PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

NAVISTAR, INC.
HEALTH PLAN

for Employees of:

- Non-Represented Employees of Navistar, Inc.
- Navistar Big Bore Diesels, LLC
- Navistar Defense, LLC
- Navistar Diesel of Alabama, LLC
- Navistar Financial Corporation
- Navistar International Employee Leasing Company
- International Truck and Engine Export Corporation
- International Truck and Engine Overseas Corporation
- International Truck Intellectual Property Company, LLC
- International Engine Intellectual Property Company, LLC
- Navistar, Inc. Employees represented by the International Union of Operating Engineers of Chicago and Vicinity, AFL-CIO, Local 399
- Uptime Parts, LLC
- Navistar, Inc. Employees of Las Vegas Parts and Distribution Center (PDC) located in Las Vegas, NV represented by the United Automobile, Aerospace & Agricultural Implement Workers of America, Local 2162

Navistar, Inc.
2701 Navistar Drive
Lisle, IL 60532 USA

November 13, 2020

Non-Represented Employees of Navistar, Inc.
Employees of Navistar Big Bore Diesels, LLC
Employees of Navistar Defense, LLC
Employees of Navistar Diesel of Alabama, LLC
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Re: Summary of Changes to Your Benefits Program Effective January 1, 2021

This letter provides you with a detailed explanation of changes to your health benefit program. This letter is a Summary of Material Modifications (SMM) to your existing Summary Plan Description (SPD). You should retain a copy of this SMM with your copy of the SPD.

MEDICAL PLAN CHANGES

Lower Premium Plan:

- Increase in deductibles as shown in the chart below:

	2020		2021	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Individual)	$1,000	$2,000	$1,200	$2,400
Annual Deductible (Family)	$2,000	$4,000	$2,400	$4,800

- Increase in out-of-pocket maxiums as shown in the chart below:

	2020		2021	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Out-Of-Pocket Maximum (Individual)	$3,000	$5,000	$3,400	$5,800
Annual Out-Of-Pocket Maximum (Family)	$6,000	$10,000	$6,800	$11,600

Standard Plan:

- Increase in deductibles as shown in the chart below:

	2020		2021	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Individual)	$500	$1,000	$700	$1,400
Annual Deductible (Family)	$1,000	$2,000	$1,400	$2,800

- Increase in out-of-pocket maxiums as shown in the chart below:

	2020		2021	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Out-Of-Pocket Maximum (Individual)	$2,500	$4,000	$2,900	$4,800
Annual Out-Of-Pocket Maximum (Family)	$5,000	$8,000	$5,800	$9,600

PRESCRIPTION PLAN CHANGES

Prescription Drug "Dispense as Written"

Starting in 2021, if your doctor writes "Dispense as Written" or "DAW" on your prescription for a brand-name drug that has a generic equivalent available, your cost will be the lesser of: (1) the generic copay plus the cost differential between the generic and brand-name drug or (2) 100% of the drug. This cost differential also applies if you request a brand-name drug when a generic equivalent is available.

In the rare event that you must take the brand-name version of the drug, there is a medical exception process. If approved, you will pay the normal copay.

The cost differential will not apply to your prescription drug out of pocket maximum.

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Re: Summary of Changes to Your Benefits Program Effective as shown below

This letter provides you with a detailed explanation of changes to your health benefit program. This letter is a Summary of Material Modifications (SMM) to your existing Summary Plan Description (SPD). You should retain a copy of this SMM with your copy of the SPD.

- Effective March 10, 2020. Provide COVID-19 testing at no cost to the member at authorized locations.
- Effective March 18, 2020. Provide costs associated with COVID-19 testing at no cost to the member (office visit copays, urgent care center copays and emergency room copays) in compliance with the Families First Coronavirus Response Act.
- Effective March 20, 2020. Remove the prohibition on "Telephone and Other Electronic Consultation" for physical, occupational and speech therapies. These therapies can now be provided via a telemedicine.

Navistar will comply with all current and future change in the law due to the COVID-19 outbreak. Once the end of the public health emergency (PHE) for COVID-19 is declared by the Secretary of Health and Human Services, our plan(s) will return to their state prior to the emergency and these changes will be rescinded.

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Re: Summary of Changes to Your Benefits Program Effective January 1, 2019

This letter provides you with a detailed explanation of changes to your health benefit program. This letter is a Summary of Material Modifications (SMM) to your existing Summary Plan Description (SPD). You should retain a copy of this SMM with your copy of the SPD.

MEDICAL PLAN CHANGES

Health Plan Changes Effective January 1, 2019

Medical Plan Coverage:

- Increase in Doctor on Demand discount. As a pilot for 2019, the discount for telemedicine visits through Doctor On Demand will be increasing from $20 to $49, this means your medical telemedicine visit will essentially be free. We will review to determine how we will handle telemedicine in the fall of 2019.

PRESCRIPTION PLAN CHANGES

- Effective January 1, 2019, your specialty drug benefits will change. Your standard copayment for specialty drugs is $100 for up to a 30-day supply or $200 for a 90-day supply. This copay will be increasing for select drugs.

  The impacted specialty medications may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. Under many of these programs, we will reduce the copay for the allowable amount for the specialty medication by an amount which is equivalent to the maximum benefit of the applicable coupon or rebate.

  You will not receive credit toward their maximum out-of-pocket for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

  CVS/Caremark's care management process, provided through its affiliate CVS/specialty, will provide you the support and resources necessary to navigate these benefit changes, including helping you pursue third party copayment assistance for these particular prescribed drugs. If you choose not to participate in the care management process, you will be subject to the full copayment liability. Eligibility for third party copay assistance programs is dependent on the applicable terms and conditions required by that particular program and are subject to change.

EAP PLAN CHANGES

Employee Assistance Program:

- Effective January 1, 2019, the EAP provides you and your eligible dependents up to six (6) sessions per person per incident per year.

If you have any questions regarding these changes, please contact Navistar's Employee/Retiree Information Center (ERIC) at ERICOperations@Navistar.com or 1-855-331-3742.

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INTRODUCTION

This document is a description of Navistar, Inc. Health Plan (the Plan) for Employees of:

- Navistar, Inc. (Non-Represented Employees)
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No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. Throughout this booklet, Navistar, Inc. will be referred to as "Navistar".

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, maximums, exclusions, limitations, definitions, eligibility and the like.

To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care Provider who is acting within the scope of the Provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of Providers as a Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

The Plan is administered by Navistar. Navistar has contractual agreements with other companies to provide administrative services for the Plan. Navistar, as the Plan Administrator, shall have discretionary authority to determine eligibility for benefits under the Plan. Navistar and such other companies with whom Navistar has contracted to perform administrative services under the Plan, as the Claims Administrator, shall have discretionary authority to construe the terms of the Plan including discretionary authority to correct mistakes, to reconcile inconsistencies, and to correct drafting errors or omissions. Benefits under this Plan will only be paid if the Plan Administrator or Claims Administrator, as appropriate, decides in its discretion that the applicant is entitled to them. This Summary Plan Description supersedes all prior summaries of benefits programs (or prior programs that were replaced by these programs) for the category of Employees identified herein and their eligible covered Dependents.

This document is not a contract and does not give rise to any contractual obligations. If there is an expressed direct conflict between this document and an applicable collective bargaining agreement, the applicable collective bargaining agreement will govern.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies, and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of:

- Navistar, Inc. (Non-Represented Employees)
- Navistar Big Bore Diesels, LLC
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Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is an Active Employee of the Employer on the regular payroll of the Employer, or is in a class otherwise eligible for coverage, whether by contract, agreement, or otherwise; and

(2) completes the employment Waiting Period as an Active Employee. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. Any applicable Waiting Period will be communicated separately by the Employer.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married and does not include domestic partnerships. The Plan Administrator may require documentation proving a legal marital relationship.

(2) A covered Employee's child through the end of the month of their 26th birthday.

The terms "child" or "children" shall include natural children, step-children, adopted children, foster children, a son or daughter (and to the extent required by applicable State law, a stepson or stepdaughter) for whom you are required to provide health coverage pursuant to a Qualified Medical Child Support Order ("QMCSO"), or children lawfully placed with a covered Employee in anticipation of adoption.

(3) A covered Employee's child who reaches age 26 and is Totally Disabled, incapable of self-sustaining employment by reason of mental retardation or physical disability, provided such child is or was under the limiting age of dependency at the time of application for coverage in the Plan.

The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

Except for Dependents considered Totally Disabled, when a child reaches age 26, coverage will end on the last day of the child's birthday month.

If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "lawfully placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children may be covered as Dependents of the mother or father, but not of both.

No person may be covered both as an Employee and Dependent and no person may be covered as a Dependent of more than one Employee.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan. Failure to provide the required proof in a timely manner may disqualify that Dependent(s) and any existing coverage will be terminated.

FUNDING

Employee contributions are required for coverage under the Plan. The contribution represents a small portion of the Company's cost of coverage under the Plan. These contributions will be funded on a pretax basis through the Navistar, Inc. Cafeteria Plan, which was established under Section 125 of the Internal Revenue Code. You will be treated as having elected to have your pay reduced by the amount of the required contributions, and the Company will make the contributions to the Plan. IRS regulations that govern the Cafeteria Plan impose limitations on when election changes can be made during the period of coverage. Therefore, you will only be allowed to make an election change (1) during the annual open enrollment period, or (2) if you experience a Change in Status Event during the period of coverage. For more details, see the section of this booklet entitled "Special Enrollment Rights" as well as the Cafeteria Plan document.

Contributions are deducted from your paycheck(s) in advance of the period of coverage; for example, a deduction from your February paycheck(s) is for March coverage.

Required Employee contributions to the Plan are subject to change at any time. You will be notified of such changes in advance of their becoming effective.

Smoker Premium.
Smoking is a behavior that Navistar, Inc. would like to discourage. To encourage Employees to quit smoking and lead a healthier lifestyle, Navistar, Inc. will charge an **additional $50.00 monthly** health care premium for Employees who choose to smoke. In order to avoid this additional monthly cost, you must certify that you are a non-smoker. Navistar, Inc. expects your response to be truthful, and submission of any false or inaccurate response could constitute a violation of Navistar's Code of Conduct, resulting in discipline, up to and including termination. Navistar, Inc. is committed to helping you achieve your best health. Rewards for choosing a smoke-free lifestyle are available to all Employees. If you think you might be unable to meet the standard for this reward, you might qualify for an opportunity to earn the same reward by a different means. Contact ERIC (Navistar's Employee/Retiree Information Center) and we will work with you (and if you wish, your doctor) to find an alternative with the same reward that is right for you, in light of your health status. In order to modify your smoking status during the year, the Smoking Status Change Affidavit (located under the Forms section of the ERIC homepage via the corporate intranet) must be submitted. You are responsible for submitting the affidavit to ERIC if:

> **Your status has changed from a non-smoker to a smoker**, the monthly smoking premium will be added for the remainder of the calendar year, upon receipt of your completed form.
>
> **Your status has changed from a smoker to a non-smoker**, the monthly smoking premium deduction will be removed for the remainder of the calendar year and a retroactive premium refund from the beginning of the calendar year will be provided as soon as administratively feasible upon receipt of your completed form, including a Physician signature.

Definition of a Smoker: *A person who has smoked at least 100 cigarettes in his or her lifetime and who has smoked at least one cigarette in the past thirty (30) days. Navistar is including e-cigarettes in this definition; as adapted from the Centers for Disease Control (CDC) definition of a smoker.*

Working Spouse Premium.
You are required to pay an additional premium of $150 per month for medical coverage if you enroll your spouse in the Plan; and your spouse is a full-time Employee of another employer; and your spouse is eligible for but declines coverage under that employer's group health plan (thus making Navistar's Plan the primary coverage for your spouse). The additional premium will not apply if your spouse does not work, works part-time, or enrolls in his or her employer's group health plan. If your full-time working spouse enrolls in his or her own employer's group health plan, you may enroll your spouse in the Navistar Plan for secondary coverage.

Working Child (Age 19+) Status.
If you have a working adult child age 19-25 that you elect to cover under your Navistar plan and he or she is a full-time Employee of another employer and is eligible for, but declines, coverage under that employer's group health plan, you will be subject to the $150 monthly Working Child premium per child. This means that you elect the

Navistar health plan as the primary coverage for your working child in place of his or her (or their) employer-based group health plan. The additional $150 monthly premium will be set for the entire calendar year, except upon the occurrence of certain events. Please refer to the list of Change in Status Events that permit a mid-year election change. If you experience a mid-year Change in Status Event, you are responsible for completing and submitting the Working Child Affidavit to ERIC for approval to eliminate the premium on a prospective basis. Navistar, Inc. expects your response to be truthful and that submission of a false or inaccurate response could constitute a violation of Navistar's Code of Conduct, which can be found on the corporate intranet.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization and returning them to ERIC within 31 days of the eligible Employee's date of hire. If the enrollment process is not completed within 31 days of hire, unless a Change in Status Event occurs, the Employee will be required to wait until the annual Open Enrollment period to make a change.

Eligible Dependents for whom the covered Employee requests coverage must be listed on the enrollment application. Supporting documentation of Dependent eligibility must also accompany this enrollment process. Failure to do so will make the Dependents Late Enrollees. Enrollment for Dependents will then be subject to the Late Enrollee terms and conditions.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - the enrollment will be "timely" if the enrollment form and supporting Dependent documentation is provided to ERIC within 31 days of the hire date. Coverage will take effect on commencement of the first day of work for Navistar.

If two Employees are married to each other and are covered under the Plan, and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period, as long as coverage has been continuous.

Eligible Dependents listed on the Employee's initial enrollment form under the Plan are covered starting on the Employee's first day of work. Otherwise, the new Dependents may be enrolled:

- During the annual open enrollment period in the Fall for the following January 1, or
- During a Change in Status Event eligible for Special mid-year election.

(2) **Late Enrollment** - An enrollment is "late" if it is not made within the earlier of 31 days of the Employee's hire date or 60 days of the date the person becomes eligible for coverage for the first time. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself/herself or his/her Dependents (including his/her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 60 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days from the date of the event.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Navistar, Inc., 2701 Navistar Drive, P.O. Box 4080, Lisle, Illinois 60532, by calling ERIC at 1-855-331-ERIC (3742) or by emailing ERICOperations@Navistar.com.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to any of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage period was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan not later than 60 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions described above.

(e) For purposes of these rules, a loss of eligibility occurs if:

(i) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.

(ii) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time Employees).

(iii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent child under the plan), death, termination of employment, reduction in the number of hours of employment, or contributions towards the coverage were terminated.

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual).

(v) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual) and no other benefit package is available to the individual.

(vi) Significant Cost or Coverage Change – This includes:

(a) Cost changes – When there is a cost increase or decrease during a period of coverage, eligible affected Employees are required to make a prospective corresponding change in their elective contributions to the Plan. However, when there is a significant cost increase or decrease, the Plan will allow all eligible affected Employees (including those who had not previously participated in the Plan) to elect a new option or drop coverage altogether if no other benefit package providing similar coverage is available.

(b) Cost increases or decreases refer to an increase or decrease in the amount of the elective contributions under the Plan and may be a result of either Employee action (such as switching from full-time to part-time) or Employer actions (such as reducing the amount of Employer contributions for a class of Employees).

(c) Significant curtailment without loss of coverage - If there is a significant curtailment of coverage under the Plan during a period of coverage that is not a loss of coverage (for example, there is a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under the Plan), the Plan will allow eligible affected Employees participating in the Plan and receiving that coverage to revoke their election for that coverage and to prospectively select another benefit package option providing similar coverage; however, Employees may not drop coverage.

(d) Coverage under the Plan is significantly curtailed only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally. Thus, in most cases, the loss of one particular Physician or Hospital in a network does not constitute a significant curtailment.

