CATERPILLAR INC.
RETIREE BENEFIT PROGRAM

SUMMARY OF MATERIAL MODIFICATIONS

This Summary of Material Modifications ("SMM") summarizes recent changes made to the Caterpillar Inc. Retiree Benefit Program (the "Program"). This SMM also supplements or modifies the information presented to you in the Summary Plan Description ("SPD") with respect to the Program. **Please keep this document with your copy of the SPD for future reference**.

SUMMARY OF CHANGES

The following changes are effective January 1, 2022 unless otherwise noted.

Changes Related to Affordable Care Act Coverage – Effective January 1, 2023, you may revoke your family coverage election under the Program if 1) a family member is eligible for a special enrollment period to enroll in a "qualified health plan" through an "exchange" pursuant to guidance issued by the Department of Health and Human Services and other applicable guidance; and 2) the revocation of your family coverage election corresponds to the intended enrollment of your family member in a qualified health plan through an exchange for new coverage that is effective no later than the day immediately following the last day of your coverage under the Program.

Covered Health Services - the following changes and clarification have been made:

Gender Dysphoria: Coverage for the treatment of Gender Dysphoria is currently based on identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence based professional society guidance. Since standards and guidance are updated routinely, please contact the Claims Administrator for additional details.

Influenza Vaccinations: Effective November 15, 2021, coverage for influenza vaccinations may be determined as Medical Benefits or as Prescription Drug Benefits.

Insulin Pumps: Effective November 15, 2021, insulin pumps may be determined as Medical Benefits with the exception of those listed on the Caterpillar Drug Formulary which may be determined under the Prescription Drug Benefit.

Prescription Drug Benefit Limitations: Charges for digital therapeutics, cell and gene therapy are excluded unless listed on the Caterpillar Drug Formulary.

Online Security Tips – Refer to the attached document for basic ways to help prevent fraud when using online accounts. Although some of the references are to retirement accounts, the tips are equally applicable to all of your online interactions. You may also access this information online at https://www.dol.gov/sites/dolgov/files/ebsa/key-topics/retirement-benefits/cybersecurity/online-security-tips.pdf.

ADDITIONAL INFORMATION

If you have any questions about this SMM or the Program, please contact the Caterpillar Benefits Center at 1-877-228-4010 or 1-718-354-1345 (outside the U.S.) or via internet access at CatBenefitsCenter.com.

The official plan documents control the actual payment of benefits and the administration of the Program and the FSA Plan. This SMM merely highlights the changes made to the Program and does not replace the plan documents. In the case of any discrepancy between this SMM, the SPD or the official Plan documents, including any and all amendments, the terms of the Plan documents control.

The SPD (including this Summary of Material Modifications ("SMM") within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and the regulations issued thereunder) is based on the official plan document (which includes all amendments). Every effort has been made to give you the correct and complete information about your benefits. However, if the SPD and/or this SMM inadvertently say anything that grants greater rights or benefits to participants or beneficiaries than the official plan documents, then the official plan documents will govern. You may obtain a copy of the plan documents from the Plan Administrators.

The Plan Administrators retain the sole and complete discretionary authority to determine eligibility and entitlement to plan benefits and to construe the terms of the plans, including the making of any factual determinations. The Plan Administrators also have the sole discretionary authority to grant or deny benefits under the plans. Benefits under the plans will be paid only if the Plan Administrators decide, in their sole discretion, that the applicant is entitled to them. The decisions of the Plan Administrators shall be final and conclusive to all questions relating to the plans.

No benefits under the plans are vested. The Caterpillar Inc. (or its duly authorized designee) reserves the sole discretionary authority to amend or terminate the plans in whole or in part for any reason and at any time. Any such amendment or termination may affect the benefits payable to you and/or your Dependents.

ONLINE SECURITY TIPS

You can reduce the risk of fraud and loss to your retirement account by following these basic rules:

• REGISTER, SET UP AND ROUTINELY MONITOR YOUR ONLINE ACCOUNT

- Maintaining online access to your retirement account allows you to protect and manage your investment.
- Regularly checking your retirement account reduces the risk of fraudulent account access.
- Failing to register for an online account may enable cybercriminals to assume your online identify.

