to add to, subtract from or modify any provisions of this insurance agreement.

(c) Appeal Procedure. Any dispute arising over the interpretation of the insurance agreement, which cannot be resolved satisfactorily at the local level at the location in question, may be referred to the appeal board. Notice of such referral must be in writing from the International Union to the Industrial Relations Department of the company at its Head Office and must be made no later than thirty (30) days after the local P & I R management has given its final position.

6.08 The company will make arrangements for employees to be afforded the option to subscribe to pre-paid group practice plans as required by law, or as agreed to by the parties instead of being covered by the company's plans. Enrollment periods will be provided annually at a time mutually acceptable to the parties during which all employees may elect to change enrollment and the enrollment of their regular dependents from the company plan to the pre-paid group plan or the reverse. Employees who have retired, and surviving spouses who are eligible for the benefits of the company's plans, who are residing in an area in which employees are being offered enrollment in a pre-paid group practice plan, will be offered enrollment at the same time as active employees subject to the same limitations on the company's obligation to pay contributions. In the event such a retiree or surviving spouse moves out of an area where a pre-paid plan is offered, such person will be transferred to the coverage provided by the company's plans the first day of the month following the last month for which

contribution was made to the pre-paid plan. To the extent such a group practice plan does not provide dental, hearing aid, or vision care benefits substantially equivalent to the company plan, arrangements will be made to provide those benefits through the company plan to persons eligible for such benefits and enrolled in a pre-paid plan.

Subject to the above qualification, the company will contribute the full subscriber fee for each enrolled employee, retiree, surviving spouse and their regular dependents, if any, provided, however, the company's cost shall not exceed the cost the company would have incurred if the employee, retired employee, or surviving spouse were covered by the company plan.

In the event there is excess cost, the rates for single and family enrollees will be established by developing composite rates for both plans and allocating the excess cost to the single and family rates so that the contribution required of single and family members bears the same percentage relationship to the insurance company single and family rates. The enrolled person will be notified in advance of the next enrollment period of the contribution required, if any, and the benefits of the alternate plan.

Commencing the first month after the enrollment period, the company shall have the right to deduct the required contribution monthly from wages, salary or pension benefit as permitted by law, or require payment of the required contribution in advance as a condition of continued coverage under such alternate plan. The company may, from time to

time, in areas it may designate, waive contributions.

In the event an employee wishes to enroll a sponsored dependent in such a pre-paid group practice plan, the company and the union will attempt to arrange coverage as nearly comparable to sponsored dependent coverage as possible.

ARTICLE VII. DEFINITIONS

7.01 The following terms shall have the meanings set forth below unless the context clearly indicates otherwise:

(a) Actively at Work. An employee is considered to be actively at work if he is on the active employment roll and works on the day in question or is working on the first normal working day following said day provided he was actively at work on the last normal working day prior to said day. For purposes of this paragraph 7.01 (a) an employee shall be deemed actively at work if he is not working but is eligible to receive Bereavement Pay, Jury Duty Pay, Witness Pay or Vacation Pay for the day in question.

(b) Base Hourly Rate. The "Regular Day Work Rate" as defined in Paragraph 11.08 of the master agreement, excluding shift premium, in effect on the last day the employee was actively at work. For Accident and Sickness Benefits calculation only, base hourly rate shall exclude any cost of living adjustments.

(c) Dependent. A spouse of an employee; each child of an employee to the end of the calendar year in which such child attains age twenty-five (25), (or any age if permanently and totally disabled), is unmarried; is not employeed on a regular and full time basis and is dependent on the employee for one-half of his support as defined by the Internal Revenue Code, and must either qualify in the current tax year for dependency tax status or has been reported as a dependent on the employee's most recent federal income tax return.

(d) Employee. Any person who, during the terms of this insurance agreement, has seniority status under the master agreement.

(e) Health Benefits. The benefits coverage described in Section 2.07, 2.08, 2.10, dental in Article III, visi under Article IV, prescription drug, and hearing aid unless specifically designated or excluded.

(f) Life and Limb Insurance. The insurance benefits described in Section 2.01.

(g) Master Agreement. The master collective bargaining agreement between the company and the union dated March 10, 1980, covering the appropriate units described in Appendix "A" thereof, or any renewal thereof or successor agreement thereto.

(h) Pension. The amount of pension benefit (including supplemental pension, but excluding any deferred vested pension payable to an employee terminated prior to retirement) received by a pensioner under the pension agreement between the company and the union dated March 10, 1980.

(i) Pensioner. A former bargaining unit employee:
(1) who has retired from employment with the company and who is receiving or is entitled to receive a current pension; or
(2) whose seniority is or was broken at or after age sixty-five (65) and after December 1, 1964, for a reason other than discharge for cause and who is not eligible to receive a pension.

(j) Sponsored Dependent. A person other than a dependent as defined in Section 7.01 (c) who is a member of the employee's household and who is dependent on the employee for more than one half of his support as defined by The Internal Revenue Code and who has been reported as such on the employee's most recent federal income tax return.