(e) Significant curtailment with loss of coverage - If there is a significant curtailment of coverage under the Plan during a period of coverage that is a loss of coverage, the Plan will allow eligible affected Employees to revoke their election under the Plan and to select either to prospectively receive coverage under another benefit package option providing similar coverage or to drop coverage altogether if no similar benefit package option is available.

(f) Loss of coverage means a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a benefit package option).

(g) Addition or improvement of a benefit package option - If the Plan adds a new benefit package option or other coverage option, or coverage under an existing benefit package option or other coverage option is significantly improved during the period of coverage, the Plan will allow all eligible Employees (whether or not they have previously made an election under the Plan or previously elected the benefit package option) to revoke their election and to elect to prospectively receive

coverage under the new or improved benefit package option or other coverage option.

(h) Change in coverage under another employer-sponsored plan - This Plan will allow Employees to make a prospective election change that is on account of and corresponding with a change made under another employer plan (including a plan sponsored by Navistar or by another employer) if the other plan permits Participants to make an election change due to a Change in Status Event or permits Participants to make an election for a different period of coverage (for instance, coverage is provided on a non-calendar year basis).

(i) This change made by the Employee must be "on account of" and must "correspond with" the change made under the other employer's plan.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or legal placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 60 days, beginning on the date of birth, marriage, adoption or legal placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during the Special Enrollment Period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, on the date of the marriage;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or legal placement for adoption, the date of the adoption or legal placement for adoption.

(3) Medicaid and State Child Health Insurance Programs. An Employee or Dependent who is eligible for, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan) and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

There may be other circumstances where a Participant can change coverage elections outside of Open Enrollment. For questions regarding whether an Employee or Dependent can make such a change, contact ERIC at 1-855-331-3742.

EFFECTIVE DATE

Effective Date of Employee Coverage. Upon completion of the enrollment form and forwarding to ERIC within 31 days of the hire date, an Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met, the Employee is covered under the Plan and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee, Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee, Retiree and/or covered Dependents for the period of time coverage was in effect, terminate coverage as of a date to be determined at the Plan's discretion or immediately terminate coverage. The employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's, Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage:

(1) The date the Plan is terminated.
(2) The date the covered Employee's Eligible Class is eliminated.
(3) The day in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.)
(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
(5) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate

coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such termination.

For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled Continuation Coverage Rights under COBRA.

Continuation During Periods of Employer-Certified Disability. A person may remain eligible for a limited time if Active Employment ceases due to disability or leave of absence. This continuance only applies to full-time Employees and will end as follows:

For disability: If an Employee becomes disabled while in Active Employment, eligibility for coverage under the Plan continues for as long as the Employee is receiving a disability income benefit from Navistar. If coverage should continue for the Employee and eligible Dependents, the Employee must make the same contributions as required from an Employee in Active Employment. However, the company reserves the right to change or terminate the Plan.

For approved leave of absence only: If the Employee takes an approved leave of absence, other than leave taken under the Family and Medical Leave Act, health care coverage will be extended through the end of the month following the month in which the Employee last worked. The Employee must make the same contributions as required from an individual in Active Employment.

Coverage for the Employee and eligible Dependents may continue for up to 12 additional months beyond this period only if the Employee contributes the full cost of the coverage. The full cost of this coverage may be obtained by contacting ERIC.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

If the Employee refuses to contribute to any continued coverage, coverage will terminate as of the end of the period for which the required contribution was paid, either before or during the disability or leave.

Coverage continued under this provision is in addition to coverage continued under the Plan's COBRA continuation provisions.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall, at all times, comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

While on an unpaid leave, the Employee must continue to pay their portion of the health care premium. The Employee will be contacted by ERIC regarding this payment. The payment must be received by ERIC in a timely manner each month. If the payment is more than 30 days late, the Employee's health care coverage may be dropped for the duration of the leave.

While on paid leave, the Employer will continue to make payroll deductions to collect the Employee's share of the premium.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated.

If the Employee chooses not to return to work for reasons other than a continued serious health condition, the Employer may require the Employee to reimburse the Employer the amount it paid for the full cost of the Employee's health care coverage during the leave period.

Return to Work. An Employee returning to work directly from Navistar COBRA coverage who is otherwise eligible to participate in the Plan will not be required to satisfy a new eligibility waiting period requirement. The returning Employee must re-enroll in the Plan on the same basis and according to the same rules as a new Employee.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of an Employee and the Employee's Dependents under such an election shall be the lesser of:

(a) The 24-month period beginning on the date on which the Employee's absence begins; or

(b) The day after the date on which the Employee was required to apply for or return to a position of employment and fails to do so.

(2) An Employee who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except an Employee on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator, Navistar, Inc., 2701 Navistar Drive, P.O. Box 4080, Lisle, Illinois 60532. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage:

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) On the first date that a person ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period-of-time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(7) When a Dependent child reaches age 26, coverage will end the last day of the child's birthday month.

For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA.

OPEN ENROLLMENT

Every year during the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective the following January 1 and remain in effect until the next January 1 unless there is a change in status during the year (birth, death, marriage, divorce, adoption), loss of coverage due to loss of a spouse's employment or loss of Dependent child eligibility. To the extent previously satisfied, coverage waiting periods will be considered satisfied when changing from one plan to another plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages to the extent that: (1) those coverages remain available and (2) the Employee and Dependents (if any) remain eligible for coverage under the Plan.

Plan Participants will receive detailed information regarding open enrollment from Navistar each Fall. Navistar reserves the right to request documentation from Employees as it relates to eligibility for themselves and/or Dependents for any plan they choose to enroll in.

Open enrollment is handled through a Navistar online system (currently PeopleSoft). During the open enrollment period, an Employee is able to update elections and/or changes as often as he or she would like. However, the last update, election or change saved on the open enrollment website will be the final information applied to the Employee's and eligible Dependent's health care coverage. If the open enrollment process via the website is successfully completed, the Employee will be able to print a confirmation statement indicating the final changes made. Updates, elections and changes are irrevocable upon the earlier of 1) the end of the applicable open/special enrollment period, and 2) the effective date of coverage. Please be sure to carefully review the various annual open enrollment communications that will be provided and made available. No exceptions will be made to make election changes after the open enrollment period has ended.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the Claims Administrator's established Coverage Policy, Allowable Charge and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is Medically Necessary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called In-Network Providers. Because these In-Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

A listing of In-Network Providers is available on the web at www.blueadvantagearkansas.com.

Deductibles payable by Plan Participants, per Calendar Year

In-Network

Lower Premium Plan
Per Covered Person $1,000
Per Family Unit $2,000

Standard Plan
Per Covered Person $500
Per Family Unit $1,000

Out-of-Network

Lower Premium Plan
Per Covered Person $2,000
Per Family Unit $4,000

Standard Plan
Per Covered Person $1,000
Per Family Unit $2,000

In-Network and Out-of-Network charges both contribute to the Calendar Year Deductible

The Calendar Year Deductible is waived for the following Covered Charges:

- In-Network Primary Care Physician services rendered in an Office Setting
- In-Network Specialist services rendered in an Office Setting
- In-Network Routine Physical Exams
- In-Network Well Child Care
- Hearing Aid Benefits
- Vision Care Benefits

Maximum Out-of-Pocket payments, per Calendar Year

The Plan will pay 70% of In-Network Covered Charges (Lower Premium Plan) and 80% of In-Network Covered Charges (Standard Plan) and 50% of Out-of-Network Covered Charges (both Lower Premium Plan and Standard Plan) until the following amounts of out-of-pocket payments are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

In-Network

Lower Premium Plan
Per Covered Person $3,000
Per Family Unit $6,000

Standard Plan
Per Covered Person $2,500
Per Family Unit $5,000

Out-of-Network

Lower Premium Plan
Per Covered Person $5,000
Per Family Unit $10,000

Standard Plan
Per Covered Person $4,000
Per Family Unit $8,000

Out-of-pocket expenses (including deductible and coinsurance amounts) incurred for In-Network care also apply towards the out-of-pocket limits for the Out-of-Network care and vice versa.

The charges for the following do not apply to the 100% benefit limit:

- Healthcare this plan does not cover
- Premiums
- Prescription services
- Office visits or other services to which copayments are applied
- Cost containment penalties

Employee Assistance Program (EAP)

The EAP can help Employees and their family members deal with many problems including:

- Interpersonal conflicts and stress
- Marital and family issues
- Chemical dependency
- Emotional problems
- Legal issues and questions
- Financial and credit concerns
- Pre-retirement planning

The EAP provides the Covered Person and eligible Dependents four sessions per person per incident per year. There is no cost to the Covered Person for these sessions. However, a prior authorization form must be received by Optum before care is received or the charges may not be covered. For a referral to a counselor, contact the EAP at 1-800-977-7909.

If help beyond the four (4) EAP sessions is needed, treatment can be continued under the Mental Health Services and Substance-Related and Addictive Disorder Services with Optum. See **MANAGED BEHAVIORAL HEALTH PROGRAM AND EAP** section of this SPD for additional details.

HOSPITAL BENEFITS

Precertification is required for all inpatient hospital admissions, hospice care, home health care and skilled nursing care.

Penalty for failure to pre-certify Out-of-Network hospital admissions, hospice care, home health care and skilled nursing care $400

- Penalty is in addition to any deductible amount and will be applied to charges billed by the facility.

Inpatient Admittance reimbursement rate

Lower Premium Plan
In-Network facility .....$250 per confinement deductible, then 70%, after medical deductible
Out-of-Network facility.....$250 per confinement deductible, then 50%, after medical deductible

Standard Plan
In-Network facility .....$250 per confinement deductible, then 80%, after medical deductible
Out-of-Network facility.....$250 per confinement deductible, then 50%, after medical deductible

Emergency Room Services
For treatment sought due to a medical emergency, as defined by the Plan:

Lower Premium Plan
In-Network and Out-of-Network reimbursement rate ..... $150 copay, then 100%, deductible waived
- Emergency Room copay will be waived if admitted at any facility.

Standard Plan
In-Network and Out-of-Network reimbursement rate ..... $100 copay, then 100%, deductible waived
- Emergency Room copay will be waived if admitted at any facility.

For emergency room services which are not related to a medical emergency, as defined by the Plan:

Lower Premium Plan
In-Network and Out-of-Network reimbursement rate ..... 50%, after deductible
- Emergency Room copay will be waived if admitted at any facility.

Standard Plan
In-Network and Out-of-Network reimbursement rate ..... 50%, after deductible
- Emergency Room copay will be waived if admitted at any facility.

Room and Board Allowances
Covered Charges for room and board during an inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.

Reimbursement Rates

In-Network facility
Lower Premium Plan.....70%, after deductible
Standard Plan.....80%, after deductible

Out-of-Network facility
Out-of-Network reimbursement rate .....50%, after deductible

Navistar has adopted the "Prudent Layperson" definition of Medical Emergency to help Employees determine whether or not the situation is a Medical Emergency and, therefore, how the claim will be paid. The following defines what the "Prudent Layperson" standard is:

"A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a "Prudent Layperson", who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions or (iii) serious dysfunction of any bodily organ or part."

IN-NETWORK PRIMARY CARE PHYSICIAN SERVICES

Primary Care Physicians include General Practitioners, Family Practitioners, Pediatricians, Doctors of Internal Medicine, Registered Nurse Practitioners, Physician Assistants and Obstetrician/Gynecologists and related urgent care services.

Services rendered in an Office Setting
Reimbursement rate..... 100% after copay, no deductible
Lower Premium Plan.....$45 copay
Standard Plan.....$35 copay

- Allergy services are not subject to a copay unless the Physician charges for an office visit.

Services rendered outside of an Office Setting
Lower Premium Plan.....70%, after deductible
Standard Plan.....80%, after deductible

Telemedicine (Doctor On Demand)
Plan Subsidy.....$20 off normal Doctor on Demand rate

CVS Minute Clinic Program
Lower-Premium Plan……. reduced copay is $25 ($20 off the Physician's Care copay of $45)
Standard Plan ……..... reduced copay is $15 ($20 off the Physician's Care copay of $35)

Out-of-pocket expenses for healthcare services provided at a CVS Minute Clinic will accumulate under the prescription annual out-of-pocket amount. To learn more, visit https://www.cvs.com/minuteclinic.

Lab and x-ray services billed by a pathologist, anesthesiologist, radiologist, or independent lab
Lower Premium Plan …….70%, after deductible
Standard Plan …….80%, after deductible

- This applies to services which are not Routine Preventive Care.

IN-NETWORK SPECIALIST SERVICES

Services rendered in an Office Setting
Reimbursement rate..... 100% after copay, no deductible
Lower Premium Plan.....$55 copay
Standard Plan.....$45 copay

- Allergy services are not subject to a copay unless the Physician charges for an office visit.

Services rendered outside of an Office Setting
Lower Premium Plan.....70%, after deductible
Standard Plan.....80%, after deductible

Lab and x-ray services billed by a pathologist, anesthesiologist, radiologist or independent lab
Lower Premium Plan.....70%, after deductible
Standard Plan.....80%, after deductible

- This applies to services which are not Routine Preventive Care.

OUT-OF-NETWORK PRIMARY CARE PHYSICIAN SERVICES

Office visit charge only
Lower Premium Plan.....50%, after deductible
Standard Plan.....50%, after deductible

All other services
Lower Premium Plan.....50%, after deductible
Standard Plan.....50%, after deductible

Lab and x-ray services billed by a pathologist, anesthesiologist, radiologist, or independent lab
Lower Premium Plan.....50%, after deductible
Standard Plan.....50%, after deductible

Routine Preventive Care is not covered Out-of-Network.

OUT-OF-NETWORK SPECIALIST SERVICES

Office visit charge only
Lower Premium Plan.....50%, after deductible
Standard Plan.....50%, after deductible

All other services
Lower Premium Plan.....50%, after deductible
Standard Plan.....50%, after deductible

Lab and x-ray services billed by a pathologist, anesthesiologist, radiologist, or independent lab
Lower Premium Plan.....50%, after deductible
Standard Plan.....50%, after deductible

Routine Preventive Care is not covered Out-of-Network.

OTHER BENEFIT LIMITS AND MAXIMUMS

Ambulance services

Lower Premium Plan
In-Network and Out-of-Network reimbursement rate..... 70%, after deductible

Standard Plan
In-Network and Out-of-Network reimbursement rate..... 80%, after deductible

If you are transported from a Navistar facility because a Navistar 'first responder' (doctor, nurse or security personnel) made a determination that your condition required immediate transport to a Hospital via ambulance, the Plan will pay 100% of the cost of such transportation.

Breast prosthesis following mastectomy
Lifetime limit.....initial breast prosthesis

Chiropractic Services

Calendar Year limit ..... 20 visits, four modalities per visit

Lower Premium Plan
In-Network reimbursement rate ..... $55 copay, then 100%, deductible waived
Out-of-Network reimbursement rate ..... 50%, after deductible

Standard Plan
In-Network reimbursement rate ..... $45 copay, then 100%, deductible waived
Out-of-Network reimbursement rate ..... 50%, after deductible

Eyeglasses or contact lenses following cataract surgery
Lifetime limit..... initial pair of glasses or contact lenses

- Disposable contact lenses will be limited to a single box or pre-packaged supply.

Hearing
Per ear maximum ..... $500, every 36 months
In-Network and Out-of-Network reimbursement rate..... 100% up to maximum, deductible waived

- Per ear maximum applies to hearing aid only

Home Health Care
Calendar Year maximum..... 120 days

Hospice Care
Inpatient lifetime limit..... 30 days
Outpatient lifetime maximum $5,000

Occupational, Physical and Speech Therapies
Calendar Year limit……. 60 visits

Post-mastectomy bra, prescribed by a Physician
Calendar Year limit .....two

Routine Vision Services
Calendar Year maximum.....$110

- Benefits include vision exam, lenses and frames.