• USE STRONG AND UNIQUE PASSWORDS

- Don't use dictionary words.
- Use letters (both upper and lower case), numbers, and special characters.
- Don't use letters and numbers in sequence (no "abc", "567", etc.).
- Use 14 or more characters.
- Don't write passwords down.
- Consider using a secure password manager to help create and track passwords.
- Change passwords every 120 days, or if there's a security breach.
- Don't share, reuse, or repeat passwords.

• USE MULTI-FACTOR AUTHENTICATION

- Multi-Factor Authentication (also called two-factor authentication) requires a second credential to verify your identity (for example, entering a code sent in real-time by text message or email).

• KEEP PERSONAL CONTACT INFORMATION CURRENT

- Update your contact information when it changes, so you can be reached if there's a problem.
- Select multiple communication options.

• CLOSE OR DELETE UNUSED ACCOUNTS

- The smaller your on-line presence, the more secure your information. Close unused accounts to minimize your vulnerability.
- Sign up for account activity notifications.

• BE WARY OF FREE WI-FI

- Free Wi-Fi networks, such as the public Wi-Fi available at airports, hotels, or coffee shops pose security risks that may give criminals access to your personal information.
- A better option is to use your cellphone or home network.

• BEWARE OF PHISHING ATTACKS

- Phishing attacks aim to trick you into sharing your passwords, account numbers, and sensitive information, and gain access to your accounts. A phishing message may look like it comes from a trusted organization, to lure you to click on a dangerous link or pass along confidential information.

- Common warning signs of phishing attacks include:
  - A text message or email that you didn't expect or that comes from a person or service you don't know or use.
  - Spelling errors or poor grammar.
  - Mismatched links (a seemingly legitimate link sends you to an unexpected address). Often, but not always, you can spot this by hovering your mouse over the link without clicking on it, so that your browser displays the actual destination.
  - Shortened or odd links or addresses.
  - An email request for your account number or personal information (legitimate providers should never send you emails or texts asking for your password, account number, personal information, or answers to security questions).
  - Offers or messages that seem too good to be true, express great urgency, or are aggressive and scary.
  - Strange or mismatched sender addresses.
  - Anything else that makes you feel uneasy.

- **USE ANTIVIRUS SOFTWARE AND KEEP APPS AND SOFTWARE CURRENT**
  - Make sure that you have trustworthy antivirus software installed and updated to protect your computers and mobile devices from viruses and malware. Keep all your software up to date with the latest patches and upgrades. Many vendors offer automatic updates.

- **KNOW HOW TO REPORT IDENTITY THEFT AND CYBERSECURITY INCIDENTS**
  - The FBI and the Department of Homeland Security have set up valuable sites for reporting cybersecurity incidents:
    - **https://www.fbi.gov/file-repository/cyber-incident-reporting-united-message-final.pdf/view**
    - **https://www.cisa.gov/reporting-cyber-incidents**

Caterpillar Inc.
Retiree Benefit Program

Summary Plan Description

Caterpillar Retirees Who Retired On or After February 1, 1991, Caterpillar Global Mining LLC Retirees, and Certain Solar Turbines Incorporated Retirees

* * *

This Summary Plan Description ("SPD") describes benefits for:

- ***Certain salaried, management and non-bargained hourly retirees of Caterpillar Inc. and related companies, other than Caterpillar Global Mining LLC and Solar Turbines Incorporated, who retired under the Caterpillar Inc. Retiree Benefit Program on or after February 1, 1991; and***
- ***Certain salaried, management and non-bargained hourly retirees of Caterpillar Global Mining LLC (formerly known as Bucyrus International, Inc.); and***
- ***Certain salaried, management and hourly retirees of Solar Turbines Incorporated.***

Benefits of retirees who retired under the Caterpillar Inc. Retiree Benefit Program prior to February 1, 1991 are described in another summary. Benefits of retirees who retired from Solar Turbines Incorporated as salaried employees on or before January 1, 1986 are described in another summary.