(k) Total and Permanent Disability. A physical or mental condition which will prevent the employee from engaging in any work in the bargaining unit.

ARTICLE VIII. DURATION OF AGREEMENT

8.01 Effective Period. This insurance agreement shall remain in full force and effect without change through October 31, 1982. Until ninety (90) days prior to the last mentioned date, neither party shall have the right to request any change in, amendment of, or addition to this insurance agreement, it being hereby expressly stipulated that should either party make such a request, the other party shall have no duty to negotiate nor bargain with respect to such request.

8.02 No Strike or Lockout. The parties agree that until the termination date of this insurance agreement, neither shall resort to any strike, lockout or other exercise of economic force of whatever name or nature, or threat thereof, for the purpose of inducing the other party to agree to negotiate or to bargain concerning any proposed change, amendment or addition to this insurance agreement. Each party shall be at liberty, however, to request such change, amendment, or addition or to give notice of termination of this insurance agreement, by specifying the same in writing to the other party not earlier than ninety (90) days nor later than sixty (60) days in advance of the termination date of this insurance agreement.

8.03 Termination on Failure to Agree. Failure to reach agreement prior to the date of termination of this insurance agreement concerning any request for change, amendment or addition, shall cause the insurance agreement to terminate, unless the parties by mutual agreement agree to continue the terms thereof for a specified period.

APPENDIX A

Experimental Agreement on Resolving Deadlocks of the Insurance Board of Appeal. Effective as of March 10, 1980, and through October 31, 1982, the company and union agree on the establishment of this experimental procedure for the resolution of deadlocks of the Insurance Board of Appeal. This procedure shall be limited to the interpretation of the insurance agreement. Where there is a dispute as to the interpretation of the insurance agreement which has been heard by the Board of Appeal in accordance with the procedure established in Section 6.07 of that agreement, and such Board is unable to resolve the dispute by a majority vote of its members, such Board shall select an arbitrator from the panel listed in the Master Agreement and in accordance with the provisions established therein.

The jurisdiction of the Arbitrator shall be limited to the issue which deadlocked the Board of Appeal concerning the interpretation of a specific provision or provisions of the Insurance Agreement. He shall have no power to add to, subtract from or modify the language of such Agreement or to adjudicate individual claims; however, claims which give rise to the need for the interpretation of the Agreement by an arbitrator, shall be held in abeyance until the arbitrator has disposed of the issue in question and shall thereafter be governed by such dispositon. Any interpretation by such arbitrator shall thereafter govern the interpretation of the language.

MASSEY-FERGUSON INC.
BY

INTERNATIONAL UNION, UNITED AUTOMOBILE,
AEROSPACE AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW
BY

Local 174 (North American Tractor Plant Unit)
BY

Local 174 (Engineering Experimental Shop Unit)
BY

Local 174 (Engineering Laboratory Unit)
BY

Local 244 (Racine Warehouse Unit)
BY

Local 256 (Gear and Shaft Plant Unit)

BY

Local 256 (Transmission and Axle Plant Unit)

BY

Local 1446 (North American Implement Plant Unit)

BY

AGREEMENT ON
PRESCRIPTION DRUG BENEFITS

I. Definitions

A. Local Plan

Plan through which the member is enrolled for Prescription Drug Benefits.

B. Local Plan Area

The geographic area in which a Local Plan ordinarily offers Coverage. Any other area is considered to be out of a Local Plan Area.

C. Physician

One who is legally qualified and licensed to practice medicine and perform surgery at the time and place services are rendered; and for the purpose of this Program, a doctor of medicine, a doctor of osteopathy or a podiatrist who is legally licensed to prescribe medications within the scope of that license.

D. Dentist

A doctor of dental surgery or a doctor of dental medicine legally licensed to prescribe medications within the scope of that license.

E. Prescription Drugs

Means only (i) Legend Drugs (any medical substance, the label of which under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal

Law prohibits dispensing without prescription."), and (ii) any of the following listed drugs:

Non-Legend	Injectibles
Adrenalin	Insulin
Aveeno	Adrenalin
Isuprel (inhalant)	Mercuhydrin
Peritrate	Thiomerin
Acetaminophen N.F.	
Acidolate	

F. Pharmacist

A person licensed to dispense Prescription Legend Drugs under the laws of the State wherein he practices.

G. Pharmacy

A licensed establishment where Prescription Legend Drugs are dispensed by a Pharmacist.

If a Pharmacy operates under the licensure of a facility or institution of which it is an integral part, but the pharmacy itself is not a separately licensed establishment, such a Pharmacy will meet the intent of this definition.

H. Provider

A Pharmacy, Pharmacist, Physician, Dentist or any other person or organization legally licensed to dispense drugs.

I. Prescription Order

A written or oral request by a Physician or Dentist for a single Prescription Legend Drug.

Injectable insulin is not a Prescription Legend Drug and does not require a Prescription Order.