ROUTINE PREVENTIVE CARE
Routine Preventive Care Physicians include General Practitioners, Family Practitioners, Pediatricians, Doctors of Internal Medicine, Registered Nurse Practitioners, Physician Assistants and Obstetrician/Gynecologists. At all times, this Plan will comply with the Patient Protection and Affordable Care Act (the Affordable Care Act).

You may also contact Navistar's Employee/Retiree Information Center, (ERIC), at 1-855-331-3742 for more information about what routine Preventive Care this Plan covers.

Routine Well Adult Care

In-Network reimbursement rate ..... 100%, deductible waived

- No coverage for Out-of-Network services

Routine Well Child Care for covered Dependents through age 17
In-Network reimbursement rate ..... 100%, deductible waived

- No coverage for Out-of-Network services

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at: www.HealthCare.gov/center/regulations/prevention.html and https://www.cdc.gov/vaccines/acip/recs/index.html.

Routine Care exclusions (both Well Adult and Well Child)

- Services that are covered to any extent under any other part of this Plan or any other group plan of the Employer.
- Services that are for diagnosis or treatment of a suspected or identified Injury or disease.
- Exams given while the Covered Person is confined in a hospital or other facility for medical care.
- Services which are not given by a Physician or under his or her direct supervision.
- Psychiatric, psychological, personality or emotional testing or exams (except as required by federal law).
- Exams in any way related to employment.
- Premarital exams.
- Vision, hearing, or dental exams.
- A Physician's office visit in connection with immunization or testing for tuberculosis.

DOCTOR ON DEMAND

Doctor On Demand is a service that allows you to connect with a board-certified doctor or licensed psychologist (by appointment) face-to-face through your computer, laptop or smartphone.

Some of the medical and behavioral health conditions they treat:

- Cold & Flu
- Asthma & Allergies
- Pharmacy Rx*
- Bronchitis & Sinus Issues
- Anxiety
- Upset Stomach
- Depression
- Relationship Issues
- Eye Issues
- Pediatric Issues
- Women's Health (UTI, Yeast Infections)
- Rashes & Skin Issues

For more information, visit http://www.doctorondemand.com or call 1-800-997-6196.

*** Doctor On Demand Physicians do not prescribe DEA controlled substances and may elect not to treat or prescribe other medications based on what is clinically appropriate.**

SPECIAL IN-NETWORK PROVISIONS

Although eligible services listed within the Special In-Network Provisions section may qualify to be reimbursed at the In-Network benefit level, non-participating Providers may bill the member for all amounts billed in excess of the Allowable Charge.

- Non-contracted suppliers and specialists will be reimbursed at the In-Network level of benefits.
- If services are not available from an In-Network Provider, Covered Charges will be reimbursed at the In-Network level of benefits.
- If services from an In-Network Provider are not accessible, Covered Charges will be reimbursed at the In-Network level of benefits.
- Covered Charges for emergency and accident services will be reimbursed at the In-Network level of benefits.
- Covered Charges for inpatient or outpatient services rendered by an Out-of-Network anesthesiologist, pathologist or radiologist in connection with an In-Network facility will be paid at the In-Network level of benefits.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits. This amount will accrue toward the 100% maximum out-of-pocket payment. The Inpatient per Confinement deductible is separate from and does not apply to the Calendar Year deductible.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year.

COVERED CHARGES

All benefits described in this document are subject to the Claims Administrator's established Coverage Policy, Allowable Charge and the benefit limits and exclusions described more fully herein including, but not limited to, the determination that: care and treatment is Medically Necessary; that services, supplies and care are not Experimental and/or Investigational. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

(2) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a Covered Employee or Covered Spouse.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

There is no coverage for routine obstetrical ultrasounds.

(3) **Skilled Nursing Facility Care.** The Inpatient care in a Skilled Nursing Facility, Extended Nursing Facility or Nursing Home, for patients who no longer need the full range of the acute care hospital's services.

The facility must be approved by the Claims Administrator, the patient must be certified by the attending Physician as needing such care and the care must be substantially more than seeing to the patient's day-to-day living activities.

Covered services include skilled care ordered by a Physician, room and board, general nursing care and prescription drugs during a covered admission.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) Coverage is provided for services of Physicians for surgery, either as an inpatient or outpatient. If coverage is provided for two or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate.

(b) Payment for a covered assistant surgeon shall be limited to a single Physician, qualified to act as an assistant for the surgical procedure. Covered Charges for assistant surgery services or minimum assistant surgery services will be paid at a reduced rate which will never exceed 20% of the surgeon's Allowable Charge.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to the extent that care is Medically Necessary or not Custodial in nature.

(6) **Home Health Care Services.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. Covered services must be provided through and billed by a licensed home health agency.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan. Coverage is limited as described in the Schedule of Benefits.

Bereavement counseling services for the patient's immediate family (covered Spouse and/or covered Dependent Children) when rendered by a Hospice Care team.

(8) **Diabetes Management Services.** The Plan will pay for Diabetes Self-Management Training Program per Covered Person. Such training program must be in compliance with the national standards for diabetes self-management education programs developed by the American Diabetes Association. If there is significant change in the Covered Person's symptoms or conditions which under Coverage Policy make it necessary to change the Covered Person's diabetic management process, the Plan will pay for an additional Diabetes Self-Management Training Program. This benefit is payable for training in or out of the hospital that has been prescribed by a Physician.

The following services related to Diabetes Management are also covered by the Plan:

(a) Coverage is provided for glucometers (diabetic testing supplies).

(b) Coverage is provided for insulin pumps and pump supplies.

(c) The Plan will cover eye examinations to screen for diabetic retinopathy for Covered Persons who are diagnosed with diabetes.

(d) Coverage of routine foot care, orthopedic shoes and custom foot orthotics is provided when required for prevention of complications associated with diabetes mellitus.

(9) **Therapy Services.** Coverage is provided for inpatient and outpatient therapy services when performed or prescribed by a Physician. Such therapy services include physical and occupational therapy. Such therapy services shall include services provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate State Licensing Board.

(10) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Treatment of **Acquired Immunodeficiency Syndrome (AIDS)** is covered as any other Illness.

(b) **Allergy-related services,** including testing, extracts and injections.

(c) Local Medically Necessary professional land or air **ambulance** service to a Hospital or Skilled Nursing Facility where necessary treatment can be provided. Charges for ambulance services which do not result in transport to a medical facility are not covered.

(d) **Anesthetic**; oxygen, blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(e) **Cardiac rehabilitation** services are covered when the services are ordered by a Physician. Subject to the Occupational, Physical and Speech Therapy limits.

(f) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(g) **Cochlear implants** are covered, subject to established Coverage Policy.

(h) Initial **contact lenses** or glasses required following cataract surgery.

(i) **Contraceptive** coverage under Medical Benefits includes charges billed by Physicians for contraceptive implants, diaphragms, cervical cap, intrauterine devices (IUD's) and injections, and includes all services related to the administration, fitting and insertion of such. Pharmacy services, including oral contraceptives, contraceptive patches, rings and shields, are covered under the prescription drug program.

(j) **Dietitian services** for treatment of a covered medical condition.

(k) Coverage is provided for **Durable Medical Equipment (DME)** when prescribed by a Physician according to the guidelines specified below:

(i) Durable Medical Equipment is equipment which (1) can withstand repeated use and (2) is primarily and customarily used to serve a medical purpose and (3) generally is not useful to a person in the absence of an Illness or Injury and (4) is appropriate for use in the home.

(ii) Coverage for Durable Medical Equipment and Medical Supplies is provided when the Durable Medical Equipment is provided in accordance with Coverage Policy. Examples of Durable Medical Equipment include, but are not limited to, oxygen equipment, wheelchairs and crutches.

(iii) Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Covered Person.

(iv) When it is more cost effective, the Plan, in its discretion, will purchase, rather than lease, equipment. In making such purchase, the Plan may deduct previous rental payments from its purchase Allowance.

(a) **Eye exams** are covered when ordered by a Physician during treatment of a medical condition or Injury.

(b) **Genetic testing** is covered in accordance with established Coverage Policy.

(c) **Hearing exams** are covered when ordered by a Physician during treatment of a medical condition or Injury.

(d) **Laboratory services.**

(e) Injury to, or care of, the **mouth, teeth and gums**. Charges for Injury to, or care of, the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

(i) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

(ii) Emergency repair due to Injury to sound natural teeth. Coverage does not include Injury caused by biting or chewing.

(iii) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

(iv) Excision of bony growths of the jaw and hard palate.

(v) External incision and drainage of cellulitis.

(vi) Incision of sinuses, salivary glands or ducts.

Coverage is provided for hospital services, including anesthesia services in connection with treatment for a complex dental condition provided to: (1) a child under seven years of age who is determined by two dentists (in separate practices) to require the dental treatment without delay; (2) a Covered Person with a diagnosis of serious mental or physical condition; or (3) a Covered Person, certified by his or her Physician to have a significant behavioral problem.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, prosthetic devices, implants, grafts, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(f) **Obesity** treatment coverage, including gastric bypass surgery or any other procedure performed for the purpose of weight loss, is subject to prior written approval from the Claims Administrator, acting on behalf of the Plan Administrator.

(g) **Organ transplant** limits. Coverage is provided for human-to-human organ or tissue transplants in accordance with the following specific conditions:

(i) Not all transplants are covered. There must be a specific Coverage Policy which allows benefits for the transplant in question and the Covered Person must meet all the required criteria necessary for coverage set forth in the Coverage Policy and in this Plan Document.

(ii) Except for kidney and corneal transplants, coverage for transplant services requires Prior Approval from the Claims Administrator. A request for approval must be submitted to the Claims Administrator prior to receiving any transplant services, including transplant evaluation.

(iii) The transplant benefit is subject to the deductible, coinsurance and any applicable copays or maximums specified in the Schedule of Benefits.

(iv) Notwithstanding any other provisions, the Allowable Charge for an organ transplant, including any charge for the procurement of the organ, hospital services, Physician services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) ninety percent (90%) of the billed charges or (b) the global payment determined as payment in full by a BlueCross and BlueShield Association Blue Distinction Centers for Transplant participating facility, if the Covered Person chooses to use that facility. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network but is contracted with a local BlueCross and/or BlueShield Plan, the Allowable Charge shall be the price contracted by such BlueCross and/or BlueShield Plan. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network and does not contract with the local BlueCross and/or BlueShield plan, the Allowable Charge for the transplant services provided in the Transplant Global Period is eighty (80%) percent of the average usual and reasonable charge authorized by participating facilities in the Blue Distinction Centers for Transplant network located in the geographic region where the transplant is performed.

(v) Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. Benefits under this Plan will be payable only if there is no coverage available under the donor's plan. Donor charges include those for evaluating the organ or tissue, removing the organ or tissue from the donor and transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

(h) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(i) Services rendered by **Physician Assistants.**

(j) **Podiatry services** are limited to surgical services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root and treatment of fractures or dislocations of bones of the foot.

(k) **Prescription** Drugs (as defined) are covered under the prescription drug program administered by the pharmacy benefits manager. However, diabetic supplies purchased from a durable medical equipment vendor are covered under Medical Benefits. Coverage under Medical Benefits is available for injectable medications while confined as an inpatient, or when provided

and administered by a Physician in a clinic setting.

(l) **Routine Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by an In-Network Provider. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol and obesity.

- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

  - Women's contraceptives, sterilization procedures and counseling.
  - Breastfeeding support, supplies and counseling.
  - Gestational diabetes screening.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

https://www.healthcare.gov/coverage/preventive-care-benefits

https://www.cdc.gov/vaccines/acip/recs/index.html

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness. Standard Preventive Care shall be provided as required by applicable law if provided by an In-Network Provider. Standard Preventive Care for children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:

  - Diphtheria
  - Pertussis
  - Tetanus
  - Polio
  - Measles
  - Mumps
  - Rubella
  - Haemophilus influenzae b (Hib)
  - Hepatitis B
  - Varicella

- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

https://www.healthcare.gov/coverage/preventive-care-benefits

https://www.cdc.gov/vaccines/acip/recs/index.html

(m) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(n) **Reconstructive Surgery.** Correction of abnormal congenital conditions, reconstructive procedures following surgical treatment of an Illness or Accidental Injury and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

(o) Services rendered by **Registered Nurse Practitioners.**

(p) **Sleep apnea treatment** and **sleep studies** are covered in accordance with established Coverage Policy.

(q) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. Coverage is limited as shown in the Schedule of Benefits when performed by a licensed D.C.

(r) **Sterilization** procedures (tubal ligation and vasectomy).

(s) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(t) Treatment of **Temporomandibular Joint (TMJ) Disorder and Cranial Mandibular Disharmony** consistent with established Coverage Policy.

(u) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Allowable Charges for nursery care for the first five days after birth while the newborn child is Hospital-confined as a result of the child's birth or until the mother is discharged, whichever is less.

Charges for covered routine nursery care will be applied toward the Plan of the mother. If the mother is not covered under this Plan, charges will be applied toward the Plan of the newborn child.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician for routine pediatric care for the first five days after birth while the newborn child is Hospital-confined, or until the mother is discharged, whichever is less.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

(v) **Wigs** following chemotherapy or radiation therapy, burns or reconstructive surgery are covered.

(w) Diagnostic x-rays, magnetic resonance imaging (MRI) and other radiological procedures.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer.

Allowable Charge when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Claims Administrator, in its sole discretion, to be reasonable. The customary allowance is the basic Allowable Charge. However, Allowable Charge may vary, given the facts of the case and the opinion of the Claims Administrator.

Allowable Charges for services or supplies received out of Arkansas may be determined by the local BlueCross and BlueShield Plan. Please note that all benefits under this Plan are subject to and shall be paid only by reference to the Allowable Charge as determined at the discretion of the Plan. This means that regardless of how much a health care Provider may bill for a given service, the benefits under this Plan will be limited by the established Allowable Charge. If services are rendered by a participating Provider, that Provider is obligated to accept the established rate as payment in full and should only bill the member for Deductible, Coinsurance and any non-covered services; however, if services are rendered by a non-participating Provider, the member will be responsible for all amounts billed in excess of the Allowable Charge.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Autism Spectrum Disorder is a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Birthing Center means any freestanding health facility, place, professional office or institution that is not a Hospital, or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Surgery means any surgical procedure, including corrective plastic or reconstructive plastic surgical procedures, having the primary purpose of improving physical appearance. Cosmetic Surgery also includes any procedure required in order to correct complications caused by or arising from prior Cosmetic Surgery. However, Cosmetic Surgery does not include in connection with a mastectomy, (a) reconstruction of the breast on which the mastectomy has been performed and (b) surgery and reconstruction of the other breast to produce a symmetrical appearance.

Coverage Policy - With respect to certain drugs, treatments, services, tests, equipment or supplies, the Claims Administrator has developed specific Coverage Policies, which have been put into writing and are available upon request from the Claims Administrator. If the Claims Administrator has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that you received or seek to have covered under your Plan, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service,

test, equipment or supply meets the coverage criteria; however, the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test, equipment or supply shall not be construed to mean that such drug, treatment, service, test, equipment or supply meets the coverage criteria.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Navistar, Inc.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; Mental Health Services and substance-related and addictive disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental or Investigational. The Plan shall have full discretion to determine whether a drug, device or medical treatment is experimental or investigational. Any drug, device or medical treatment may be deemed experimental or investigational, in the Plan's discretion, if:

(1) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and final regulatory approval for marketing has not been announced to the public at the time the drug or device is furnished; or

(2) the drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval;

(3) Reliable Evidence (as defined below) shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;

(4) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

(5) Reliable Evidence (as defined below) shows that a majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure neither supports nor denies its use for a particular condition or disease.

(6) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that it should not be used as a first line therapy for a particular condition or disease.