ISSUED NOVEMBER 2022
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INTRODUCTION

ABOUT THIS DOCUMENT

This document is a summary of the retiree welfare benefits provided by Caterpillar Inc. (the "Company") under the Caterpillar Inc. Retiree Benefit Program (the "Program"), which was formerly known as the Caterpillar Inc. Group Insurance Program.

This SPD describes benefits under the Program for eligible individuals who retired from Caterpillar Inc. or a Participating Company (other than Caterpillar Global Mining LLC or Solar Turbines Incorporated) on or after February 1, 1991, eligible individuals who retired from Caterpillar Global Mining LLC, and certain eligible individuals who retired from Solar Turbines Incorporated. This SPD does not describe benefits under the Program for those eligible individuals who retired from Caterpillar Inc. prior to February 1, 1991 or those eligible individuals who retired from Solar Turbines as salaried employees on or before January 1, 1986. The benefits of such individuals are described in other summaries.

Program eligibility has been completely closed to newly hired and rehired employees as of the dates set forth below. Except for certain rehired retirees, employees hired or rehired by Caterpillar Inc. or a Participating Company (other than Solar Turbines Incorporated) on or after January 1, 2013 are not eligible to participate in the Program. Salaried employees of Solar Turbines Incorporated hired or rehired on or after January 1, 2014 are not eligible to participate in the Program. Hourly employees of Solar Turbines Incorporated hired or rehired on or after January 1, 2016 are not eligible to participate in the Program.

The provisions of this SPD are generally effective January 1, 2022. You are encouraged to read this SPD in its entirety.

To help you understand your benefits, the SPD is divided into the following sections:

- *Eligibility and Participation* – This section describes the eligibility requirements of the Program and how to enroll in Program coverage.
- *Traditional Healthcare Benefits* – The following sections describe the Traditional Healthcare Benefits available to Eligible Persons under the Program (Age 64 and Under):
    - *Traditional Medical Coverage* – This section describes the medical coverage available to Eligible Persons under the Program.
    - *Traditional Prescription Drug Coverage* – This section describes the prescription drug coverage available to Eligible Persons under the Program.
    - *Traditional Dental Coverage* – This section describes the dental coverage available to Eligible Persons under the Program.
    - *Traditional Vision Coverage* – This section describes the vision coverage available to Eligible Persons under the Program.
- *Health Savings Account* – This section contains general information about the HSA, though the HSA is not a component of the Program and is not an employee welfare benefit plan.
- *Health Reimbursement Arrangement (HRA) Benefits* – This section describes the HRA benefits available to Eligible Persons under the Program (Age 65 and Older).
- *Life Insurance Benefits* – This section describes the life insurance benefits available to Eligible Persons under the Program.
- *Voluntary Benefits* – This section describes the voluntary benefits to Eligible Person under the Program.
- *General Administration* – This section describes (i) how to file a claim and the appeals process under the Program; (ii) the legal provisions applicable to the Program, and (iii) the Program's contact information, including contact information for the Plan Administrator and Claims Administrator.

- *Definitions* – Certain capitalized words have special meanings. The Definitions section contains the definitions for these capitalized words.

OFFICIAL PLAN DOCUMENT OVERVIEW

This SPD is based on the official plan documents for the Program.

In the event of any discrepancy between this SPD and the official plan documents, those plan documents will govern. Specifically, when this SPD says anything that grants or provides greater rights or benefits than the plan documents, the plan documents control.

This SPD is not a contract, and is not a guarantee of your benefits.

BENEFITS NOT VESTED

No benefits under the Program are vested and the Company does not intend to vest you in any benefits under the Program under any circumstances.

TEMPORARY COST-SHARING PROVISIONS

Suspension of Cost-Sharing for COVID-19 Testing and Related Visits

Effective March 18, 2020 through the end of the National Emergency Period, the Program is temporarily suspending cost-sharing (Annual Deductible, Co-insurance and Co-payments) for COVID-19 testing and other related respiratory illness testing and related office visits (including virtual visits), Urgent Care Center and Emergency room visits where the test is ordered or administered, pursuant to applicable law and in accordance with the Claims Administrator's procedures. Benefits for COVID-19 treatment and Hospital admission are payable by the participant in accordance with the Program's terms.