J. Covered Drug

Any Prescription Legend Drug or any medication compounded

by the Provider which contains a Prescription Legend Drug (except contraceptive medications) when ordered by a Physician or a Dentist for which a written Prescription Order is customarily prepared, a separate Usual and Customary Charge of more than $2.00 is made and which is not entirely consumed at the time and place of the Prescription Order; and injectable insulin. Compounded medications which contain a Prescription Legend Drug are not required to bear the legend "Caution: Federal Law prohibits dispensing without a prescription". However, when a Provider prepares, pursuant to a Prescription Order, a compounded medication in which at least one ingredient is a Prescription Legend Drug, the compounded medication is a Covered Drug if it meets the other requirements in the definition of a Covered Drug. The two phrases "...for which a written Prescription Order is customarily prepared..." and "and which is not entirely consumed at the time and place of the Prescription Order" exclude from the Program drugs administered and entirely consumed in connection with care rendered in the home and office.

Any drug for which Provider's Usual and Customary Charge is $2.00 or less is <u>not</u> a Covered Drug under the Program. A drug requiring a prescription by State Law, but not Federal Law, is <u>not</u> a Covered Drug.

The following comprise the list of Maintenance Legend Drugs to be dispensed in maximum quantities of 34-day supply or 100 unit doses, whichever is greater:

- Acetohexamide
- Acetazolamide
- Allopurinol
- Bendroflumethiazide
- Cardiac Gylocosides
- Chlorothiazide
- Chlorpropamide
- Chlorthalidone
- Colchicine & Colchicine-Probenecid
- Conjugated Estrogens U.S.P.
- Furosemide
- Gitalin
- Hydrochlorothiazide
- Methyclothiazide
- Metolazone
- Propranolol Hydrochloride
- Nitroglycerin
- Pentaerythritol-Tetranitrate
- Phenformin
- Phenylbutazone
- Polythiazide
- Potassium Chloride Liquid
- Probenecid
- Quinidine Sulfate
- Reserpine
- Spironolactone
- Tolazamide
- Tolbutamide
- Triamterene
- Trichlormethiazide
- Benzthiazide

Effective March 10, 1980, up to 100 unit doses of insulin and 100 units of syringes and needles will be covered on one co-payment amount.

The following comprise the list of Maintenance Legend Drugs to be dispensed in maximum quantities of 34-day supply or 200 unit doses, whichever is greater:

- Diphenylhydantoin Sodium
- Isoniazid
- Levothyroxine
- Liothyronine
- Para-Aminosalicylic Acid
- Primidone
- Propylthiouracil
- Thyroid, Natural and Synthetic
- Thyroglobulin

K. Co-Payment Amount

An amount, to be paid by a member for each separate Prescription Order and refill of a Covered Drug, not to exceed $2.00.

For drugs dispensed by a Participating Provider the member will not, for any reason (such as sales tax, delivery charges, etc.), be required to pay any amount in addition to the Co-Payment Amount. A Co-Payment Amount of $2.00 will be used by a Local Plan in all instances for determining the amount of benefit payment.

L. Participating Contract

The agreement entered into between a Local Plan and a Participating Provider which sets forth their respective rights and obligations.

A Participating Contract with a Pharmacy applies to all Pharmacists who practice in that establishment.

M. Participating Provider

A Provider who has entered into a Participating Contract with a Local Plan to provide a Covered Drug at a cost to a member not to exceed the Co-Payment Amount of $2.00.

N. Non-Participating Provider

A Provider who has not entered into a Participating Contract with a Local Plan.

O. Acquisition Cost

The actual invoice cost of a drug (with the exception of cash discounts, but including trade discounts) to the Provider or to the company, organization or its affiliates with which the Provider is associated, whichever is less.

This definition recognizes that the actual cost of a drug to certain large chain stores, hospitals, etc., is often less than the cost to other Providers. Consequently, the cost of the drug to the company or organization will be used rather than the cost to the establishment or individual actually dispensing the drug.

Cash discounts allow a reduction from invoice price for prompt payment. Cash discounts are not considered in determining the actual invoice cost.

Trade discounts allow reductions from invoice price without regard to date of payment. Discounts given for quantities purchased or for items purchased at a time other than when they are in high demand are examples of trade discounts. Trade discounts are considered in determining the actual invoice cost.

Providers sometimes receive discounts in the form of cash rebates from a supplier based on the dollar volume purchased during a given period of time. To the degree possible such rebates are to be considered in the determination of Acquisition cost.

P. Dispensing Fee

An amount or amounts predetermined by a Local Plan to compensate Participating Providers for dispensing Covered Drugs.

Local Plans may set a single uniform Dispensing Fee for all Participating Providers in the Local Plan Area or may use variable Dispensing Fees, based, for example, on geographic location or on some other categorization of Providers. Any applicable sales tax is to be considered as included in the Dispensing Fee.

Q. Usual and Customary Charge

When determined by a Local Plan to be a reasonable amount, the Usual and Customary Charge is the amount, including sales tax, actually charged by: (1) a Participating Provider for injectable insulin; (2) a Non-Participating Provider for a Covered Drug; or (3) a Provider out of a Local Plan Area for a Covered Drug. In determining what constitutes a reasonable amount a Local Plan should take into consideration:

(a) The amount which the Provider most frequently charges the majority of recipients for the Covered Drug;

(b) The range of charges by other Providers for the Covered Drug.