"Reliable Evidence" shall mean only the following sources:

(a) the patient's medical records or other information from the treating Physician(s) or from a consultant(s) regarding the patient's medical history, treatment or condition;

(b) the written protocol(s) under which the drug, device, treatment or procedure is provided to the patient;

(c) any consent document the patient has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;

(d) published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the drug, device, treatment or procedure at issue as applied to the Injury, Illness or condition at issue; or

(e) the written protocol(s) used by another facility studying substantially the same drug, device, medical treatment or procedure.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third-party payer of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means a child who meets the eligibility requirements shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency.

A covered Foster Child is <u>not</u> a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic drug means a Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved Generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being Generic.

Genetic Information means information about the genetic tests of an individual or his family members and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic Information does not include information about the age or gender of an individual.

Health Intervention or Intervention means an item or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital means an acute general care Hospital, a psychiatric Hospital and a rehabilitation Hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law: Hospitals owned or operated by state or federal agencies, convalescent homes or Hospitals, homes for the aged, sanitariums, long term care facilities, infirmaries or any institution operated mainly for treatment of long-term chronic diseases.

Illness means a bodily disorder, disease, physical Sickness or mental disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

In-Network refers to a Provider who participates in the Preferred Provider Organization (PPO). Due to their nature, the Plan has classified certain services as “In-Network” and subject to the “In-Network” provisions even though the Provider or facility may not be a member of the PPO.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intellectual Disabilities means Intellectual Disabilities as described by the American Psychiatric Association.

Intensive Behavioral Therapy (IBT) is outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include Applied Behavioral Analysis (ABA), The Denver Model and Relationship Development Intervention (RDI).

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the earlier of 31 days of Employee's hire date or 60 days of the date the person becomes eligible for coverage for the first time.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of another person and managing the property and rights of that person, generally a minor child.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that a condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Health Services means Covered Charges for the diagnosis and treatment of Mental Illness. The fact that a condition is listed in the current American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders* does not mean that treatment for the condition is a covered charge.

Mental Illness means mental health or psychiatric diagnostic categories listed in the current American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, unless they are listed in Section **Plan Exclusions**.

Morbid Obesity is a diagnosed condition in which the patient has a BMI of 40 or greater, or a BMI of 36-39 with the presence of other high-risk co-morbid conditions.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center or the patient's home.

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Out-of-Network refers to a Provider not participating in the Preferred Provider Organization (PPO). Due to their nature, the Plan has classified certain services as "In-Network" provisions even though the Provider or facility may not be a member of the PPO.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place a claimed intervention is rendered. Physician also means a Doctor of Podiatry (D.P.M.), a Chiropractor (D.C.), a Psychologist (Ph.D.), an Oral Surgeon (D.D.S.) or an Optometrist (O.D.) duly licensed and qualified to perform the claimed health intervention at the time and place such intervention is rendered.

Plan means Navistar, Inc. Group Medical Plan, which is a benefits plan for certain Employees of Navistar, Inc. and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on 11/01 and ending on the following 10/31.

Preferred Provider Organization or **PPO** means the PPO with which this Plan has contracted to provide medical care, services and supplies to Plan Participants.

Preferred Provider means a facility or Physician who has a written agreement to provide health care services and supplies to PPO Plan Participants for a set fee.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Provider means a Hospital or a Physician. Provider also means a certified registered nurse anesthetist; a licensed audiologist; a chiropractor; a dentist; a licensed certified social worker; a licensed durable medical equipment Provider; an optometrist; a pharmacist; a physical therapist; a podiatrist; a psychologist; a respiratory therapist; a speech pathologist and any other type of health care Provider which the Plan Administrator, in its sole discretion, approves for reimbursement for services rendered.

Sickness is for a covered Employee covered Spouse and covered Dependent: Illness, disease or Pregnancy.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24-hour a day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance-Related and Addictive Disorder Services means Covered Charges for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders* unless those services are specifically excluded. The fact that a disorder is listed in the current American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders* does not mean that treatment of the disorder is a covered charge.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Transplant Global Period means a period of time that begins on or prior to the day of the transplant procedure and extends for a number of days after the transplant procedure. The length of the Transplant Global Period varies, depending upon the type of transplant involved.

Urgent Care Services means care and treatment for an Illness, Injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

PLAN EXCLUSIONS

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Active Duty.** Charges for an Injury sustained, or an Illness contracted while on active duty or military service, unless payment is legally required.

(2) **Acupuncture.** Charges for acupuncture unless services are rendered for anesthetic purposes.

(3) **Administrative Fees.** Fees incurred for acquiring or copying medical records, sales tax, preparation of records for other insurance carriers or insurance agencies, medical evaluation for life, disability or any type of insurance coverage.

(4) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol. The following must be present for there to be sufficient evidence for the purpose of this exclusion: (1) the results of a valid blood, breath or urine test performed by a qualified Provider indicating the Covered Person's alcohol level exceeds the legal limit in the state where the Injury or Sickness occurred or (2) a written citation from a law enforcement officer, in attendance where the Injury or Sickness occurred, indicating the Covered Person was under the influence of alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(5) **Appointments.** Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider.

(6) **Bereavement services.** Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care.

(7) **Biofeedback.** Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition.

(8) **Blood typing.** Blood typing for paternity testing.

(9) **Clinical Trials.** Services or supplies provided in connection with a phase I, II, III or IV clinical trial or any study to determine the maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. This exclusion will not apply to routine items and services that (a) would have been Covered Expenses had they not been incurred during an approved clinical trial or (b) are provided during an approved clinical trial, as required and defined under PHSA Section 2709.

(10) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

(11) **Contraceptives.** Oral contraceptives or any other type of contraception is not covered under Medical Benefits but may be covered under the Prescription Drug Program administered by the pharmacy benefits manager. See the Prescription Drug Section for information regarding limitations and conditions of coverage.

(12) **Cosmetic Surgery.** Cosmetic Surgery, care and treatment provided for cosmetic reasons. This exclusion will not apply if services are for reconstructive procedures following surgical treatment of an Illness or Accidental Injury or correction of an abnormal congenital condition. Reconstructive mammoplasty will be covered after Medically Necessary surgery.

(13) **Custodial Care.** Services or supplies for custodial, convalescent, domiciliary or support care and non-medical services to assist a Covered Person with activities of daily living.

(14) **Custodial Care Facility.** Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged are not covered. Residential long-term care facilities for Mental Health Services or eating disorders are not covered. Youth homes or any similar institution.

(15) **Delivery Charges.** Charges for shipping, packaging, handling or delivering medications are not separately covered.

(16) **Dietary and nutritional services.** Services or supplies provided for dietary and nutritional services, unless such services are for the sole source of nutrition for a covered adult.

(17) **Eating disorders.** Anorexia, bulimia and services related to eating disorders including long-term rehabilitative services are not covered. Refer to your Managed Behavioral Health program.

(18) **Educational or vocational testing.** Services for educational or vocational testing or training.

(19) **Environmental change.** Charges for environmental change including Hospital or Physician charges connected with prescribing an environmental change.

(20) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.

(21) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(22) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(23) **Foreign travel.** Care, treatment or supplies out of the United States if travel is for the sole purpose of obtaining medical services. Services received outside of the United States must be Medically Necessary to be considered eligible for coverage.

(24) **Freestanding Residential Treatment Center.** Treatment received at a Freestanding Substance Abuse Residential Treatment Center or a Freestanding Psychiatric Residential Treatment Center.

(25) **Group Therapy.** Group therapy or group counseling at any time in any setting by any Provider is not covered.

(26) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician. However, the Plan will allow charges associated with the purchase of a wig following chemotherapy.

(27) **Health and Behavior Assessment/Intervention.** Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive and social factors affecting physical health problems.

(28) **Hippotherapy.** Charges associated with hippotherapy.

(29) **Hospital Employees.** Professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(30) **Hypnotherapy.** Hypnotherapy is not covered for any diagnosis or medical condition.

(31) **Illegal Acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(32) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness resulting from that Covered Person's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person illegally using the controlled substances. A written citation from a law enforcement officer, in attendance where the Injury or Sickness occurred, indicating the Covered Person was under the influence of a controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician must be present for there to be sufficient evidence for the purpose of this exclusion. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(33) **Immunizations.** Charges for immunizations, unless listed in the Schedule of Benefits as a covered benefit.

(34) **Impacted teeth.** Charges related to surgical extraction of impacted teeth.

(35) **Infertility treatment.** Care, supplies, services and treatment for infertility, related diagnostic testing, artificial insemination and in vitro fertilization or any other procedure performed for the purpose of achieving pregnancy.

(36) **Learning Disabilities.** Services or supplies provided for learning disabilities, i.e. reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, applied behavior analysis, intensive behavioral therapy and other learning difficulties such as:

a. Services performed in connection with conditions not classified in the current edition of the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*.
b. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*
c. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder.
d. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
e. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
f. Outside of initial assessment, unspecified disorders for which the Provider is not obligated to provide clinical rationale as defined in the current edition of the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders.*
g. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine or their equivalents for drug addiction.

(37) M**arriage and Family Therapy.** Marriage and family therapy or counseling services.

(38) **Mental disorder.** Care and treatment of mental and nervous disorders. Refer to your Managed Behavioral Health program.

(39) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(40) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(41) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(42) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(43) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(44) **Obesity.** Care and treatment of non-Morbid Obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. All treatment for Morbid Obesity is subject to prior approval by the Claims Administrator, acting on behalf of the Plan Administrator. See Defined Terms section for a definition of Morbid Obesity.

(45) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(46) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines and first-aid supplies and nonhospital adjustable beds.

(47) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(48) **Prescription drugs** are not covered under Medical Benefits but are covered under the Prescription Drug program administered by the pharmacy benefits manager.

(49) **Provider Not Defined.** Services or supplies provided by an individual or entity that is not a Provider as defined in this Plan Document.

(50) **Recreational therapy.** Services or supplies provided by a recreational therapist.

(51) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(52) **Replacement of Durable Medical Equipment, prosthetic or orthotic appliances.** Replacement of Durable Medical Equipment, prosthetic or orthotic appliances due to loss or misuse.

(53) **Replacement prosthetic and orthotic devices.** Replacement of a prosthetic or orthotic device is covered no more frequently than once per three-year period except when necessitated by normal growth or when the age of the prosthetic or orthotic device exceeds the useful life. Maintenance and repair resulting from misuse or abuse of a prosthetic or orthotic device, are the responsibility of the Covered Person.

(54) **Replacement orthotics.** Replacement of braces of the leg, arm, back, neck or artificial arms or legs, unless there is sufficient change in the Covered Person’s physical condition to make the original device no longer functional.

(55) **Residential long-term care facilities for Mental Health Services or eating disorders are not covered.** Youth homes, schools, therapeutic camps or any similar institution.

(56) **Respite care**. Charges for services which provide temporary relief to family members or friends from the duties of caring for the Covered Person are not covered.

(57) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(58) **Seasonal Affective Disorder (SAD).** Use of photo therapy or light therapy to treat seasonal affective disorder or depression.

(59) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

(60) **Smoking cessation.** Care and treatment for smoking cessation programs, unless Medically Necessary due to severe active lung Illness such as emphysema or asthma.

(61) **Social worker.** Charges billed by a social worker.

(62) **Substance-Related and Addictive Disorder Services.** Care and treatment of substance abuse and chemical dependency.

(63) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization

(64) **Telephone and Other Electronic Consultation.** Telephone calls or other forms of electronic consultation (e.g. e-mail, internet or video) between a Provider and a Covered Person, or between a Provider and another Provider, for medical management or coordinating care, are not covered. This includes reporting or obtaining tests or laboratory results. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, communications made by a Physician responsible for the direct care of a Covered Person in Case Management with involved health care Providers are covered.

(65) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for: (1) ambulance charges defined as a covered expense and (2) travel and accommodation charges as defined in the transplant coverage section.

(66) **Unlicensed Provider.** Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed or (2) has had his license suspended, revoked or otherwise terminated for any reason or (3) has a license that does not include within its scope the treatment, procedure or service provided.

(67) **Vertical dimension.** Any charges related to alteration of vertical dimension, including but not limited to dental implants, surgical procedures or appliances.

(68) **War.** Any loss that is due to war, declared or undeclared, or any act of terrorism or during service in the armed forces of any county. If an Employee is on active duty for more than 30 days, the Employee and their Dependents should be covered by military health care.

(69) **Workers' Compensation.** Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Worker's Compensation law, Employer's

liability law, or occupational disease law, even though the Covered Person fails to claim rights to such benefits or fails to enroll or purchase such coverage.

VISION CARE

In response to healthcare reform, also known as the Affordable Care Act (ACA), effective November 1, 2014, Employees can choose to opt out of routine vision coverage at their initial enrollment and during the annual Open Enrollment periods.

To opt out of routine vision coverage, Employees must contact ERIC at ERICOperations@Navistar.com or at 1-855-331-ERIC (3742) within their respective timeframes of eligibility periods.

Please note: routine vision coverage will continue to be part of the medical benefit plan and carries no additional premium to remain enrolled in vision coverage. Opting out of the vision coverage will not reduce the monthly benefit premium.

VISION CARE CHARGES

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

VISION CARE CHARGES

Vision care charges is the Allowable Charge for the vision care services and supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amount shown in the Schedule of Benefits.

(1) **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 eyeglasses obtained under the prescription. It shall include: history, testing visual acuity, external examination of the eye, binocular measure, ophthalmoscopic examination, tonometry when indicated, medication for dilating the pupils and desensitizing the eyes for tonometry and summarizing the findings.

(2) **Lenses** of a quality equal to the first quality lens series manufactured by American Optical, Bausch and Lomb, Orthodon, Tilier or Univis and which met 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.

(3) **Contact Lenses** as prescribed by a Physician or Optometrist.

(4) **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.

(5) **Frames** adequate to hold Lenses which are a Covered Expense within the limits described in the Vision Limitations Section.

VISION LIMITATIONS

A Covered Person may receive the vision benefit once every 12-month period. Lenses and Frames received under the Company prescription safety glasses program for which no benefits were received under this Plan shall not be considered Lenses and Frames received under this Plan. An Employee may utilize duplicate copies of a 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 or she is otherwise eligible under both and complies with the procedures of each.

VISION EXPENSE EXCLUSIONS

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

(1) Charges for which benefits are otherwise provided under this Plan and charges set forth in General Plan Exclusions and Limitations.

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

(3) Procedures determined by the Plan to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonia Lenses and tonography.

(4) Vision testing examinations, Lenses or Frames ordered before the Covered Person became eligible for coverage or after termination of coverage.

(5) Lenses or Frames ordered while the Covered Person was eligible for benefits but delivered more than 60 days after coverage termination.

(6) Charges for vision testing examinations, Lenses or Frames that are not necessary according to accepted standards of ophthalmic practice or which are not ordered or prescribed by the attending Physician or Optometrist.

(7) 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.

(8) 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 and prescription change limitation set forth in Vision Limitations.

(9) Charges for the completion of any insurance or claim form.

COMPREHENSIVE HEARING AID BENEFITS

COVERED HEARING AID EXPENSES

Covered Hearing Aid Expenses means the charges, as outlined in the Schedule of Hearing Aid Benefits, incurred by or on behalf of a Covered Person for audiometric evaluation, hearing aid evaluation and hearing aid as described below:

(1) **Audiometric evaluation** performed by a Physician or audiologist. It shall include all tests for measuring hearing acuity such as aid conduction, bone conduction, speech reception threshold and speech discrimination.

(2) **Hearing aid evaluation,** performed by a Physician or audiologist, means a series of tests of various makes and models of hearing aids to determine which make and model will best compensate for the loss of hearing acuity. 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 aid** means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing and includes an ear mold, if necessary, but only 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.

Hearing Aid Limitations

(1) **Quantity**
The number of hearing aids will be limited to one per ear, per Covered Employee or covered Dependent.

(2) **Frequency**
If a Covered Person has received an audiometric evaluation, hearing aid evaluation or hearing aid for which benefits were paid under the Plan, benefits will be payable for each subsequent audiometric evaluation, hearing aid evaluation, or hearing aid only if received more than 36 months after receipt of the most recent previous audiometric evaluation, hearing aid evaluation or hearing aid for which benefits were payable under the Plan.