Suspension of Cost-Sharing for Non-COVID-19 Telehealth Visits

Effective March 27, 2020 through December 31, 2022 (unless otherwise provided by applicable law), the Program is temporarily suspending cost-sharing (Annual Deductible, Co-insurance and Co- payments) for non-COVID-19 telehealth visits with specific telehealth Network Providers (as determined by the Claims Administrator), in accordance with the Claims Administrator's procedures. This temporary suspension of cost-sharing does not include telehealth visits provided by non-Network Providers.

Coverage of COVID-19 Vaccinations

Effective March 27, 2020 through the end of the National Emergency Period (unless otherwise provided by applicable law), for pre-Medicare eligible participants, the Program is temporarily suspending cost-sharing (Annual Deductible, Co-insurance and Co-payments) for FDA-authorized COVID-19 vaccines, regardless of the administering Provider's or pharmacy's network status, in accordance with the Claims Administrator's procedures.

The cost-sharing rules under this provision will apply to a specific COVID-19 vaccine that has been: (i) recommended by the United States Preventive Services Task Force as an evidence- based item or service with an A or B rating; or (ii) recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Following expiration of this temporary provision as related to non-Network Providers, normal Program rules (including regular cost-sharing requirements, if applicable) for vaccines and preventive services apply. Please note, for participants enrolled in Medicare on a primary basis (Medicare pays before the Program pays benefits), COVID-19 vaccines and administration fees may be covered by Medicare at no cost to the participant.

A SPECIAL NOTE ABOUT MEDICARE

For additional information regarding Medicare, please see page 25, *When a Covered Person Qualifies for Medicare*.

RETIREES OF CATERPILLAR GLOBAL MINING LLC

Medical Benefits

Retirees of Caterpillar Global Mining LLC (formerly known as Bucyrus International, Inc.) who previously were eligible for retiree medical benefits under the Caterpillar Global Mining Legacy Salaried Employees Welfare Plan are eligible to enroll in the medical benefits of the Program, regardless of their retirement date. However, no employees, former employees or retirees of Caterpillar Mining LLC or its subsidiaries are eligible for the HRA feature of this Program.

Life Insurance Benefits

Effective January 1, 2014, certain salaried retirees of Caterpillar Global Mining LLC who retired before January 1, 2014 who previously were eligible, as of December 31, 2013, for retiree life insurance under the Caterpillar Global Mining Legacy Salaried Employees Welfare Plan became eligible for the benefits described in *Life Insurance Benefits for Certain Former Salaried Employees of Caterpillar Global Mining LLC*. Such retirees are not eligible for any other benefits under the Program.

RETIREES OF SOLAR TURBINES INCORPORATED

Effective January 1, 2017, Solar Turbines Incorporated became a Participating Company under the Program. Retirees of Solar Turbines Incorporated who were eligible for retiree benefits under the Solar Turbines Incorporated Retiree Insurance Program as of December 31, 2016 became eligible to enroll in the Program for coverage effective January 1, 2017. Individuals who retire from Solar Turbines Incorporated on or after January 1, 2017 are eligible for coverage under the Program, provided they meet the applicable eligibility requirements. No salaried employee hired or rehired by Solar Turbines Incorporated on or after January 1, 2014 and no hourly employee hired or rehired by Solar Turbines Incorporated on or after January 1, 2016 shall be eligible to participate in the Program. In addition, no hourly employees described in this paragraph are eligible for the HRA Feature of the Program.

CONTACT THE ADMINISTRATOR

Throughout this SPD you will find statements that encourage you to contact the Claims Administrator or the Plan Administrator for further information. Whenever you have a question or concern regarding eligibility, covered services, any required procedure, or about the Program generally, please contact the Claims Administrator for the particular benefit or the Plan Administrator at the number stated in the section entitled *Contact Information* beginning on page 121.

ELIGIBILITY AND PARTICIPATION

Eligibility For The Program

This *Eligibility* section describes the eligibility requirements for participation in the Program.

In addition to the requirements described in this section, other sections of this SPD may describe additional eligibility requirements that you must satisfy to be eligible for the particular benefits described in those sections.