R. Prescription Charge

1. For a Participating Provider, Prescription Charge means the Acquisition Cost plus the Dispensing Fee for a Covered Drug except for injectable

insulin. In the case of injectable insulin, Prescription Charge means the Usual and Customary Charge or the Acquisition Cost plus the Dispensing Fee, whichever is lower.

2. For a Non-Participating Provider, Prescription Charge means the Usual and Customary Charge for a Covered Drug.
3. For a Provider out of a Local Plan Area, Prescription Charge means the Usual and Customary Charge for a Covered Drug.

II. Benefits and Limitations

Benefits shall be provided for Covered Drugs dispensed on and after the effective date of the Program even though the Prescription Order may have been issued prior to the effective date.

It is the intent of this Program that the benefits shall be uniform for all members except in those instances where such might be contrary to the laws of the State in which the prescription is dispensed.

A. Payment - In a Local Plan Area (Iowa, Wisconsin, Michigan, Ohio)

1. Participating Provider: A Local Plan will pay to a Participating Provider the Prescription Charge for each Covered Drug less the Co-Payment amount of $2.00.

Examples: (Other than the Co-Payment, all amounts are hypothetical.)

Participating Provider
Prescription Legend Drug

Acquisition Cost	$7.50
Dispensing Fee	+1.75
Prescription Charge	$9.25
Less Co-Payment	-2.00
Payment to Provider	$7.25

Participating Provider
Injectable Insulin

(4 Vials of U-40 Insulin)

#1		#2	
Acquisition Cost	$4.00	Usual and Customary	$5.00
Dispensing Fee	+1.90		
Prescription Charge	$5.90	Prescription Charge	$5.00
Less Co-Payment	-2.00	Less Co-Payment	-2.00
Payment to Provider	$3.90	Payment to Provider	$3.00

In the example of injectable insulin, a Local Plan will pay a Participating Provider according to #2 because the Usual and Customary Charge method results in a lower Prescription Charge than does the Acquisition Cost plus the Dispensing Fee method.

2. Non-Participating Provider: A Local Plan will pay to a member 75% of the remainder of the Prescription Charge of a Non-Participating Provider for each Covered Drug after deducting the Co-Payment Amount of $2.00. Example: (Other than the Co-Payment, all amounts are hypothetical.)

Non-Participating Provider

Usual and Customary Charge	$6.40
Less Co-Payment	-2.00
	$4.40
Percent of Remainder	x .75
Benefit Payment	$3.30

B. Payment - Out of a Local Plan Area

When services are received out of a Local Plan Area, payment to the member will be 100% of the remainder of the Prescription Charge for each Covered Drug after deducting the Co-Payment Amount of $2.00.

Example:

Provider Out of a Local Plan Area

Usual and Customary Charge	$6.40
Less Co-Payment	-2.00
	$4.40
Percent of Remainder	x1.00
Benefit Payment	$4.40

III. Exclusions

A. No benefits shall be available to a member if he is entitled to receive reimbursement under Worker's Compensation laws or is entitled to benefits without charge from any municipal, state or federal program except Title XIX of Social Security Amendments of 1965 (Public Law 89-98, 89th Congress, First Session) of any sort whether contributory or not.

B. In the event of any payment for services under this program, the Local Plan shall be subrogated to all the member's rights of recovery therefore against any person

insurance issued to and in the name of the subscriber, and the member shall execute and deliver such instruments and papers and do whatever else is necessary to secure such rights.

C. Any charge for a contraceptive medication, even if such medication is a Prescription Legend Drug, and any charge for therapeutic devices or appliances (e.g., hypodermic needles, syringes, support garments, and other non-medicinal substances) regardless of their intended use. In accordance with paragraph J of the Prescription Drug Agreement the exclusion of hypodermic needles and syringes under this paragraph, III C is hereby excluded.

D. Any charge for administration of Prescription Legend Drugs and injectable insulin.

E. The charge for medications furnished on an in-patient. out-patient basis covered under any other contract, carrier providing Group Coverage for Prescription Legend Drugs or injectable insulin through a Coordination of Benefits Provision.

F. The charge for more than a 34-day supply of medication, except that the Program will cover 100 unit doses (tablet or capsule, etc.) or 200 unit doses of those maintenance type drugs specified in the Plan document.

G. The charge for any prescription refill in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's order.

ELIGIBILITY

Hearing Aid Benefits will be paid to an employee, retiree, surviving spouse and respective dependents as hereinafter provided and such expenses are incurred on or after the effective date of coverage for such insured employee.

EFFECTIVE DATE

The benefits provided in the Hearing Aid Program Agreement shall be effective per Article 1.01 of the Insurance Agreement.