(3) **Replacement**
Replacement of the hearing aid will be covered if the hearing aid has been in use for at least three years and such replacement is made on the written recommendation of a Physician or audiologist.

HEARING AID EXPENSE EXCLUSIONS

Covered Hearing Aid expense does not include, and no benefits are payable for:

(1) Charges for services or supplies which are covered in whole or in part under any other portion of the Medical Expense Benefits Plan or under any other Medical Expense Benefits or Hearing Aid Benefits provided by the Employer, or charges set forth in General Plan Exclusions and Limitations.

(2) Audiometric examinations by an audiologist that are not ordered by a Physician.

(3) Medical or surgical treatment.

(4) Drugs or other medication.

(5) Audiometric examinations, hearing aid evaluation tests and hearing aids provided under any applicable Workers' Compensation Law.

(6) Audiometric examinations, hearing aid evaluation tests performed and hearing aids ordered before the Covered Person became eligible for coverage or after termination of coverage.

(7) Hearing aids ordered while the Covered Person was eligible for benefits but delivered more than 60 days after termination of coverage.

(8) 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 Expense Benefits coverage.

(9) 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.

(10) Charges for audiometric examinations, hearing aid evaluation tests and hearing aids that do not meet professionally accepted standards of practice, including charges for any such services or supplies that are experimental in nature.

(11) 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.

(12) Charges for audiometric examinations, hearing aid evaluation tests and hearing aids provided by any governmental agency that are obtained by the Covered Person without cost by compliance with laws or regulations enacted by a federal, state, municipal or other government body.

(13) 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 political subdivision thereof.

(14) Replacement of hearing aids that are lost, broken or stolen unless at the time of such replacement the Covered Person is otherwise eligible under the frequency limitations set forth herein.

(15) Charges for the completion of any insurance or claim form.

(16) Replacement parts for and repairs of hearing aids.

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

COST MANAGEMENT SERVICES

CERTIFICATION OF MEDICAL SERVICES

The Plan has a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

Please refer to the member ID card for the Precertification Services phone number.

The program consists of:

(a) Precertification of Medical Necessity for the following services before Medical and/or Surgical services are provided:

Inpatient Admissions
Emergency Inpatient Admissions (call must be made within 48 hours of admission)
Home Health Care
Hospice Care
Skilled Nursing Care

(b) Retrospective review of Medical Necessity of the listed services provided

(c) Concurrent review, in consideration of extended services

(d) Discharge planning.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

Precertification requirements are waived for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works:

The responsible party must call the Precertification Services telephone number on the member ID card.

Through the precertification process, the number of days of Medical Care Facility confinement authorized for payment will be determined. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

Concurrent Review, Discharge Planning

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the precertification program. The Covered Person's Medical Care Facility stay or use of other medical services will be monitored and either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services will be coordinated with the attending Physician, Medical Care Facility and Covered Person.

Responsibility for Obtaining Precertification

The following table identifies services which require precertification and who is responsible for obtaining precertification.

Services requiring precertification	**Party Responsible for Notification if Provider is In-Network**	**Party Responsible for Notification if Provider is Out-of-Network**
Inpatient admissions, including emergency admissions	**In-Network Hospital** The In-Network Hospital is responsible for any penalty amounts incurred for failure to obtain precertification.	**Covered Person** Failure to obtain precertification will result in ***no coverage for Room & Board, and/or $400*** reduction in benefits paid by the Plan. The Covered Person is responsible for reimbursing the Provider for the penalty amount.
Inpatient admissions, concurrent care extension	**In-Network Hospital** The In-Network Hospital is responsible for any penalty amounts incurred for failure to obtain precertification.	**Covered Person** Failure to obtain precertification will result in ***no coverage for Room & Board, and/or $400*** reduction in benefits paid by the Plan. The Covered Person is responsible for reimbursing the Provider for the penalty amount.
Home Health Care	**Covered Person** The In-Network Hospital is responsible for any penalty amounts incurred for failure to obtain precertification.	**Covered Person** Failure to obtain precertification will result in a ***$400*** reduction in benefits paid by the Plan. The Covered Person is responsible for reimbursing the Provider for the penalty amount.
Hospice Care	**Covered Person** The In-Network Hospital is responsible for any penalty amounts incurred for failure to obtain precertification.	**Covered Person** Failure to obtain precertification will result in ***no coverage for Room & Board, and/or $400*** reduction in benefits paid by the Plan. The Covered Person is responsible for reimbursing the Provider for the penalty amount.
Skilled Nursing Care	**Covered Person** The In-Network Hospital is responsible for any penalty amounts incurred for failure to obtain precertification.	**Covered Person** Failure to obtain precertification will result in ***no coverage for Room & Board, and/or $400*** reduction in benefits paid by the Plan. The Covered Person is responsible for reimbursing the Provider for the penalty amount.

Note: Some Out-of-Network Providers may have contracts with either the Claims Administrator or the BlueCross and BlueShield plan in the state where services were provided, which make them responsible for any penalty amounts incurred for failure to obtain precertification. The Covered Person may contact BlueAdvantage at the customer service telephone number listed on the member ID card to determine if a specific Out-of-Network Provider has this type of contract.

CASE MANAGEMENT

Case Management is a program under which nurses communicate with Plan Participants' Physicians to facilitate access to benefits under the Plan Participants' Medical Benefits Plan, to identify benefit options for outpatient or home treatment settings, and, where appropriate in the Physician's independent professional judgment, to identify and offer Plan Participants a choice of cost-effective alternatives to hospitalization. Case management nurses are licensed professionals who use their specialized skills to communicate effectively with Physicians; they do not, however, provide any medical services to Plan Participants. All treatment decisions remain exclusively with the Plan Participant and his or her Physicians.

Case management services can provide the following value-added benefits for Plan Participants and the Plan:

- maximize the benefits available under the Medical Benefits Plan;
- at the same time, identify cost-effective alternatives to high-cost treatment settings such as hospitalization;
- educate Plan Participants and their Physicians on cost-effective alternatives from which they may choose;
- provide health education to Plan Participants to empower them and their families to self-manage aspects of their care as deemed appropriate by their Physician; and,
- help Plan Participants better understand and deal with the complexities of the health care system and their Medical Benefits Plan

PREADMISSION TESTING SERVICE

Diagnostic lab tests and x-ray exams will be reimbursed according to standard Plan benefit levels when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be paid even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

MANAGED BEHAVIORAL HEALTH PROGRAM AND EAP

All Mental Health Services and Substance-Related and Addictive Disorder Services, including the Employee Assistance Program, is administered by **Optum. You may contact Optum by calling toll-free at 1-800-977-7909 or 1-866-216-9926 (TDD/TTY) or visiting their website at www.liveandworkwell.com**. The access code for all Navistar Employees is *Navistar*.

Employee Assistance Program (EAP)

The EAP can help Employees and their family members deal with many problems including:

- Interpersonal conflicts and stress
- Marital and family issues
- Chemical dependency
- Emotional problems
- Legal issues and questions
- Financial and credit concerns
- Pre-retirement planning

The EAP provides you and your eligible Dependents four sessions per person per incident per year. There is no cost to you for these sessions. To utilize EAP benefits, you must contact the EAP at the number listed above for a referral to a counselor.

If you need help beyond the four EAP sessions, and you are enrolled in the Plan, you can continue treatment under your Managed Behavioral Health Program.

Employees and their eligible Dependents who waive participation in the Plan will have access to the EAP but will not have coverage under the Managed Behavioral Health Program.

Benefits Under the Managed Behavioral Health Program
Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an alternate facility or in a Provider's office. All services must be provided by or under the direction of a properly qualified behavioral health Provider.

Benefits include the following levels of care:

- Inpatient treatment
- Residential treatment
- Partial hospitalization/day treatment
- Intensive outpatient treatment
- Outpatient treatment

Services include the following:

- Diagnostic evaluations, assessment and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Provider-based case management services
- Crisis intervention

The Mental Health Service/Substance-Related and Addictive Disorders Administrator, Optum, provides administrative services for all levels of care.

The Plan will pay for emergency services rendered to you prior to stabilization, or during periods of destabilization when you need immediate emergency care. The Plan will pay emergency care regardless of the Provider’s contract

status with Optum. You are encouraged to use appropriately the "911" emergency response system, where established, when an emergency medical condition exists that requires an emergency response.

Benefits payable under the Managed Behavioral Health Program are detailed below. These benefits apply separately to each Covered Person.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. (Medical treatment of Autism Spectrum Disorder is a Covered Charge for which Benefits are available as described under the applicable medical Covered Charge categories.)

Benefits include the following levels of care:

- Inpatient treatment
- Residential treatment
- Partial hospitalization/day treatment
- Intensive outpatient treatment
- Outpatient treatment

Services include the following:

- Diagnostic evaluations, assessment and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family and group therapy
- Provider-based case management services
- Crisis intervention

Substance-Related and Addictive Disorder Services include those received on an inpatient or outpatient basis in a Hospital, an alternate facility, or in a Provider's office. All services must be provided by or under the direction of a properly qualified behavioral health Provider.

Benefits include the following levels of care:

- Inpatient treatment
- Residential treatment
- Partial hospitalization/day treatment
- Intensive outpatient treatment
- Outpatient treatment

Services include the following:

- Diagnostic evaluations, assessment and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family and group therapy
- Crisis intervention
- Provider-based case management services
- Transitional living services

The Mental Health/Substance-Related and Addictive Disorders Administrator, Optum, provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator, Optum, for referrals to Providers and coordination of care.

Lower Premium Plan:

	In-Network	Out-of-Network
Mental Health Services Inpatient	$250 per confinement, 70% after deductible	Covered at 50% of Allowable Charge, after deductible
Mental Health Services Outpatient	$45 copay	Covered at 50% of Allowable Charge, after deductible
Psychological Testing	Covered at 100%	Covered at 50% of Allowable Charge, after deductible
Substance-Related and Addictive Disorder Services Inpatient	$250 per confinement, 70% after deductible	Covered at 50% of Allowable Charge, after deductible
Substance-Related and Addictive Disorder Services Outpatient	$45 copay	Covered at 50% of Allowable Charge, after deductible

Standard Plan:

	In-Network	Out-of-Network
Mental Health Services Inpatient	$250 per confinement, 80% after deductible	Covered at 50% of Allowable Charge, after deductible
Mental Health Services Outpatient	$35 copay	Covered at 50% of Allowable Charge,
Psychological Testing	Covered at 100%	Covered at 50% of Allowable Charge,
Substance-Related and Addictive Disorder Services Inpatient	$250 per confinement, 80% after deductible	Covered at 50% of Allowable Charge, after deductible
Substance-Related and Addictive Disorder Services Outpatient	$35 copay	Covered at 50% of Allowable Charge, after deductible

When determining annual maximums for Mental Health Service/Substance-Related and Addictive Disorders, any benefits obtained for preferred care will apply towards any non-preferred care benefits received and vice versa. Out-of-Network charges you pay for Managed Behavioral Health benefits will apply to the Plan's Calendar Year out-of-pocket maximum.

Refer to annual deductibles and out-of-pocket maximums listed in the medical benefit section: these amounts apply to medical and Mental Health Service/Substance-Related and Addictive Disorders combined.

Out-of-pocket expenses (including deductible and coinsurance amounts) incurred for In-Network care also apply towards the out-of-pocket limits for the Out-of-Network care and vice versa.

Limitations to Behavioral Health Care Expenses
Benefits are not payable for:

- Inpatient or outpatient treatment for any medically treated physical Illness (see Medical Expense Coverage section).
- Prescription Drugs (see Prescription Drug Program section).
- Treatment of mental deficiency or Intellectual Disabilities. However, in such cases, coverage may be provided for the period of time needed to evaluate and diagnose such conditions.
- Counseling required by law or a court, or paid for by workers compensation.
- Post EAP treatment that is not Medically Necessary.
- Charges excluded under the "Plan Exclusions" section or other limitations in the Plan.
- Charges in conjunction with cognitive or IQ testing.
- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*.

- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder.
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
- Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
- Outside of initial assessment, unspecified disorders for which the Provider is not obligated to provide clinical rationale as defined in the current edition of the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.

Prior Authorization Requirement

- A scheduled admission for Mental Health Services (including partial hospitalization/day treatment and services at a residential treatment facility) requires authorization prior to the admission.
- A non-scheduled admission (including emergency admissions) you must provide notification as soon as is reasonably possible.
- Partial hospitalization/day treatment; intensive outpatient treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management, requiring pre-authorization before services are received.

If the Covered Person fails to obtain prior authorization for hospital admission, a $400 penalty will apply.

Penalty is in addition to any deductible amount and will be applied to charges billed by the facility.

Claims Procedures

If the Covered Person uses an In-Network Provider, the covered person will not have to complete claim forms. If the Covered Person uses an Out-of-Network Provider, the covered person may be required to pay the Provider in full and then submit the claim to Optum for processing.

The Covered Person's claims for benefits under the Managed Behavioral Health Program should be submitted in writing to Optum, P.O. Box 30755, Salt Lake City, UT 84130-0755, on or before the second anniversary of the date incurred.

The phone number is 1-800-977-7909.

Please see section titled "Claims Procedures and Appeal Rights" for more information.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.
The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

When this Plan is the secondary or subsequent payer, the balance due shall be the amount that would have been paid by this Plan as the first payer reduced by the amount(s) paid by the other plan(s).

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Group practice and other group prepayment plans.

(3) Federal government plans or programs. This includes Medicare.

(4) Other plans required or provided by law. This does not include Medicaid or any benefit plan that, by its terms, does not allow coordination.

(5) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other In-Network only plans: This Plan will not consider any charges in excess of what an HMO or network Provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network Provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network Provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the Plan which covers the person directly (that is, as an Employee, member or subscriber) ("Plan A") are determined before those of the Plan that covers the person as a Dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired

Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

Reimbursement

This section applies when a Covered Person, or the legal representative, estate or heirs of the Covered Person (sometimes collectively referred to as the "Covered Person") recovers damages, by settlement, verdict or otherwise, for an Injury, Sickness or other condition. If the Covered Person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an Injury or Illness or the treatment of such an Injury or Illness. These benefits are specifically excluded.

However, if the Plan does advance moneys or provide care for such an Injury, Sickness or other condition, the Covered Person shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by the Covered Person (or by the legal representative, estate or heirs of the Covered Person), to the Plan for the reasonable value of the medical benefits advanced or provided by the Plan to the Covered Person, regardless of whether or not [1] the Covered Person has been fully compensated, or "made-whole" for his/her loss; [2] liability for payment is admitted by the Covered Person or any other party; or [3] the recovery by the Covered Person is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over the Covered Person, or any other party, to receive reimbursement of the benefits advanced on the Covered Person's behalf. This reimbursement shall be from any recovery made by the Covered Person, and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans) and direct recoveries from liable parties.

In order to secure the rights of the Plan under this section, and because of the Plan's advancement of benefits, the Covered Person hereby [1] acknowledges that the Plan shall have first priority against proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and [2] assigns the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. The Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement of judgment, including a Covered Person's claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions. The Plan will provide its own form of written reimbursement agreement that every Covered Person will be required to sign. If the Plan pays a claim in the absence of a reimbursement agreement, or pays a claim in error, that payment will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights to reimbursement or a lien. By accepting any benefits advanced by the Plan under this section, a Covered Person acknowledges that any proceeds of settlement of judgment, including the Covered Person's claim to such proceeds, held by the Covered Person or by another person, are being held for the benefit of the Plan under these provisions.

The Covered Person shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The Covered Person shall not take any action that prejudices the Plan's rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section and/or to set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat

this right.

