Magna Powertrain - Syracuse Division

Benefit Plans for UAW SBU and HBU Employees Effective 4/1/2008

General Provisions	Explanation	
Eligibility	All full time employees.	
Dependent Eligibility	Dependent children under age 19 or under age 23 if a full time student	
Waiting Period	Following the end of the probationary period (medical/dental/vision/life/STD/LTD)	
Weekly Contributions	**Payroll Deduction - BC/BS Gold PPO Plan**	**Payroll Deduction - BC/BS Silver PPO Plan**
	(covers Medical/Dental/Vision)	**(covers Medical/Dental/Vision)**
Employee	$3.46	$0.00
Employee + One Dependent	$5.77	$0.00
Family	$7.21	$0.00

Medical Benefits	Gold PPO Plan		Silver PPO Plan	
	In Network	**Out Of Network**	**In Network**	**Out Of Network**
Deductible/Calendar Yr				
Individual/Family	$100/$300	$750/$1,500	$300/$600	$750/$1,500
Co-Insurance Limit				
Individual/Family	$1,000/$2,000	$3,000/$6,000 (cross accumulate)	$2,000/$4,000	$3,000/$6,000 (cross accumulate)
Out of Pocket Max/Calendar Yr				
Individual/Family	$1,100/$2,300	$3,750/$7,500	$2,300/$4,600	$3,750/$7,500
Wellness Care (adult & spouse only)	**No Deductible**	**No Deductible**	**No Deductible**	**No Deductible**
Routine Physical Exam	$15.00 co-pay	Not Covered	$20.00 co-pay	Not Covered
Routine Physical -Lab & X-Rays	100%	Not Covered	100%	Not Covered
Routine Gyn/Mamo/PSA Exam*	$15 co-pay	80%	$20 co-pay	80%
Routine PAP/Mamo/PSA Test*	100%	80%	100%	80%
**Age restrictions apply with mammograms and PSA procedures*				
Dependent Children (to age 6)				
Well Child Exam (birth to under age 1=6 exams / age 1 through age 17 = 1 per calendar year)	$15 co-pay	Not Covered	$20 co-pay	Not Covered
Well Child Care immunizations & TB Test	$15 co-pay	Not Covered	$20 co-pay	Not Covered

Medical Benefits	Gold PPO Plan		Silver PPO Plan	
	In Network	Out Of Network	In Network	Out Of Network
Routine Hospital Care	**Subject to the Deductible**	**Subject to the Deductible**	**Subject to the Deductible**	**Subject to the Deductible**
Hospital - Pre-admission testing	90%	80%	80%	70%
Hospital - Semi Private Room	90%	80%	80%	70%
Hospital - Ancillary Services	90%	80%	80%	70%
Hospital's Professionals (Radiologist/Pathologist, etc.)	90%	80%	80%	70%
Ambulance	90%	80%	80%	70%
Surgery	90%	80%	80%	70%
In-Hospital Physician	90%	80%	80%	70%
Emergency Hospital Care	**Subject to the Deductible**	**Subject to the Deductible**	**Subject to the Deductible**	**Subject to the Deductible**
Hospital - Emergency Room Services	$50 co-pay- then covered at 90%**	$50 co-pay- then covered at 90%**	$50 co-pay - then covered at 80%**	$50 co-pay - then covered at 80%**
Hospital - Semi Private Room	90%	90%	80%	80%
Hospital - Ancillary Services	90%	90%	80%	80%
Hospital's Professionals (Radiologist/Pathologist, etc.)	90%	90%	80%	80%
Ambulance	90%	90%	80%	80%
Surgery	90%	90%	80%	80%
In-Hospital Physician	90%	90%	80%	80%
**Waived if admitted or if treatment is for an accidental injury				
Miscellaneous Services	**Subject to the Deductible**	**Subject to the Deductible**	**Subject to the Deductible**	**Subject to the Deductible**
Office Visits (excludes injections/supplies/tests, etc)	$15 co-pay	80%	$20 co-pay	70%
Office Visit - Specialist	$15 co-pay	80%	$20 co-pay	70%
Urgent Care Facility	$15 co-pay	80%	$20 co-pay	70%
Injections/Supplies/Tests	90%	80%	80%	70%
Second Surgical Option	90% (deductible waived)	80% (deductible waived)	80% (deductible waived)	70% (deductible waived)
Out-Patient Surgery	90%	80%	80%	70%
Out-Patient X-Ray & Lab	90%	80%	80%	70%
Non-Custodial Nursing Care	90%	80%	80%	70%
Physical Therapy	90%	80%	80%	70%
Prosthetic Devices	90%	80%	80%	70%
Durable Medical Equipment	90%	80%	80%	70%
All Other Medically Necessary Treatment	90%	80%	80%	70%
Additional Plan Maximums	**Subject to the Deductible**	**Subject to the Deductible**	**Subject to the Deductible**	**Subject to the Deductible**
Infertility Treatment per lifetime	90% to max of $3,000	80% to max of $3,000	80% to max of $3,000	70% to max of $3,000
TMJ Treatment per lifetime	90% to max of $3,500	80% to max of $3,500	80% to max of $3,500	70% to max of $3,500
Chiropractic Treatment - per plan year	$15 co-pay to max of $500	80% to max of $500	$20 co-pay to max of $500	70% to max of $500
	No Deductible	**No Deductible**	**No Deductible**	**No Deductible**
Home Health Care - per plan year	90% for 130 visits	80% for 130 visits	80% for 130 visits	70% for 130 visits
Hospice/Bereavement Counseling	90% to $15,000 / $300	80% to $15,000 / $300	80% to $15,000 / $300	70% to $15,000 / $300