COVERED HEARING AID BENEFITS

A. Benefits will be paid to the employee subject to the limitations and provisions hereinafter contained for charges as follows:

(1) Audiometric examination performed by a physician or audiologist, but only when performed following or in conjunction with the most recent medical examination of the ear by an otologist or otolaryngologist. Except for the initial examination by a physician paid by the employee to determine the necessity for specialist examination and testing, the plan will pay every 36 months the cost of audiometric examinations.

(2) Hearing aid evaluation test performed by a physician or audiologist, which could include the trial and testing of various hearing aid makes and models to determine which make and model will best compensate for the loss of hearing acuity but only when indicated by the most recent audiometric evaluation. It shall include one visit by the covered person subsequent to obtaining the hearing aid for an evaluation of its performance and a determination of its conformity to the prescription.

(3) Hearing aids of the following functional design: in-the-ear, behind-the-ear and on-the-body and if the hearing aid is purchased as a result of a written recommendation by a physician or audiologist based on the most recent audiometric examination and hearing aid evaluation. Such examination must result in a determination that a hearing aid would compensate for the loss of hearing acuity. The number of hearing aids is limited to one per ear per insured employee or covered dependent. Benefits for eyeglass-type hearing aids will be a covere benefit up to the reasonable cost of a single hearing ai

BENEFIT LIMITATION AND PAYMENT

A. Frequency.
The benefit will be payable for no more than one audiometric examination, hearing aid evaluation test or hearing aid in any period of 36 consecutive months after receipt of the most recent previous audiometric evaluation, hearing aid evaluatic or hearing aid for which benefits were payable under this Pl

B. The maximum benefits payable in any period of 36 consecutive months for an audiometric examination, hearing aid evaluatic test or hearing aid shall be the actual charge but in no eve more than the following schedule:

Audiometric Examination	$30.00
Hearing Aid Evaluation Test	$30.00
Hearing Aid and Dispensing Fee	$275.00

C. If the employee or the employee's dependent shall request unusual services from the physician, audiologist or dealer, such person shall pay the full additional charge therefor.

EXCLUSIONS

Covered hearing aid expense does not include and no benefits ar payable for:

A. Audiometric examinations by an audiologist that are not ordered by a physician.

B. Medical or surgical treatment;

C. Drugs or other medication;

D. Audiometric examinations, hearing aid evaluation tests and hearing aids provided under any applicable Workers' Compensation Law;

E. Audiometric examinations and evaluation tests performed, and hearing aids ordered;

1. before the covered person became eligible for coverage,

2. After termination of coverage;

F. Hearing aids ordered while covered but delivered more than 60 days after termination of coverage;

G. Charges for audiometric examinations, hearing aid evaluation tests and hearing aids for which no charge is made to the covered person or for which no charge would be made in the absence of Hearing Aid Benefits Coverage;

H. Charges for audiometric examinations, hearing aid evaluation tests and hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not recommended or approved by the physician;

J. Charges for audiometric examinations, hearing aid evaluation tests and hearing aids received as a result of ear disease, defect or injury due to an act of war, declared or undeclared;

K. Charges for audiometric examinations, hearing aid evaluation tests and hearing aids provided by any government agency that are obtained by the covered person without cost by compliance with laws or regulations enacted by any federal, state, municipa or other governmental body;

L. Charges for any audiometric examinations, hearing aid evaluation tests and hearing aids to the extent benefits therefore are payable under any health care program supported in whole or in part by funds of the Federal government or any state or politica subdivision thereof;

M. Replacement of hearing aids that are lost or broken unless at the time of such replacement the covered person is otherwise eligible under the frequency limitations set forth therein;

N. Charges for the completion of any insurance forms;

O. Replacement parts for and repairs of hearing aids;

P. Charges for failure to keep a scheduled visit with a physician or audiologist;

Q. Eyeglass-type hearing aids, to the extent the charge for such hearing aids exceeds the covered hearing aid expense for one hearing aid.

VI. COORDINATION OF BENEFITS

Coordination of benefits will be administered under the same provisions applicable to other Health Care benefits under the Insurance Program.

VII. SUBROGATION

In the event of any payment for hearing aids under this Plan, the Plan carrier shall be subrogated to all covered person's rights of recovery against any person organization, except against insurers on policies of insurance issued to and in the name of the covered person, and the covered person shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights.

VIII. COST AND QUALITY CONTROLS

The Plan carrier shall undertake appropriate review procedures to assure a high degree of cost and quality control. Where appropriate, such actions may include utilization review, price review and evaluati of services rendered.