The Plan's reimbursement and lien rights apply without regard to state law limitations on any and all liens, including, but not limited to, liens against workers compensation recoveries, and the Plan specifically disavows any claims that a Covered Person may make under such state law defenses.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of Covered Person, whether under comparative negligence or otherwise.

A Covered Person, and those acting on his/her behalf, shall hold in a constructive trust for the Plan a portion of any third party recovery in the amount of the Recoverable Amount paid by the Plan. The Covered Person, and those acting on his/her behalf, shall place and maintain such portion of any recovery in a separate, segregated account until any dispute concerning reimbursement or lien rights is resolved and the Plan receives all amounts that must be reimbursed. The location of the account, name of the custodian, if any, and the account number must be provided to the Plan. The Recoverable Amount includes: (a) any and all amounts paid by the Plan in relation to the Injury, Sickness or Illness or related treatment; (b) any and all administrative fees and expenses paid in relation to the claim such as to a third party administrator; and (c) any and all costs and reasonable attorney fees (even to appeals), regardless of the amount of the actual recovery.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's Injury, Sickness or other condition (including insurance carriers who are financially liable) and the Plan has advanced benefits.

In consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's Injury or Illness, or is or may be liable for the payment for the medical treatment of such Injury or occupational Illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person. This right includes, but is not limited to, the Covered Person's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Covered Person's rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Covered Person, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses. The Plan will provide its own form of written subrogration agreement that every Covered Person will be required to sign. If the Plan pays a claim in the absence of a subrogation agreement, or pays a claim in error, that payment will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights to subrogation.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that the Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Covered Person shall be borne solely by the Covered Person.

Suspension of Benefits

The Plan may suspend or withhold benefits from the Covered Person, if he or she fails to cooperate or comply with the reimbursement, subrogation and recovery terms of the Plan or if payment is made in error under the Plan.

If the Plan learns that a Covered Person has received a recovery without making reimbursement to the Plan, the Plan has the right to suspend benefits or withhold any pending and/or future benefits that the Covered Person or his or her Dependents may be entitled to receive until the Plan has been reimbursed. Benefits should recommence after the total amount of payments withheld equals the Recoverable Amount due to the Plan.

The Plan may suspend benefit payments for claims related to Injury, Sickness or Illness caused by or claimed to be caused by a third-party until the Covered Person returns a signed subrogation agreement and/or reimbursement agreement to the Plan Administrator. The Plan may also suspend benefits or withhold pending and/or future benefit payments if the Covered Person refuses to provide information to the Plan or otherwise refuse to cooperate with the Plan Administrator.

The Plan may also offset Recoverable Amounts against pending and/or future benefit claims related to the Covered Person or the Covered Person's Dependents; and may recover any mistaken payments or overpayments made on the Covered Person's Dependents' behalf by offsetting against pending and/or future benefit claims related to the Covered Person or Covered Person's Dependents.

The Plan may settle reimbursement claims or liens on terms other than as provided under the Plan, as it may deem prudent.

PRESCRIPTION DRUG BENEFITS

Navistar's Prescription Drug program pays for drugs that are prescribed by a Physician to treat a disease, Injury, Pregnancy or Illness.

Prescription Drugs are legend drugs under the Food, Drug, and Cosmetic Act that are required, at a minimum, to contain the symbol "Rx only."

Navistar's Prescription Drug program is administered by Navistar's Pharmacy Benefits Manager (PBM), CVS Caremark, Inc. at 1-866-559-6851 or at www.caremark.com.

The two components to this program are:

- Home Delivery/Mail Service Program
- Retail Pharmacy Program

Eligibility

Under the Plan, the Covered Person will automatically receive Prescription Drug coverage through the CVS Caremark program. The Covered Person's drug coverage will be effective the same day the medical coverage is effective.

There will be a separate ID card for Prescription Drug benefits from CVS Caremark.

Summary of Prescription Drug Benefits

Navistar's Prescription Drug program allows for three different copayment levels on prescription benefits:

1st Tier (Generic)	Generics are FDA- Brand Name equivalents. Generic medicines typically have the lowest copay.
2nd Tier (Brand Name/Formulary)	Brand Name/Formulary medicines typically have a higher cost than Generics. Brand Name/Formulary drugs, which are typically lower in cost than the Non-Formulary Brand, are based on their clinical effectiveness, safety profile and relative cost. Such Brand Name/Formulary drugs are listed on CVS Caremark's Preferred Drug List (PDL); usually carries the middle copayment level (excluding medication categories on a Therapy Protocol, see section later in this summary plan description.). The PDL includes medications from most major pharmaceutical manufacturers.
3rd Tier (Brand Name/Non-Formulary)	Brand Name/Non-Formulary drugs are not included on CVS Caremark's PDL and usually have the highest copay. To help determine which medications are on the PDL and the appropriate copayment under the Navistar plan, contact CVS Caremark.

If a Prescription Drug is dispensed by a Pharmacy to a Covered Person for Medically Necessary treatment of a disease, Injury, Pregnancy or Illness, a benefit will be paid, determined by the following summary, but only if the Pharmacy's charge for the drug is more than the applicable copayment per prescription or refill and subject to the other limitations and exclusions provided in the Plan.

Prescription Drugs are covered under the Prescription Drug program administered by the Pharmacy Benefits Manager.

Lower Premium Plan

	Mail Order Program	Retail Pharmacy Program
Days Supply	Up to a **90-day** supply for each prescription/refill	Up to a **30-day** supply for each prescription/refill
Copayment	$20 Generic 25% ($60 min - $120 max) Brand Name/Formulary 50% Brand Name/Non-Formulary 25% ($200 maximum) specialty	$10 Generic 25% ($30 min - $60 max) Brand Name/Formulary 50% Brand Name/Non-Formulary 25% ($100 maximum) specialty
Non-participating Pharmacy	N/A	25% of Allowable Charge plus copayment

Standard Plan

	Mail Order Program	Retail Pharmacy Program
Days Supply	Up to a **90-day** supply for each prescription/refill	Up to a **30-day** supply for each prescription/refill
Copayment	$30 Generic 25% ($60 min - $100 max) Brand Name/Formulary 50% Brand Name/Non-Formulary 25% ($200 maximum) specialty	$15 Generic 25% ($30 min - $50 max) Brand Name/Formulary 50% Brand Name/Non-Formulary 25% ($100 maximum) specialty
Non-participating Pharmacy	N/A	25% of Allowable Charge plus copayment

Note: By law, certain controlled substances (called schedule II drugs) are limited to a 30-day supply with no refills.

Maximum Prescription Drug Out-of-Pocket payments, per Calendar Year

The Covered Person will pay the copayments/coinsurance above until the following amounts of out-of-pocket payments are reached, at which time the Plan will pay 100% of the remainder of covered drugs for the rest of the Calendar Year unless stated otherwise.

Lower Premium Plan
Per Covered Person.....$4,350
Per Family Unit.....$8,700

Standard Plan
Per Covered Person.....$4,850
Per Family Unit.....$9,700

The medical out-of-pocket maximum amounts and the pharmacy out-of-pocket amounts are totally separate and do not contribute toward or offset each other.

Mail Order Drug Program

The mail order drug program is administered by CVS Caremark. Up to a 90-day supply of any Prescription Drug is covered by the Plan through the mail order Pharmacy. The Covered Person will be responsible for a copayment as described above. To get started with the mail order program, contact CVS Caremark.

Retail Pharmacy Program

The retail Pharmacy program is administered by CVS Caremark.

Mandatory 90-day supply for maintenance medications

For every maintenance medication (defined as the 2nd refill of the same Rx product), the beneficiary shall use the mail order option or fill through a CVS pharmacy – See "CVS Caremark Maintenance Choice® Program" below). In the event the beneficiary elects to continue receiving the maintenance medication through a non-CVS retail Pharmacy, the beneficiary shall be responsible for 100% of the applicable cost.

The only exception to this provision will be for individuals using mail order who will run out of their medication prior to the arrival of their scheduled shipment. The PBM's customer service representative will coordinate immediate outreach to the Participant's retail Pharmacy of choice to transfer the prescription to the retail Pharmacy for immediate availability of a short-term supply at the applicable retail copayment on a pro-rated basis.

CVS Caremark Maintenance Choice® Program

If the Covered Person takes any medications on a regular basis, such as those used to treat high blood pressure or diabetes, the Covered Person can save time and money by using the CVS Caremark Maintenance Choice® Program. The Covered Person may use this program for any medication that requires more than two refills; after that, the Covered Person will pay the full cost of the medication at a retail pharmacy, except at a CVS pharmacy.

When the Covered Person purchases prescriptions through the CVS Caremark Maintenance Choice® Program, the Covered Person pays the mail order copayment or coinsurance and receives up to a 90-day supply of the Covered Person's medication for the Covered Person's maintenance prescriptions. The Covered Person may use the CVS Caremark Mail Service Pharmacy to have the Covered Person's medications sent directly to the Covered Person's home, or the Covered Person has the convenience of getting the Covered Person's long-term medications at a CVS pharmacy location at the mail order cost.

Breast Cancer Preventive Services Coverage

Effective for Plan Years beginning on or after September 24, 2014, the Generic drug tamoxifen and the Generic drug raloxifene have been added to the CVS Caremark ACA preventive services coverage recommendations. This aligns with the U.S. Preventive Services Task Force (USPSTF) action taken on September 24, 2013, which added a new recommendation that clinicians offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.

The Plan will cover the drugs tamoxifen and raloxifene at $0 cost-sharing when they are prescribed for *primary prevention* in women at increased risk for breast cancer.

Diabetes Care

Beginning 1/1/2018, certain diabetes medications will only be covered if the Covered Person gets them in 90-day supplies at CVS Pharmacy® or through CVS Caremark® Mail Service Pharmacy. This program, offered by Navistar, helps people with diabetes stay on track with their care and better manage their health. The program provides Employees with personalized tools and support and helps save money on diabetes medications.

Drug categories not covered

Due to the availability of many over-the-counter medications, the following classes of drugs are no longer covered under the Plan:

- *Proton Pump Inhibitors (PPIs)**:*
  For example: Prilosec, Prevacid, Aciphex, Protonix, Nexium, etc.
- *Non-Sedating Antihistamines (NSAs):*
  For example: Claritin, Allegra, Clarinex, etc.
- *Non-Steroidal Anti-Inflammatory Drugs (NSAIDs):*
  For example: aspirin, ibuprofen, naproxen, Toradol, Lodine, Indocin, etc.

*** There is an exception for people with Barrett's Esophagitis and Zollinger-Ellison Syndrome. In order to apply for this exception, you will need to appeal to Caremark when your claim is denied.*

If the Covered Person wishes to use Caremark's discounts, the Covered Person may still use their prescription drug ID card at the Pharmacy. However, the Covered Person will be paying 100% of the cost of the drug.

Lifestyle drugs

The Plan no longer covers lifestyle and related medications in the following therapeutic classes: erectile dysfunction and cosmetic (including acne, skin depigmentation, hair growth, hair removal and anti-wrinkle) medications.

Participating Pharmacy

Under the retail Pharmacy program, higher level benefits are available if you use a participating Pharmacy to obtain your prescription. To locate a participating Pharmacy, contact CVS Caremark.

Non-participating Pharmacy

A non-participating Pharmacy is one that does not have an agreement with CVS Caremark to provide Prescription Drug services.

Purchased Prescription Drugs from a non-participating Pharmacy will require payment of Pharmacy's full charge for each Prescription Drug or refill at the time it is filled. Upon submission of a claim to CVS Caremark, the Plan will pay 75% of the *actual cost* or Allowable Charge, whichever is lower, less the retail Pharmacy copayment for each covered Prescription Drug or refill. Submit claim forms to:

CVS Caremark, Inc.
P.O. Box 52196
Phoenix, AZ 85072-2196

Please note you must submit your Prescription Drug claim within 90 days of the date filled in order for it to be eligible for reimbursement under the Plan.

MANAGEMENT PROGRAMS

Generic Step Therapy Program

Generic Step Therapy is a program designed to make sure that you get the safest, most effective and reasonably priced medications for you and your family. You may be required to first try other drugs before "stepping up" to drugs that cost more. This helps you save money by using less costly prescriptions when it makes sense. Step therapy programs are developed using Food and Drug Administration (FDA) guidelines, clinical evidence and research.

A clinically appropriate, cost effective standard process will include the following steps in determining the medication prescribed:

A tier one (Generic) medication must be the first recommended course of treatment. A **2-Generic** requirement for select drug classes (such as ARBs, Cox2 and Urinary Antispasmodics) in which three or more Generics are available will be required. In these classes, participants and beneficiaries must try two Generics before a Brand Name is covered. All other classes have a **1-Generic requirement** only. In the event the tier one therapy failed to improve or manage the condition, a Formulary Brand drug from CVS Caremark's Preferred Drug List (PDL) would be the next step in therapy. A documented medical history of the condition and evidence of having tried a tier one medication are a prerequisite to qualifying for step two therapy. A receipt of purchase or a Physician's record of prescribing a drug for the patient, along with an explanation of why it was inappropriate or not effective, constitutes evidence. When a Brand Name/Formulary drug is qualified as step two therapy, it will be reimbursable at the lower cost second tier

level. If the Brand Name/Formulary drug is ordered without completing the qualifying first step, the required copayment is 50% of the cost (i.e., the Brand Name/Non-Formulary cost).

If the second tier, Brand Name/Formulary drug from the CVS Caremark PDL is not effective in treating the condition, a Brand Name/Non-Formulary (third tier) drug requiring a copayment of 50% of the cost may still be an alternative.

An Employee may appeal the coverage of a prescription medication if he or she believes an error has been made in determining the appropriate tier level. All appeals should be in writing. The appeal letter and supporting written documentation should be mailed to:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

More detailed information concerning the right of appeal is described under the section titled "Claims Procedures and Appeal Rights". From time to time, brand drugs may move from the 2nd Formulary tier to the 3rd Non-Formulary tier and vice versa. For a list of the drugs and their respective tiers, contact CVS Caremark to request the most up-to-date PDL free of charge.

Managed Prior Authorization

To ensure safety in taking certain prescribed medications while helping to manage the rising cost of these drugs, the Prescription Drug program provides coverage for some drugs only if they are prescribed for certain uses, time periods and/or quantities. For this reason, some medications must receive prior authorization before they can be covered under the Plan.

Drug categories and examples of drugs that fall into these categories affected by this change are:

- Anti-influenza (e.g. Relenza, Tamiflu)
- Antiemetic therapy (e.g. Anzemet, Kytril, Zofran)
- COX-2 inhibitors or arthritic medications (e.g. Celebrex)
- Hypnotic agents (e.g. Ambien, Sonata)
- Migraine medications (e.g. Amerge, Axert, Imitrex, Maxalt, Toradol, Zomig)
- Onychomyxcosis or infection medications (e.g. Diflucan, Lamisil, Sporanox)
- Compound drugs – when costs are in excess of $300 – see guidelines below

Once the Physician has provided the information needed to make a coverage decision, CVS Caremark will contact the Covered Person about the decision. This process typically takes two business days.

If the medication is not approved by CVS Caremark, either the Physician may decide an alternate medication is appropriate or the Covered Person has the option to pay the full cost of the drug. The Covered Person also has the option to appeal this decision to Navistar. Please refer to the section of the booklet entitled "Claims Procedures and Appeal Rights" for further information on how to file an appeal.

Compound Drugs

All compound medications over $300 in total cost will be subject to a Prior Authorization for medical necessity. Compound medications below $300 in total cost will not be subject to Prior Authorization. A compound medication is one that is made by combining, mixing or altering ingredients in response to a prescription to create a customized medication that is not otherwise commercially available.

Specialty Pharmacy Program

The Specialty Pharmacy Program provides high-quality personal health and Pharmacy services for specialty pharmaceuticals that the Covered Person or eligible Dependent are being prescribed or may need in the future. Specialty pharmaceuticals are a category of drugs, derived from advances in drug development research, technology and design that target and treat chronic or Genetic conditions.