Individual	Eligibility Requirements
You	Generally, retirees who, at the time of their retirement, were classified as a salaried, management, non-bargained hourly, bargained hourly employee whose collective bargaining agreement provides for participation in the Program, or Part-Time Employee of Caterpillar Inc. or a Participating Company and who were participants in the Employee Program are eligible for participation. This SPD only describes the benefits of those eligible retirees of: (a) Caterpillar Inc. or a Participating Company (other than Caterpillar Global Mining LLC or Solar Turbines Incorporated) who retired on or after February 1, 1991; and (b) Caterpillar Global Mining LLC (formerly known as Bucyrus International, Inc.), regardless of their retirement date; and (c) Solar Turbines Incorporated (other than salaried employees who retired on or before January 1, 1986). The Program is closed to: • Former employees hired or rehired by Caterpillar Inc. or a Participating Company (other than Solar Turbines Incorporated) on or after January 1, 2013, except for certain rehired retirees; • For medical expense provisions, former employees of Bucyrus International, Inc. who were hired on or after January 1, 2005 and before July 9, 2011; • Former employees of Caterpillar or an Affiliate who were hired on or after July 9, 2011 but prior to January 1, 2013 into positions in which they were designated as employees of Caterpillar Global Mining LLC; • Former salaried employees of Solar Turbines Incorporated who were hired or rehired on or after January 1, 2014; and • Former non-bargained hourly employees of Solar Turbines Incorporated who were hired or rehired on or after January 1, 2016. When the words “you” and “your” are used in this SPD, they generally refer to people who are Covered Persons as the term is defined in the *Definitions* section beginning on page 123. Note: If your employment terminates for Cause, you are not eligible for participation in the Program under any circumstances.
Retirees	
Retirees	***Caterpillar Retirees*** You are eligible to participate in the Program as a retiree and this SPD describes your benefits if: 1. You retired from the Company or a Participating Company (other than Solar Turbines Incorporated) on or after February 1, 1991 but prior to January 1, 2011 and you: (a) were a participant in the Program as a retiree on December 31, 2010 or (b) were eligible to participate in the Program as a retiree on December 31, 2010; or

	2. You meet the applicable eligibility requirements described in Appendix A. ***Caterpillar Global Mining Retirees*** You are eligible to participate in the Program as a retiree and this SPD describes your benefits if: 1. You retired from Caterpillar Global Mining LLC (formerly known as Bucyrus International, Inc.) or its subsidiaries prior to January 1, 2012 (for salaried or management employees) or January 1, 2013 (for non-bargained hourly employees) and you: (a) Were a participant in the Caterpillar Global Mining Legacy Salaried Employees Welfare Plan (formerly the Bucyrus International, Inc. Salaried Employees Welfare Plan) (the "CGM Legacy Plan") as a retiree on December 31, 2011 (for salaried or management employees) or December 31, 2012 (for non-bargained hourly employees); or (b) Were eligible to participate in the CGM Legacy Plan as a retiree on December 31, 2011 (for salaried or management employees) or December 31, 2012 (for non-bargained hourly employees); provided you did not become an employee of Bucyrus International, Inc. or its subsidiaries as a result of the acquisition of Terex Corporation or DBT Group; or 2. For medical expense benefit coverage up to age 65 only, you meet the applicable eligibility requirements described in Appendix A. 3. For life insurance benefits coverage only, you were a management, salaried or non-bargained hourly employee of Caterpillar Global Mining LLC or its subsidiaries, and you retire on or after January 1, 2012 (for salaried and management employees) or January 1, 2013 (for non-bargained hourly employees), and you meet the criteria specified in 1(a) or 1(b) above, as applicable. Please see *Transfers To/From Caterpillar Global Mining* beginning on page 15 for more information regarding how these eligibility rules apply to individuals who transfer to or transfer from Caterpillar Global Mining. ***Denver Logistics Employees*** You are eligible to participate in the Program as a retiree and this SPD describes your benefits if you meet the applicable eligibility requirements described in Appendix A. ***St. Paul Logistics Employees*** You are eligible to participate in the Program as a retiree and this SPD describes your benefits if you meet the applicable eligibility requirements described in Appendix A. ***Solar Turbines Incorporated Retirees*** You are eligible to participate in the Program as a retiree and this SPD describes your benefits if: 1. You retired from Solar Turbines Incorporated or its subsidiaries on or before December 31, 2016 and you were eligible to participate in the Solar Turbines Incorporated Retiree Insurance Program as of December 31, 2016; or