HEARING AID BENEFITS

DEFINITIONS

As used herein:

A. "physician" means an octologist or otolaryngologist who is board certified or eligible for certification in his specialty in compliance with standards established by his respective professional sanctioning body, who is a licensed doctor of medicine legally qualified to practice medicine and who, within the scope of his license, performs a medical examination of the ear and determines whether the patient has a loss of hearing acuity and whether the loss can be compensated for by a hearing aid;

B. "audiologist" means any person who (1) possesses a Master's or Doctorate Degree in Audiology or Speech Pathology from an accredited university, (2) possesses a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association and (3) is qualified in the state in which the service is provided to conduct an audiometric examination and hearing aid evaluation test for the purposes of measuring hearing acuity and determining and prescribing the type of hearing aid that would best improve the covered person's loss of hearing acuity. Where a physician performs the foregoing services he shall be deemed an audiologist for purposes of this Program;

C. "dealer" means any person or organization that sells hearing aids prescribed by an audiologist to improve hearing acuity in compliance with the laws or regulations governing such sales, if any, of the state in which the hearing aids are sold;

D. "participating" means having a written agreement with the carrier pursuant to which services or supplies are provided under this Plan;

E. "hearing aid" means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiolog process of hearing, and includes an ear mould, if necessary;

F. "ear mould" means a device of soft rubber, plastic or a non-allergenic material which may be vented or nonvented that individually is fitted to the external auditory canal and pinna of the patient;

G. "audiometric examination" means a procedure for measuring hearing acuity that includes tests relating to air conduction, bone conduction, speech reception threshold and speech discrimination;

H. "hearing aid evaluation test" means a series of subjective and objective tests by which an audiologist determines which make and model of hearing aid will best compensate for the covered person's loss of hearing acuity and which make and model will therefore be prescribed, and shall include one visi by the covered person subsequent to obtaining the hearing aid for an evaluation of its performance and a determination of its conformity to the prescription;

I. "covered person" means the eligible employee, retired employee, eligible surviving spouse and the employee or retiree's eligible dependents;

J. "covered hearing aid expense" means the charges incurred for hearing aids of the following functional design; in-the-ear, behind-the-ear (including air conduction and bone conduction types) and on-the-body, but only if (1) the hearing aid is prescribed based upon the most recent audiometric examination and most recent hearing aid evaluation test and (2) the heari

aid provided by the dealer is the make and model prescribed by the audiologist and is certified as such by the audiologis in order for the charges for a hearing aid as described in Section II (K) to be payable as Hearing Aid Benefits under this Plan, upon each occasion that a covered person receives such a hearing aid the covered person must first obtain a medical examination of the ear by a physician, and such examination or such examination in conjunction with the audiometric examination must result in a determination that a hearing aid would compensate for the loss of hearing acuity.

1901 Bell Avenue, Des Moines, Iowa 50315 • (515) 284-3011

#1

February 4, 1980

Mr. Jack G. Derry
International Representative
UAW Agricultural Implement Dept.
8000 East Jefferson Avenue
Detroit, Michigan 48214

Dear Jack:

This memo will confirm the Company's practice regarding payment of abortion. Reasonable and customary charges will be paid for doctors and hospital fees for abortion where legislation permits such operations.

In addition, benefits will be paid when the surgical service is performed in any facility licensed by the state for the performance of such services, provided, however, the charges of a facility not licensed as a hospital shall not exceed such facility's usual charges nor shall such usual charges exceed the usual charges of hospitals in the area for the same services.

Very truly yours,

Gene Lapko

E. C. Lapko
Hourly Benefits
Administration Manager

Jack G. Derry

Massey-Ferguson Inc.
P.O. Box 322, Detroit, Michigan 48232 • (313) 493-7000

November 29, 1979

Mr. Jack G. Derry
International Representative
UAW Agricultural Implement Dept.
8000 E. Jefferson Avenue
Detroit, Michigan 48214

Re: Alcohol and Drug Abuse Program

Dear Mr. Derry:

This is to confirm our understanding reached at negotiations that the Company and Union shall meet at the central level during the term of this Contract as needed to accomplish the following objectives concerning the development of an Alcohol and Drug Abuse Program.

1. Develop prototype treatment programs that experience has indicated are most likely to be effective in treatment of alcoholism and drug reliance.

2. Identify the medical and nonmedical treatment programs and facilities in each community where Company facilities are located that can provide effective treatment.

3. Recommend to the Company and the Union appropriate utilization of the hospital, medical and psychiatric benefits now provided by the Insurance Agreement and such additional programs as these studies show would be effective.

The Company and Union further agree to give good faith consideration to the principles and suggestions set forth by both parties at the commencement of these deliberations. No changes recommended for implementation during the life of the Contract shall be made except by mutual agreement of the Company and the Union.

Very truly yours,

R. A. Rzonca
Industrial Relations Director

Jack G. Derry
International Representative

RAR:mp

Massey-Ferguson Inc.
P.O. Box 322, Detroit, Michigan 48232 • (313) 493-7000

November 29, 1979

Mr. Jack G. Derry
International Representative
UAW Agricultural Implement Dept.
8000 E. Jefferson Avenue
Detroit, Michigan 48214

Dear Mr. Derry:

This is to confirm our understanding reached at negotiations that when the Company calls an ambulance to transport an employee from a Company facility to a hospital, and such employee is not held in overnight at that hospital, the Company shall pay the cost of such ambulance service directly from Company funds.