Some examples of such conditions and common specialty medication are:

Multiple Sclerosis drugs Avonex and Copaxone
Rheumatoid Arthritis drugs Enbrel or Humira
Hepatitis C drug Pegasys

CVS Caremark Specialty Pharmacy Services is Navistar's exclusive Provider for specialty medications and will coordinate your care with you and your Physician. CVS Caremark has a dedicated Pharmacy and service department that provides you with:

- Personal attention for patient's unique needs
- Condition-specific education and training
- 24 hours a day, 7 days a week pharmacist assistance
- Ease of delivery of medication to the location of the Covered Person's choice
- Care coordination with the Physician
- Proactive refill reminders

For further questions or to receive the most up-to-date Specialty Drug List free of charge, please contact CVS CaremarkConnect® toll-free at 1-800-237-2767 Monday through Friday 6:30 a.m. – 8:00 p.m. CT.

Specialty Pharmacy Step Therapy Program

The step therapy program encourages utilization of clinically appropriate and the most cost-effective medications within the following therapy classes:

- Autoimmune (rheumatoid arthritis, Crohn's disease, psoriasis)
- Multiple sclerosis

Limitations and Exclusions from coverage under the Prescription Drug plan:

- Prescription Drug charges paid for by another group benefit plan.
- Devices of any type, even if they require a prescription (including therapeutic devices, artificial appliances, hypo-spray jet injectors, support garments, bandages and other similar items).
- Drugs used for cosmetic purposes.
- Prescription Drug refills dispensed more than one year from the date of the Physician's last prescription. A new prescription from the Physician may be required if the number of refills has not been indicated on the prescription and the actual number of refills appears to be excessive.
- Benefits provided under medical benefits such as drugs billed by a Hospital in conjunction with an inpatient confinement. The medical plan covers these charges as part of Hospital expense.
- Drugs used for the treatment of impotence (e.g. Viagra, Caverject, Edex, Muse), unless approved through the managed prior authorization program.
- Drugs that are entirely consumed at the time and place of prescription.
- Administration or injection of any drug, except as provided for in the medical benefits section. (Administration or injection is covered under the medical benefits.
- Drugs for which the pharmacist's charge is less than the copayment.

- More than a 30-day supply of medication, except for prescriptions filled through the mail order drug program or for the legend maintenance drugs listed earlier.
- Needles and syringes, except when prescribed at the same time as insulin.
- Benefits excluded under the “Plan Exclusions” section or other limitations in the Plan.

Note: Diabetic test strips and lancets are covered under the Durable Medical Equipment benefit under the medical benefits section.

Claim Procedures and Appeal Rights

Initial Claims for Benefits

Any claim for eligibility to participate in the Plan should be submitted in writing to Navistar, Inc., Employee/Retiree Information Center, P.O. Box 4080, Lisle, IL 60532.

Your claims under the Plan for Medical Expense, Vision Care and Comprehensive Hearing Aid benefits should be submitted in writing to **BlueAdvantage Administrators of Arkansas**, P.O. Box 1460, Little Rock, AR 72203-1460. Claims should be submitted on a properly completed standardized claim form, including any medical documentation necessary in order to review your claim, or, in the case of electronically filed claims, providing BlueAdvantage Administrators of Arkansas (BAAA) with the data elements that they specify in advance. Most Providers participating in the BAAA network are aware of the claim filing requirements and will file claims for you. Claims must be submitted and received by BAAA within 24 months after the service takes place to be eligible for benefits. In order to file a pre-service claim, you or your Provider must call BAAA's Customer Service Department at 1-888-872-2531 and must submit your claim in writing (or orally for an urgent pre-service claim) with a complete description of the services to be provided, along with the appropriate diagnosis code(s) and other relevant medical background required to evaluate your prior approval request under the Plan. (Note: Pre-service claims are limited to claims for which the Plan requires prior approval of benefits before the service is provided; for all other claims, the Plan does not allow for pre-service determination of claims or coverage, but instead requires that a written (or oral, in the case of an urgent claim) claim fully describing the services be submitted following the services, at which time an evaluation of coverage will be made in accordance with the terms and conditions of the Plan. Pre-service claims determinations, where required by the Plan, do not guarantee coverage but mean only that coverage will not be denied for lack of medical necessity if correct information has been submitted for pre-service claims review, and prior approval has been given as required under the Plan. All other terms and conditions of the Plan still must be met for the pre-service claim to eventually be paid in accordance with the Plan's terms. Courtesy pre-determinations (described more fully, below) may be available from BAAA in some limited instances, but do not constitute pre-service claims).

Your claims under the Plan for Prescription Drug benefits should be submitted in writing to **CVS Caremark, Inc.**, Appeals Department, MC109, P.O. Box 52084, Phoenix, AZ 85072-2084 or faxed to 1-866-689-3092. Claims must be submitted within 90 days of the date incurred to be eligible for benefits. The phone number is 1-866-559-6851.

Your claims under the Plan for benefits under the Managed Behavioral Health Program should be submitted in writing to Optum, P.O. Box 30755, Salt Lake City, UT 84130-0755. Claims must be submitted on or before the second anniversary of the date incurred to be eligible for benefits. The phone number is 1-800-977-7909.

Depending on the nature of your claim under the Plan, any reference to the **"Claims Administrator"** shall mean Navistar, BlueAdvantage, CVS Caremark, or Optum, as appropriate.

Notification of Benefit Determinations-Special Rules

Urgent Care Claims. You will be notified of the Plan's decision (whether adverse or not) on your claim for urgent care as soon as possible, but not later than 72 hours after receipt of your claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of your claim by the Plan, of the specific information needed to complete your claim. You will have at least 48 hours to provide the specified information. You will be notified of the Plan's benefit determination as soon as possible, but not later than 48 hours after the Plan's receipt of the specified information, or, if earlier, the end of the period afforded you to provide the specified additional information. If your claim is denied, you will be notified in the manner set forth below.

Concurrent Care Claims. If your Plan has approved Plan coverage for an ongoing course of treatment, any reduction or termination of coverage for such course of treatment shall be considered a denial of Plan benefits. You will be notified in the manner set forth below of any denials of coverage for ongoing treatment at a time sufficiently in advance of the reduction or termination of Plan benefits to allow you to appeal and obtain a determination on appeal of your denial before your Plan benefits are reduced or terminated. If you request that coverage for your course of treatment be extended beyond the period of time or number of treatments and it is a claim involving urgent care, you will be notified of the Plan's decision on your claim within 24 hours after receipt of the claim by the Plan, provided that your claim is made to the Plan at least 24 hours prior to the expiration of your original course of treatment. If your claim is denied, whether your claim involves urgent care or not, you will be notified in the manner set forth below.

Pre-Service Claims. You will be notified of the Plan's decision (whether adverse or not) on your pre-service claim not more than 15 days after receipt of your claim by the Plan. This period may be extended by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and you shall be afforded at least 45 days from the receipt of the notice within which to provide the specified information. In order to expedite the receipt of the information, the Claims Administrator may request it from your Provider. In the event that a period of time is extended due to a failure to submit information necessary to decide your claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Courtesy pre-determinations are not pre-service claims under the Plan. If you ask for a courtesy pre-determination, the Claims Administrator will use commercially reasonable efforts to provide you with a timely response. However, the Claims Administrator will not be bound by the time frames and standards that apply to pre-service claims. Additionally, it may not be possible for the Claims Administrator or any other party to pre-determine coverage for a particular proposed treatment, procedure or service, in which case the Claims Administrator may decline to state any position on coverage prior to actual receipt of a claim following administration of the services and evaluation of all related medical documentation to determine whether Plan coverage is available. In order to request a courtesy pre-determination, you or your Provider should call the Claims Administrator at the number listed on your member ID card.

Failure to Follow Procedures in Filing a Pre-Service Claim. If you fail to properly file a pre-service claim, the Claims Administrator will notify you of the failure within 24 hours (for urgent pre-service claims) or 5 days (for non-urgent pre-service claims). The Claims Administrator's notification may be oral unless you ask for it in writing. The Claims Administrator will provide this notification to you only if (i) your attempt to submit a pre-service claim was received by a person or organizational unit of the Claims Administrator that is customarily responsible for handling benefit matters, and (ii) your submission contains the name of a Plan member, a specific condition or symptom and a specific treatment or service for which approval is being requested.

Post-Service Claims. You will be notified of the Plan's decision (whether adverse or not) on your post-service claim not more than 30 days after receipt of your claim by the Plan. This period may be extended by the Plan one time for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and you shall be afforded at least 45 days from the receipt of the notice to provide the specified information. In order to expedite the receipt of the information, the Claims Administrator may request it from your Provider. In the event that a period of time is extended due to a failure to submit information necessary to decide your claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Authorized Representative. An authorized representative may act on your behalf in filing claims and appeals. The Claims Administrator may request that you complete a form to designate your authorized representative. The Claims Administrator will determine whether a person is actually authorized to act as your representative. However, if your claim is a claim for urgent care, a health care professional with knowledge of your medical condition shall be authorized to act on your behalf. Contact the Claims Administrator at the number listed on your member ID card for further details.

Manner and Content of Your Notification of Benefits Determination

Any notification of a benefits determination will be provided in writing or in electronic media (such as email) in a manner easily understood by a reasonable layperson. Notification of urgent care claims may be provided orally with written or electronic notice furnished within 3 days of oral notice.

If your claim for benefits is denied, your notice will: (i) state the specific reasons for your denial; (ii) state the specific Plan provisions on which your denial was based; (iii) provide a description of any additional material or information necessary for you to perfect your claim and an explanation of why this material or information is necessary; (iv) include a description of the Plan's appeals process and the time limits applicable to such appeal, with a statement of your right to bring a civil action under section 502(a) of ERISA following a denial of your appeal; (v) if your denial was based on Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge at your request; and (vi) if your denial was based on an internal rule, protocol, guideline or similar criterion, such internal rule, protocol, guideline or similar criterion will be included or a statement that such internal rule, protocol, guideline or similar criterion was relied upon and that you may obtain a copy of such internal rule, guideline, etc. upon your request and free of charge will be included. If your denial concerns an urgent care claim, your notification will provide you with a description of the Plan's expedited review process.

Appealing Your Denial

Except in the case of a pre-service claim under the Plan involving Medical Expense, Vision Care, or Comprehensive Hearing Aid benefits (described more fully, below), there are two levels of appeal offered under the Plan.

If you wish to file an appeal of a claim denial, you must file your first level appeal request in writing (unless special urgent care procedures apply). Your appeal must contain at least the following information: a statement that you are filing an appeal; the patient's name; the patient's contract number; and sufficient information to reasonably identify the claim or claims being appealed, such as date of service, Provider name, procedure and claim number and/or the Claims Report.

Except in the case of a pre-service claim under the Plan involving Medical Expense, Vision Care, or Comprehensive Hearing Aid benefits (described more fully, below), if you are not satisfied with the results of the first level appeal and wish to pursue another appeal under the Plan, you must file your second level appeal request in writing (unless special urgent care procedures apply). Your second level appeal should set forth all bases upon which you disagree with the results of the first level appeal and should be accompanied by all supporting documentation or information that you or your authorized representative or Physician believe is relevant to the appeal determination.

Your first and second level appeal under the Plan involving eligibility to participate in the Plan should be submitted to Navistar, Inc., Employee/Retiree Information Center, P.O. Box 4080, Lisle, IL 60532.

Your first and second level appeal under the Plan involving Medical Expense, Vision Care or Comprehensive Hearing Aid benefits should be sent to BlueAdvantage Administrators of Arkansas, Attention: Customer Service Appeals, P.O. Box 1460, Little Rock, AR 72203-1460.

Your voluntary (after first and second level) appeal under the Plan involving Medical Expense, Vision Care, or Comprehensive Hearing Aid benefits should be sent to Navistar, Inc., Employee/Retiree Information Center, P.O. Box 4080, Lisle, IL 60532.

Your first and second level appeal under the Plan involving Prescription Drug benefits should be sent to CVS Caremark, Inc., Appeals Department, MC109, P.O. Box 52084, Phoenix, Arizona 85072-2084 or fax to 1-866-689-3092. The phone number is 1-866-559-6851.

Your first and second level appeal under the Plan involving benefits under the Managed Behavioral Health should be sent to Optum Employers Division Appeals, P.O. Box 32040, Oakland, CA 94604 or fax to 1-415-547-6259. The phone number is 1-800-888-2998 x5182.

Special Rule Applicable to Pre-Service Claims Under the Plan Involving Medical Expense, Vision Care, or Comprehensive Hearing Aid Benefits (where the Plan requires prior approval of benefits before the service is provided and you either have been denied such prior approval or disagree with a limitation on that approval):

Unlike post-service claims under the Plan involving Medical Expense, Vision Care, or Comprehensive Hearing Aid benefits, pre-service claims for such benefits have only one level of appeal, which is exclusively handled and decided by BAAA. Appeals for such pre-service claims must be submitted to BAAA in writing, although you may make the initial contact via telephone if you follow up with submission of a written request. The time for processing your pre-service claim appeal shall not begin to run until BAAA receives your written appeal request. To begin the process with a telephone call, you may call BAAA's Customer Service Department at 1-888-872-2531. In order to submit a valid written appeal, you should send your letter to the following address:

BlueAdvantage Administrators of Arkansas
Attention: Customer Service Appeals
P.O. Box 1460
Little Rock, AR 72203-1460

Your written appeal should list your name, contract number, the name of the facility or Provider involved, the date(s) of service and the statement that you are filing an appeal.

General Procedures Applicable to Your Appeals

Each level of appeal will provide you with a full and fair review which includes the following procedures:

(1) Your appeal must be filed within 180 days after you received notification of the benefit denial or adverse benefit determination, or, in the case of a second level appeal, within 180 days after you received notification of the first level appeal determination.

(2) The opportunity to submit written comments, documents, records and other materials relating to your claim for benefits for review upon appeal. This information will be taken into account on appeal regardless of whether it was initially submitted with your claim.

(3) The opportunity for reasonable access to and copies of, at your request and free of charge, any documents, records or other information relevant to your claim.

(4) The review will not defer to any prior denial and will be conducted by a Plan fiduciary who is neither the individual who made the initial denial (or denial upon appeal), nor a subordinate of such an individual.

(5) The review will take into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in your initial claim denial.

(6) If your denial was based on a medical judgment of any kind, including a determination with regard to whether a particular treatment, drug or other item is Experimental, Investigational or not Medically Necessary or appropriate, a health care professional with appropriate experience and training in the areas relevant to your claim will be consulted in making your benefit decision upon appeal. Such health care professional will not be any individual who was previously consulted with regard to your claim or a

subordinate of that individual.

(7) Identification of any medical or vocational experts who were consulted on behalf of the Plan regarding your claim denial, without regard to whether any advice provided by such individuals was relied upon.

(8) If your claim involves urgent care, you will have the opportunity to use an expedited review process. You will be able to file your request for appeal orally or in writing and all necessary information (including the Plan's determination on appeal) will be transmitted via telephone or via facsimile or other available similarly expeditious method; provided, however, the Claims Administrator may require follow-up submission of written information from you to verify the information submitted via telephone.

Benefit Decisions on Appeal-Special Rules

Urgent Care Claims. You will be notified of the decision on your urgent care appeal (both first and second) as soon as possible, but no later than 72 hours after the receipt by the Claims Administrator of your request for appeal.

Pre-Service Claims. You will be notified of the decision on your pre-service appeal within 15 days of the receipt by the Claims Administrator of your request for appeal (both first and second); provided, however, in the case of a pre-service claim under the Plan involving Medical Expense, Vision Care, or Comprehensive Hearing Aid benefits (where only one level of appeal is offered under the Plan), you will be notified of the decision on your pre-service appeal within 30 days of the receipt by BAAA of your request for appeal.

Post-Service Claims. You will be notified of the decision on your post-service claim within 30 days of the receipt by the Claims Administrator of your request for appeal (both first and second).