	2. You meet the applicable eligibility requirements described in Appendix A. ***UAW Retirees*** You are eligible to participate in the Program as a retiree and this SPD describes your benefits if you meet the applicable eligibility requirements described in Appendix A. **NOTE**: UAW Retirees are not eligible for life insurance benefits under the Program. ***Post-2018 Mapleton Patternmakers IAM Retirees*** You are eligible to participate in the Program as a retiree and this SPD describes your benefits if you meet the applicable eligibility requirements described in Appendix A. **NOTE**: Post-2018 Mapleton Patternmakers IAM Retirees are not eligible for life insurance benefits under the Program. ***Rehired Retirees*** Generally, any retirees rehired on or after January 1, 2013 are not eligible to participate in the Program. However, certain rehired retirees at Building HH in East Peoria, the facility in Aurora, Illinois, and the facility in Joliet, Illinois are eligible to participate in the Program. See Appendix A for Eligibility requirements.
Retirees Age 65 and Older	Your healthcare benefits under the Program will change when you Reach Age 65. When you Reach Age 65, you are no longer eligible to participate in the Traditional Healthcare Benefits of the Program but rather you will be eligible to participate in a Health Reimbursement Arrangement under the HRA Benefits of the Program. Additionally, former employees in the following groups will be eligible for the HRA feature of the Program when they Reach Age 65, if they lose eligibility for their Traditional Healthcare Benefits due to attainment of age 65 under the Caterpillar Inc. Retiree Group Insurance Plan (RGIP) (prior to January 1, 2020, Traditional Healthcare Benefits would have been under Caterpillar Inc. Group Insurance Plan A (GIP A)): ***Joliet IAM Retirees.*** Any former hourly employee who was represented by the International Association of Machinists and Aerospace Workers, AFL-CIO and Local Lodge 851 at the time of retirement, was a participant in the medical expense benefits of the Caterpillar Inc. Group Insurance Plan A on the day immediately preceding retirement, retired on or after August 20, 2012, and who had: (a) Attained age fifty-five (55) or older when he or she terminates employment, and the sum of his or her age and service is at least eighty-five (85); or (b) Accrued at least ten (10) years of Credited Eligibility Service and is age sixty (60) or older when he or she terminates employment; (c) Completed at least five (5) years of participation in the Caterpillar Inc. Non-Contributory Pension Plan and is age sixty-five (65) or older when he or she terminates employment; or (d) Accrued at least thirty (30) years of Credited Eligibility Service when he or she terminates employment. ***Mapleton Patternmakers IAM Retirees***. Any former hourly employee who was represented by the International Association of Machinists and Aerospace Workers, AFL-CIO and Local Lodge 360 at the time of retirement, was a participant in the medical expense benefits of the Caterpillar Inc. Group Insurance Plan A on the day immediately preceding retirement, retired on or after October 1, 2012 but prior to September 24, 2018, and who had: (a) Attained age fifty-five (55) or older when he or she terminates employment, and the sum or his or her age and service is at least eighty-five (85); or (b) Accrued at least ten (10) years of Credited Eligibility Service and is age sixty (60) or older when he or she terminates employment;