Very truly yours,

R. A. Rzonca
Industrial Relations Director

Jack G. Derry
International Representative

RAR:mp

Massey-Ferguson Inc.
P.O. Box 322, Detroit, Michigan 48232 • (313) 493-7000

Mr. Jack G. Derry
International Representative
UAW Ag-Imp. Dept.
8000 E. Jefferson Ave.
Detroit, Michigan 48214

Dear Mr. Derry:

This is to confirm our understanding reached at negotiations that the pre and post surgical care by the doctor who performs the surgery is considered as part of his fee for surgery; consequently, such fee is covered for benefit purposes regardless of how the doctor performing such surgery writes out the bill so long as the total bill does not exceed the Usual, Customary and Reasonable charges for such surgery. Should the fee charged by the performing doctor for surgery exceed the reasonable and customary charges, it shall be subject to the procedures of the letter concerning reasonable and customary charges.

Very truly yours,

R. A. Rzonca
Industrial Relations
Director

ACCEPTED BY THE UNION:

BY: _____

DATE: _____

1201 Bell Avenue, Des Moines, Iowa 50315 • (515) 284-2011

#13

February 17, 1980

Mr. Jack G. Derry
International Representative
UAW Agricultural Implement Dept.
8000 East Jefferson Avenue
Detroit, Michigan 48214

Dear Jack:

This will confirm the understanding reached at negotiations that in the event the Contingency Account and the SUB Fund fall below a payout level during the term of this Agreement, the Company and Union shall meet to discuss mutually acceptable alternative methods for providing relief.

Very truly yours,

R. A. Ronca

R. A. Ronca
Industrial Relations Director

Jack G. Derry

Massey-Ferguson Inc.
1901 Bell Avenue, Des Moines, Iowa 50315 • (515) 284-2011

#15

February 4, 1980

Mr. Jack G. Derry
International Representative
UAW Agricultural Implement Dept.
8000 E. Jefferson Avenue
Detroit, Michigan 48214

Dear Jack:

This will confirm our understanding reached at negotiations that time spent on Union business, excluding extended Union leaves of absences, will be credited toward vacation and pension eligibility requirements under Section 14.01 of the Master Agreement and the Pension Agreement.

Very truly yours,

R. A. Ronca
Industrial Relations Director

Jack G. Derry

Massey-Ferguson Inc.
1901 Ball Avenue, Des Moines, Iowa 50315 • (515) 284-2011

#20

February 4, 1980

Mr. Jack G. Derry
International Representative
UAW Agricultural Implement Dept.
8000 E. Jefferson Avenue
Detroit, Michigan 48214

Dear Jack:

This will confirm our understanding reached at negotiations that the Company, on a reasonable basis, will provide a pay advance to employees who have their A & S checks delayed for reasons beyond their control and where such delay would cause the employee undue hardship. Where the employee's insurance form has been filed with his doctor in a timely fashion and the doctor has delayed in processing the form and this can be substantiated to the Company, the Company will provide a pay advance with the understanding that the applicable John Hancock check will be immediately signed over to the Company.

Nothing in this letter can be construed to require an advance to any employee for disability income continuance where disability has not been medically verified. In addition, any employee that does not return such advance immediately upon receipt of the money from John Hancock or who has been found to have misled the Company into providing such advance shall be subject to immediate discharge.

Very truly yours,

R. A. Ronca
Industrial Relations Director

Jack G. Derry

Massey-Ferguson Inc.
P.O. Box 322, Detroit, Michigan 48232 • (313) 493-7000

November 29, 1979

Mr. Jack G. Derry
International Representative
UAW Agricultural Implement Dept.
8000 E. Jefferson Avenue
Detroit, Michigan 48214

Dear Mr. Derry:

If a governmental agency having appropriate authority holds that any increase in rates of pay or benefits provided for by this Agreement or any supplement thereto is disallowed or postponed, the Company will periodically, as the prescribed payments become due, place in escrow an amount of money equal to that necessary to provide the rates of pay and benefits so disallowed or postponed, if so doing is permissible under government regulation. The parties will negotiate, without strike, lockout or other interference with production, and without arbitration, means of making available to employees benefits equal in value to any monies so deposited in escrow in a manner permissible under government regulations.

Very truly yours,

R. A. Rzonca
Industrial Relations Director

Jack G. Derry
International Representative

RAR:mp

Massey-Ferguson Inc.
1901 Ball Avenue, Des Moines, Iowa 50315 • (515) 284-2011

#41

February 17, 1930

Mr. Jack G. Derry
International Representative
UAW Agricultural Implement Dept.
8000 E. Jefferson Avenue
Detroit, Michigan 48214

Dear Jack:

This will confirm our understanding reached at negotiations that any employee who is recalled from layoff before the 15th of the month, will be reimbursed for the amount of insurance premium he paid to the Company for that month.

Very truly yours,

R. A. Rzonca

R. A. Rzonca
Industrial Relations Director

Jack G. Derry

Massey-Ferguson Inc.
P. O. Box 322, Detroit, Michigan 48232 • (313) 838-2000

February 20, 1980

Mr. Jack G. Derry
International Representative
UAW Agricultural Implement Dept.
8000 E. Jefferson Avenue
Detroit, Michigan 48214

Dear Mr. Derry:

PENSION REOPENER

The company and union hereby agree to reopen Article III - Survivor Benefits of the Pension Agreement for re-negotiation effective July 1, 1982. The only issue to be discussed at that time shall be the provisions of Section 3.02.