Manner and Content of Your Notification of Benefits Determination on Appeal

Any notification of benefits determination on appeal will be provided in writing or in electronic media (such as email) in a manner easily understood by a reasonable layperson.

If your appeal for benefits under the Plan is denied, your notice will: (i) state the specific reasons for your denial; (ii) state the specific Plan provisions on which your denial was based; (iii) state that you are required to receive, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to your claims; (iv) include a description of the Plan's voluntary appeals process, if any; (v) include a statement of your right to bring a civil action under section 502(a) of ERISA; (vi) if your denial was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge at your request; and (vii) if your denial was based on an internal rule, protocol, guideline or similar criterion, such internal rule, protocol, guideline or similar criterion will be included or a statement that such internal rule, protocol, guideline or similar criterion was relied upon and that you may obtain a copy of such internal rule, guideline, etc. upon your request and free of charge will be included.

Additional Voluntary Appeal Rights

After you have exhausted your appeals as outlined above, you may also appeal for a full and fair review by Navistar. You do not, however, have to make this appeal before you can bring a civil action under Section 502(a) of ERISA, and if you bring such an action the Plan waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit the benefit dispute to this voluntary appeal. Further, if you do make this voluntary appeal to Navistar, the statute of limitations or other defense based on timeliness is tolled during the time that the voluntary appeal is pending. A voluntary appeal will have no effect on your right to any other benefits under the Plan. Decisions on voluntary appeal will be made pursuant to the same time schedule as first level appeals, except that a voluntary appeal of a pre-service claim shall be responded to in 30 days instead of 15 days and a post-service claim in 60 days instead of 30 days. If special circumstances require an extension of time for processing, you

will be notified in writing. In that case, a decision will be made as soon as possible, but not later than 120 days after Navistar receives your request for review. The manner and content of notification on appeal will be similar to the notification on a first level appeal.

Your voluntary appeal must be submitted to Navistar, Inc., Employee/Retiree Information Center, Attention: Health Plan Specialist, P.O. Box 4080, Lisle, IL 60532. The phone number is 1-855-331-3742 and email is ERICOperations@Navistar.com. Your request must be in writing, except for urgent care appeals, and must be received within 60 days after you received notification of the second level appeal denial from the Claims Administrator.

Additional Terms

In the case of a claim for benefits under the Plan, benefits hereunder will be paid only if the appropriate reviewer of the claim or appeal, as appropriate, decides, in its complete and sole discretion, that you are entitled to such benefits.

The final decision on an appeal will be accorded judicial deference in any later court action or administrative proceeding to the extent that it does not constitute an abuse of discretion and is not arbitrary or capricious.

You must exhaust the Plan's appeal procedures (with the exception of the Additional Voluntary Appeal Rights described above) before you are permitted to bring any court action or administrative proceeding.

The Plan contains a three (3) year statute of limitations. Notwithstanding any other state or federal law, any and all legal actions relating to the Plan must be filed within three (3) years of the action or inaction complained of. This includes, but is not limited to, actions to recover benefits that must be filed within three (3) years of the final decision on your claim. The situs of Plan is in DuPage County, Illinois. Legal actions must be brought in the United States District Court for the Northern District of Illinois.

Definitions

"Urgent care claim" means a claim for medical care with respect to which the application of large time periods could seriously jeopardize your life, health or ability to regain maximum function, or in the opinion of a Physician, would subject you to severe pain that could not be adequately managed without the care that is the subject of the claim.

"Pre-service claim" means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

"Post-service claim" means any claim for a benefit that is not a pre-service claim.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. This request must be filed in writing within four months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll-free number (1-866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the four-month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating Provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Appeals Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the plan.

AUTHORIZED REPRESENTATIVE

One Authorized Representative. A Covered Person may have one representative and only one representative at a time, to assist in submitting a claim or appealing an Adverse Benefit Determination.

Authority of Authorized Representative. An Authorized Representative shall have the authority to represent the Covered Person in all matters concerning the Covered Person's claim or appeal of a claim determination. If the Covered Person has an Authorized Representative, references to or "Covered Person" in the provision of this document entitled "How to Submit a Claim" refer to the Authorized Representative.

Designation of Authorized Representative. One of the following persons may act as a Covered Person's Authorized Representative:

(1) An individual designated by the Covered Person in writing in a form approved by the Claims Administrator;

(2) The treating Provider, if the claim is a claim involving urgent care or if the Covered Person has designated the Provider in writing in a form approved by the Claims Administrator;

(3) A person holding the Covered Person's durable power of attorney;

(4) If the Covered Person is incapacitated due to Illness or Injury, a person appointed as guardian to have care and custody of the Covered Person by a court of competent jurisdiction; or

(5) If the Covered Person is a minor, the Covered Person's parent or Legal Guardian, unless the Claims Administrator is notified that the Covered Person's claim involves health care services where the consent of the Covered Person's parent or Legal Guardian is or was not required by law and the Covered Person shall represent himself or herself with respect to the claim.

Term of the Authorized Representative. The authority of an Authorized Representative shall continue for the period specified in the Covered Person's appointment of the Authorized Representative or until the Covered Person is legally competent to represent him or herself and notifies the Claims Administrator in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative.

(1) If the Authorized Representative represents the Covered Person because the Authorized Representative is the Covered Person's parent or Legal Guardian or attorney in fact under a durable power of attorney, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

(2) If the Authorized Representative represents the Covered Person in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

(3) If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Claims Administrator will send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Covered Person, but the Claims Administrator will provide copies of such correspondence to the Authorized Representative upon request.

(4) The Covered Person understands that it will take the Claims Administrator at least 30 days to notify all its personnel about the termination of the Covered Person's Authorized Representative and it is possible that the Claims Administrator may communicate information about the Covered Person to the Authorized Representative during this 30-day period.

ASSIGNMENT OF BENEFITS

You and your Dependents' right to receive benefit payments, appeal a claim, or bring a cause of action against the Plan is personal to you or your Dependents. Any claim or rights under the Plan, which includes, but is not limited to, any right to appeal a claim under the procedure set forth in the Plan document, any right to bring a cause of action against the Plan in any forum, or any right to receive benefits or benefit payments from the Plan, is not assignable or transferrable in whole or in part to any other person, Provider, or other entity at any time. Any assignment or transfer of a claim or other rights to receive benefit payments is void unless you or your Dependents receive written consent from Navistar, Inc. Nothing in this clause will prevent the Plan from paying a Provider or similar entity directly and any such payment shall not constitute a waiver of this anti-assignment clause. In addition, Navistar, Inc.'s consent or lack thereof to the assignment or transfer of benefits does not affect your or your Dependents' eligibility for benefits under the Plan.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Navistar, Inc. Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is:
Navistar, Inc.
2701 Navistar Drive
P.O. Box 4080
Lisle, Illinois, 60532
1-855-331-3742

The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Change in Status Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Change in Status Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Change in Status Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Change in Status Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Change in Status Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Change in Status Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law Employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that

constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Change in Status Event? A Change in Status Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Change in Status Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Change in Status Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Change in Status Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Change in Status Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Change in Status Event. A Change in Status Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Change in Status Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. (These pre-existing condition exclusions will only apply during Plan Years that begin before January 1, 2014.) Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Change in Status Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Change in Status Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Change in Status Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Change in Status Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Change in Status Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Change in Status Event within 30 days following the date coverage ends when the Change in Status Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the Employer, or

(4) entitlement of the Employee to any part of Medicare.

IMPORTANT:

For the other Change in Status Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee within 60 days after the later of (1) the date of the Change in Status Event or (2) the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan, using the procedures specified below. If these procedures are not followed during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice that you provide must be ***provided to ERIC by calling 1-855-331-ERIC (3742), by emailing ERICOperations@navistar.com***, or sending written notice to the following address:

Navistar, Inc.
2701 Navistar Drive
P.O. Box 4080
Lisle, Illinois 60532

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Change in Status Event** and the **date** it happened.

If the Change in Status Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Change in Status Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Change in Status Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Change in Status Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

To the extent permitted by law, the Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Change in Status Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Change in Status Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Change in Status Event if there is not a disability extension and 29 months after the Change in Status Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Change in Status Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Change in Status Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(4) In the case of any other Change in Status Event than that described above, the maximum coverage period ends 36 months after the Change in Status Event.

Under what circumstances can the maximum coverage period be expanded? If a Change in Status Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Change in Status Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Change in Status Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Change in Status Event. The Plan Administrator must be notified of the second Change in Status Event within 60 days of the second Change in Status Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not that individual is the covered Employee) who is a Qualified Beneficiary in connection with the Change in Status Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

Are There Other Coverage Options Besides COBRA Coverage? Instead of enrolling in COBRA coverage, there may be other options for coverage through the Health Insurance Marketplace, Medicaid, or another group health plan. Some of these options may cost less than COBRA coverage.

Health Insurance Marketplace. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Through the Marketplace, an individual could be eligible for a tax credit with lower monthly premiums and cost-sharing reductions with lower out-of-pocket costs for deductibles, co-insurance, and copayments. Individuals have a 60-day special enrollment period following the loss of job-based coverage in which to enroll in the Marketplace. After 60 days, the special enrollment period will end, and they may not be able to enroll until the Marketplace's next annual open enrollment period. Visit www.HealthCare.gov to learn more.

Enrollment in Another Group Health Plan. An individual may be eligible to enroll in coverage under another group health plan (such as a spouse's plan) if the individual requests enrollment within 30 days of the loss of coverage. If the individual or Dependent chooses to elect COBRA coverage instead of enrolling in another group health plan for which they are eligible, that person may have another opportunity to enroll in the other group health plan within 30 days of losing their COBRA coverage.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay up to 102% of the applicable premium and up to 150% of the

applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either: (1) under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period, or (2) under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at https://www.dol.gov/agencies/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Navistar, Inc. Health Plan is the benefit plan of Navistar, Inc., the Plan Administrator, also called the Plan Sponsor. The Plan is administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Navistar, Inc. to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Navistar, Inc. shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s) and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

HIPAA PRIVACY AND SECURITY FIREWALL

The following summary establishes the circumstances under which the Plan may share a Plan Participant's protected health information with the Plan Administrator (the Employer) and limits the uses and disclosures that the Plan Administrator may make of a Plan Participant's protected health information. This is intended to establish the firewall protections required under the Health Insurance Portability and Accountability Act of 1996 and its attendant privacy regulations, 45 C.F.R. Parts 160 and 164, as amended (the "HIPAA Privacy Rules" or "Rules").

There are three circumstances under which the Plan may disclose a Plan Participant's protected health information to the Plan Administrator.

First, the Plan may inform the Plan Administrator whether a Plan Participant is enrolled in the Plan.

Second, the Plan may disclose summary health information to the Plan Administrator. The Plan Administrator must limit its use of that information to obtaining quotes from reinsurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying the Plan participant.

Third, the Plan may disclose a Plan Participant's protected health information to the Plan Administrator for Plan administrative purposes. This is because Employees of the Plan Administrator perform many of the administrative functions necessary for the management and operation of the Plan.

CERTIFICATION OF FIREWALL AMENDMENT

The Plan Administrator hereby certifies to the Plan that the Plan's terms have been amended to incorporate the terms of this summary. The Plan Administrator has agreed to abide by the terms of this summary. The Plan's privacy notice also permits the Plan to disclose the Plan Participant's protected health information to the Plan Administrator as described in this summary.

RESTRICTIONS ON USE OR DISCLOSURE OF PHI

Here are the restrictions that apply to the Plan Administrator's use and disclosure of a Plan Participant's protected health information.

(1) The Plan Administrator will only use or disclose a Plan Participant's protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA Privacy Rules. See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.

(2) If the Plan Administrator discloses any protected health information to any of its agents or subcontractors, the Plan Administrator will require the agent or subcontractor to keep Plan Participants' protected health information as required by the HIPAA Privacy Rules.

(3) The Plan Administrator will not use or disclose a Plan Participant's protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Administrator.

(4) The Plan Administrator will promptly report to the Plan any use or disclosure of a Plan Participant's protected health information that is inconsistent with the uses or disclosures allowed in this summary.

(5) The Plan Administrator will allow a Plan Participant or the Plan to inspect and copy any protected health information about the Plan Participant that is in the Plan Administrator's custody and control, as permitted or required by the HIPAA Privacy Rules, subject to certain exceptions recognized in the Rules.

(6) The Plan Administrator will amend, or allow the Plan to amend, any portion of a Plan Participant's protected health information to the extent permitted or required under the HIPAA Privacy Rules.

(7) With respect to some types of disclosures for purposes other than payment or health care operations, the Plan Administrator will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). Plan Participants have a right to see the disclosure log. The Plan Administrator does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations, or if a Plan Participant authorized the disclosures.

(8) The Plan Administrator will make its internal practices, books, and records, relating to its use and disclosure of a Plan Participant's protected health information available to the Plan and to the U.S. Department of Health and Human Services upon their request.

(9) The Plan Administrator will, if feasible, return or destroy all protected health information in the Plan Administrator's custody or control that the Plan Administrator has received from the Plan or from any business associate when the Plan Administrator no longer needs the protected health information to administer the Plan. If it is not feasible for the Plan Administrator to return or destroy protected health information, the Plan Administrator will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

If the Plan Administrator creates, receives, maintains, or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan, it will:

(1) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) ensure that the adequate separation between the Plan and Plan Administrator (i.e., the firewall), required by 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(3) ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

(4) report to the Plan any security incident of which it becomes aware.

DESIGNATION OF FIREWALL DEPARTMENT

The following classes of Employees or other workforce members under the control of the Plan Administrator (sometimes referred to as the "Firewall Department" for HIPAA Privacy Rules purposes) are hereby designated in accordance with HIPAA Privacy Rules firewall provisions to be given access to protected health information for the purposes set forth in this document:

Employees assigned to and working in the Human Resources Department, including but not limited to all Employees whose job duties require communication and interaction with the third-party administrator for the group health plan regarding any plan administration, claims or eligibility-related matters.

The above designation includes every class of Employees or other workforce members under the control of the Plan Administrator who may receive protected health information. If any of these Employees or workforce members use or disclose protected health information in violation of the rules that are set out in this summary, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Administrator becomes aware of any such violations, the Plan Administrator will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions and to mitigate any harmful effects to Plan participants.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

Plan is not an Employment Contract

The Plan is not to be construed as a contract for or of employment.

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse or other Dependents if there is a loss of coverage under the Plan as a result of a Change in Status Event. Employees or Dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

The Employee or Dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the Plan, when a person becomes

entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at https://www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Notice regarding Women’s Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a Medically Necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

(1) reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending Physician and the patient and will be subject to the same annual Deductibles and Coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on the back of your member ID card.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan and the administration is provided through a Third-Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Navistar, Inc. Health Plan

PLAN NUMBER: 534

TAX ID NUMBER: 36-1264810

PLAN EFFECTIVE DATE: 11/1

PLAN YEAR ENDS: 10/31

EMPLOYER INFORMATION

Navistar, Inc.
2701 Navistar Drive
P.O. Box 4080
Lisle, Illinois 60532
1-855-331-3742

PLAN ADMINISTRATOR

Navistar, Inc.
2701 Navistar Drive
P.O. Box 4080
Lisle, Illinois 60532
1-855-331-3742

NAMED FIDUCIARY

Navistar, Inc.
2701 Navistar Drive
P.O. Box 4080
Lisle, Illinois 60532
1-855-331-3742

AGENT FOR SERVICE OF LEGAL PROCESS

Navistar, Inc.
Office of the General Counsel
2701 Navistar Drive
P.O. Box 4080
Lisle, Illinois 60532
1-855-331-3742

CLAIMS ADMINISTRATOR

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas 72203-1460
1-888-872-2531

BlueAdvantage Administrators of Arkansas is an independent licensee of the BlueCross and BlueShield Association. BlueAdvantage Administrators does not underwrite or assume any financial risk with respect to the claims liability of the Plan.