Medical Benefits	Gold PPO Plan		Silver PPO Plan	
	In Network	Out Of Network	In Network	Out Of Network
Mental Health	**Subject to the Deductible**	**Subject to the Deductible**	**Subject to the Deductible**	**Subject to the Deductible**
In-Hospital - per Lifetime 45 days	90%	80%	80%	70%
Out-patient Treatment (does not apply to plan co-insurance limit)	$15 co-pay-1st 20 visits-25% 21-35 visits	25% - 35 visits per plan year	$20 - 1st 20 visits = 25% 21-35 visits	25% - 35 visits per plan year
Substance Abuse Limits	**Subject to the Deductible**	**Subject to the Deductible**	**Subject to the Deductible**	**Subject to the Deductible**
In-Hospital - per Lifetime 45 days	90%	80%	80%	70%
Out-patient Treatment (does not apply to plan co-insurance limit)	35 visit - $15 co-pay	80%	35 visit - $20 co-pay	70%

Prescription Drug Program	Coverage (All Plans)
PCS - Prescription Drug Program	**Retail**
Tier 1 - Generic Drug	$10 co-pay - Mandatory Generic
Tier 2 - Preferred Brand Name Drug *	$20 co-pay
Tier 3 - Non-Preferred Brand Name Drug *	$40 co-pay
** If prescribed by MD or if generic is not available*	
Brand Name Drug - by your choice	Employee pays difference between generic & brand cost + generic co-pay
PCS - Mail Order Drug Program	**Mail Order** (A 90 renewable prescription for the co-pay listed below)
Tier 1 - Generic Drug	$20 co-pay - Mandatory Generic
Tier 2 - Preferred Brand Name Drug	$40 co-pay
Tier 3 - Non-Preferred Brand Name Drug	$80 co-pay

Vision - VSP (No Preferred Provider Usage Necessary)	Coverage (We have attempted to duplicate the existing plan provisions as best as possible)
Exam* - 1 every 24 months	$10 co-pay
Frames - 1 every 24 months - Up to $23.00 maximum	$50
Conventional Lenses* - 1 every 24 months	
Single	$55
Bi-Focal or equivalent progressive	$72
Tri-Focal or equivalent progressive	$84
Lenticular	
A single lens	50% of allowed benefit
Regular Contact Lenses - Up to $75.00	$164.00

Disability Plans (employer provided)	Coverage
Short Term Disability (STD) - weekly benefit	66 2/3% of base weekly earnings Max 26 wks of covg. Benefit is based on approval of disability by insurance carrier 1st day of coverage for hospitalization & accidents/ 7 day waiting period for illnesses
Long Term Disability (LTD) - monthly benefit	60% to $5,000 monthly base earnings

Travel AD&D	Coverage
Travel Accidental Death & Dismemberment	$25,000 covg based on business travel, not including regular commuting time to & from work

Special Note:

Future healthcare cost excalation will be shared between the Company and employees, with the company assuming 85% of the increased cost and employees assuming 15%. Such cost sharing may involve adjustments to employee contributions, deductibles, out-of-pocket maximums or any combination thereof.

BC/BS Dental - DenteMax (No Preferred Provider Usage Necessary)	Coverage		
Calendar Year Maximum	$2,000 per enrolled member		
Deductible (annual)	$50/$100		**Notes on Dental Coverage:**
Diagnostic & Preventative*			* All charges subject to a Reasonable and
Oral Exams - 1 every 6 mths	100%		Customary Charge Determination.
X-Rays (bitewings 1 every 6 mths & full mouth 1 every 36 mths)	90%		
Cleanings - 1 every 6 mths - one extra with perio disease	100%		* There is a 3 day grace period on all
Periodontic cleanings - 1 every 6 mths	90%		frequency limits.
Fluorides - 1 every 6 mths - children under age of 20	100%		
Sealant - to age 14	Not covered		* Oral Surgery for the extraction of wisdom
Space Maintainers to replace prematurely lost teeth for			teeth is a medical procedure.
children under age 19	100%		
Emergency Palliative	100%		
Diagnostic Casts	90%		
Test/Lab Exams & All Other X-Rays	90%		
Basic Services*			
Amalgams (fillings)	90%		
Endodontic Treatment	90%		
All Other Periodontic Treatment	90%		
Oral Surgery	90%		
Major Services*			
Crowns & Bridges	50%		
Orthodontic (children only to age 19)*			
Lifetime Maximum	$2,000		
Co-Insurance	50%		

Hearing Aid Coverage	Coverage		
Frequency	Once every 36 months		
Hearing Aid Evaluation/Exam	$122.00		
One Hearing Aid	Reasonable and Customary		

Life Insurance	Coverage
Basic Life (employer provided)	
Coverage	1.5 x base annual earnings
Dependent Life Insurance	$5,000 Spouse
	$1,000 each dep child (birth-6mths) $2,500 each dep child (6mths-19 or 23 yrs old)
Accidental Death & Dismemberment (AD&D)	1.5 x base annual earnings
Optional Life (employee paid)	
Employee	Rates based on age & amount elected to max $200,000
Spouse - Maxximum $100,000	Rates based on age & amount elected. Coverage cannot exceed 50% of