Very truly yours,

R. A. Rzonca
Industrial Relations Director

Jack G. Derry
International Representative

Any savings realized by the Company from integrating or eliminating any duplication of benefits provided under the Insurance Agreement with the benefits provided by Law, shall be retained by the Company.

The provisions of this letter are conditioned upon obtaining and retaining governmental approval, as may be required, to integrate the benefits provided under this Insurance Agreement and those benefits provided under the law and provided further that (1) neither this letter nor the enactment of such Federal law shall deny or reduce any rights or benefits to which a person covered by the Insurance Agreement may be entitled under an unchanged Insurance Agreement or the law and (2) a person covered under the Insurance Agreement shall not incur additional cost for the benefits covered by such Agreement than if such Agreement was continued unchanged.

Very truly yours,

R. A. Rzonca
Industrial Relations Director

Jack G. Derry
International Representative

RAR:mp

Massey-Ferguson Inc.
P.O. Box 322, Detroit, Michigan 48232 • (313) 493-7000

November 29, 1979

Mr. Jack G. Derry
International Representative
UAW Agricultural Implement Dept.
8000 E. Jefferson Avenue
Detroit, Michigan 48214

Re: National Health Insurance

Dear Mr. Derry:

This confirms our understanding that, notwithstanding the provisions of Section 4.04 of the Insurance Agreement if during the term of the Agreements between the Company and the Union signed today, any National Health Insurance Program (other than a Workers Compensation or occupational health law), is enacted or amended to provide hospital, surgical, medical, prescription drug, hearing aid, vision care, and dental benefits for employees, retired employees or surviving spouses, which in whole or in part duplicate or may be integrated with the benefits under the Insurance Agreement, the benefits therein provided shall be modified in whole or in any part, so as to integrate or so as to eliminate any duplication of such benefits with the benefits provided by such Federal law. This integration shall be designed to maintain such integrated benefits as nearly comparable as possible to the benefits provided in the Insurance Program. Such integration shall not result in persons covered under the Insurance Program having to pay deductibles and co-payments for benefits which they would not otherwise pay under the Insurance Program.

If any such Federal law is enacted or amended, as provided in the paragraph above, the Company will pay through October 31, 1982, any premiums, taxes or contributions employees may be required to pay under the law, when they become effective, that are specifically earmarked or designated for the purposes of financing the program of benefits provided by law, in addition to any premiums, taxes, or contributions required of the Company by Law.

contributions employees may be required to pay under the law, when they become effective, that are specifically earmarked or designated for the purposes of financing the program of benefits provided by law, in addition to any premiums, taxes, or contributions required of the Company by law.

Any savings realized by the Company from integrating or eliminating any duplication of benefits provided under the Insurance Agreement with the benefits provided by law, shall be retained by the Company.

The provisions of this letter are conditioned upon obtaining and retaining governmental approval, as may be required, to integrate the benefits provided under this Insurance Agreement and those benefits provided under the law and provided further that (1) neither this letter nor the enactment of such Federal law shall deny or reduce any rights or benefits to which a person covered by the Insurance Agreement may be entitled under an unchanged Insurance Agreement or the law and (2) a person covered under the Insurance Agreement shall not incur additional cost for the benefits covered by such Agreement than if such Agreement was continued unchanged.

Very truly yours,

R. A. Rzonca
Industrial Relations Director

Jack G. Derry
International Representative

RAR:mp

Massey-Ferguson Inc.
1901 Ball Avenue, Des Moines, Iowa 50315 • (515) 284-2011

#46

February 4, 1980

Mr. Jack G. Derry
International Representative
UAW Agricultural Implement Dept.
8000 E. Jefferson Avenue
Detroit, Michigan 48214

Dear Jack:

This will confirm our understanding that in the event the issue of whether layoff disability or accident and sickness applies to employees in the first full month following layoff is ever arbitrated, the position of either party shall not be prejudiced by their respective positions taken at negotiations. Should such issue ever arise, it may be presented directly to arbitration.

Very truly yours,

R. A. Rzonca
Industrial Relations Director

Jack G. Derry

Massey-Ferguson Inc.
P.O. Box 322, Detroit, Michigan 48232 • (313) 493-7000

November 29, 1979

Mr. Jack Derry
International Representative
UAW Agricultural Implement Dept.
8000 E. Jefferson Avenue
Detroit, Michigan 48214

Dear Mr. Derry:

This will confirm our understanding reached at negotiations that the Company will supplement the maximum room benefit provided under the Insurance Agreement to the Usual, Customary and Reasonable charge for isolation where it has been shown that it was necessary to quarantine a covered individual because he has a contagious disease or because of a hospital requirement or due to severe burns.

Very truly yours,

R. A. Rzonca
Industrial Relations Director

Jack G. Derry
International Representative

RAR:mp