	(c) Completed at least five (5) years of participation in the Caterpillar Inc. Non-Contributory Pension Plan and is age sixty-five (65) or older when he or she terminates employment; or (d) Accrued at least thirty (30) years of Credited Eligibility Service when he or she terminates employment. ***St. Paul IAM Retirees***. Any former hourly employee who was represented by the International Association of Machinists and Aerospace Workers, AFL-CIO and District Lodge 77 at the time of retirement, was a participant in the medical expense benefits of the Caterpillar Inc. Group Insurance Plan A on the day immediately preceding retirement, retired on or after November 25, 2013 but prior to January 6, 2017, and who had: (a) Attained age fifty-five (55) or older when he or she terminates employment, and the sum or his or her age and Credited Eligibility Service is at least eighty-five (85); or (b) Accrued at least ten (10) years of Credited Eligibility Service and is age sixty (60) or older when he or she terminates employment; (c) Completed at least five (5) years of participation in the Caterpillar Inc. Non-Contributory Pension Plan and is age sixty-five (65) or older when he or she terminates employment; or (d) Accrued at least thirty (30) years of Credited Eligibility Service when he or she terminates employment. **NOTE**: No employees or retirees of Caterpillar Global Mining LLC or its subsidiaries are eligible for the HRA feature. Medical expense benefit coverage for eligible retirees of Caterpillar Global Mining LLC and its subsidiaries will cease at age 65. Additionally, no non-bargained hourly employees or retirees of Solar Turbines Incorporated are eligible for the HRA feature. Medical expense benefit coverage for eligible non-bargained hourly retirees of Solar will cease at age 65.
Certain facilities of the Company do not provide retiree Life Insurance Benefits or do not provide retiree healthcare benefits to employees who retire from those facilities. If you retired from one of these facilities, you may not be eligible for such coverage under the Program. See Appendix B, *Facilities That Do Not Provide Retiree Coverage*, for more information. In addition, regardless of which facility you retire from, you are not eligible to participate in the Program if you are an employee of Caterpillar Global Mining LLC or its subsidiaries as a result of the acquisition of Terex Corporation and DBT Group.	
Dependents	
Your Eligible Dependents	Coverage is also available to your eligible Dependents. Your eligible Dependents include your Spouse, your Same-Sex Domestic Partner and any Dependent children who meet the eligibility requirements outlined below. Except for Solar Retirees, a Spouse or Same-Sex Domestic Partner eligible in his or her own right is not covered as a Dependent by the Program. Eligible in his or her own right means the Spouse or Same-Sex Domestic Partner is an eligible employee or retiree of the Company or an Affiliate. Thus, for example, if you have a Spouse or a Same-Sex Domestic Partner who is a retiree and eligible for the Program, you are each covered separately. Spouses and Same-Sex Domestic Partners of Solar Employees can choose to be covered under the Program as a Dependent or can have their own healthcare coverage as a retiree, provided they meet all eligibility criteria. In no event can a Solar Participant be covered as both a dependent and a retiree. Your children include your natural children, your stepchildren, your adopted children or children placed with you for adoption. To be eligible for coverage, your children must be (1) Under twenty-six (26) years of age; or (2) Twenty-six (26) years of age or more but under sixty-five (65) years of age; and (i) Unmarried;

	(ii) Incapable of sustaining employment as a result of mental or physical disability as determined by the Plan Administrator; (iii) Legally reside with you or the non-retiree parent, or in a licensed special care home or facility that specializes in the treatment of physical or mental disabilities; and (iv) Receive from you more than one-half of their financial support. For purposes of determining whether your dependents are eligible for benefits under the Program, "support" is calculated by dividing the total family expenses for lodging, food and utilities (not including real estate taxes, mortgage interest and insurance), by the number of persons living in your home. Then, add to this quotient the cost of your child's clothing, education, medical care (not covered by insurance) and travel, and compare that amount to your child's support from all sources, including support he or she provided. If your share of your child's total support exceeds one-half of the expenses, the child will be considered your Dependent. For purposes of HRA Benefits, your eligible Dependents only include your Spouse or your Same-Sex Domestic Partner. Only one parent who is a Covered Person may enroll Dependent children in Traditional Healthcare Benefits. Your eligible Dependents may also include children for whom health care coverage is required through a Qualified Medical Child Support Order ("QMCSO") or other court or administrative order. The Spouse or Same-Sex Domestic Partner of a Joliet IAM Retiree, Mapleton Patternmakers IAM Retiree or St. Paul IAM Retiree will be eligible for the HRA feature of the Program when he or she reaches age 65. If such retiree and the retiree's Spouse or Same-Sex Domestic Partner are no longer eligible for coverage under the Caterpillar Inc. Retiree Group Insurance Plan (RGIP) (or, as applicable prior to January 1, 2020, the Caterpillar Inc. Group Insurance Plan A (GIP A)), and are participating in the Program, any qualifying dependent children of the retiree or the retiree's Spouse or Same-Sex Domestic Partner will be eligible for Traditional Healthcare Benefits under the Program in accordance with its terms. The Dependent of (1) a Solar Turbines Incorporated Non-Bargained Hourly Employee who retired after reaching age 65, but met the age and service requirements (as defined in Appendix A) or (2) a Solar Retiree whose coverage under the Program was terminated due to reaching age 65, may generally continue coverage until they cease to be an Enrolled Dependent or reach age 65. Note: You may be required to provide proof of dependent status at any time. If you enroll a Dependent whose eligibility has not been previously verified by the Plan Administrator in the Program, you must provide supporting documents, such as a birth certificate or marriage license, to verify that the Dependent meets the eligibility requirements of the Program. The Plan Administrator will inform you of the documents you are required to provide and the time period for providing such documents. If you do not provide the required documents to the Plan Administrator by the communicated deadline, your Dependent will be dropped from coverage under the Program, and you will not have an opportunity to re-enroll your Dependent until the Program's next Annual Enrollment Period, unless you experience a change in status event that would permit you to re-enroll such Dependent. (Solar Retirees who enrolled a new Dependent between January 1, 2017 and August 27, 2017 were not required to provide supporting documents to verify eligibility.)

QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")

The Program also provides Traditional Healthcare Benefits for your eligible child pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"), even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment season restrictions which might otherwise exist for Dependent coverage. A QMCSO can require the Program to provide coverage for benefits to a child who meets the plan eligibility requirements. Additionally, if you have not elected coverage under the Program**,** you will be required to cover yourself if you are required to cover your eligible

child. If the Program receives a valid QMCSO and you do not enroll yourself and the child, the state agency may enroll you and the affected child. If neither you nor the state agency take action to enroll yourself and the affected child, the Plan Administrator will enroll you and the affected child into default coverage. If your dependent child does not qualify under Internal Revenue Code Section 152 as your tax dependent or does not fit within the dependents described in Internal Revenue Service Notice 2010-38, the Company must include in your reportable income the cost of any benefit coverage provided to them.

A QMCSO is either a National Medical Child Support Notice issued by a state child support agency or an order, decree or a judgment from a state court or administrative body directing the Company to cover a child as your Dependent under the Program. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid. The Company or its designee is responsible for determining if an order meets the criteria of a QMCSO. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, contact the Caterpillar Benefits Center at (877) 228-4010.

DUAL COVERAGE

Dual coverage is not permitted under the Program. As described in the Eligibility Requirements chart found at the beginning of the *Eligibility* section of the SPD on page 9, unless you are a Solar Retiree, if you have a Spouse or Same-Sex Domestic Partner who is an active Employee, former Employee or a retiree eligible for or covered by the Program or another welfare benefit plan sponsored by the Company or an Affiliate, you are each eligible and covered separately. Likewise, if both you and your Spouse or Same-Sex Domestic Partner are eligible to participate in the Program or another welfare benefit plan sponsored by the Company, only one of you may cover your child(ren) as a Dependent under your Company coverage. In addition, your Dependent child may not be covered as both an eligible Employee in their own right and as your Dependent.

For purposes of Dependent child life insurance benefits under the Program, if it is determined that two Employees cover the same Dependent child, insurance coverage proceeds will be paid to the Employee whose birthday falls earlier in the calendar year. Any premium paid by an Employee whose birthday falls later in the calendar year will be returned to that Employee. The Plan Administrator may, in its sole discretion, apply a similar rule in connection with other coverage under the Program if it is determined that an individual's coverage violates this prohibition against dual coverage.

DISABLED CHILDREN

Traditional Medical Coverage for an unmarried, Enrolled Dependent child who the Claims Administrator determines is not able to be self-supporting because of mental or physical disability will not end just because the child has reached age 26. Coverage for that child may be extended beyond age 26 (up to Reaching Age 65) if the Claims Administrator determines that the Enrolled Dependent child:

- Is not able to sustain employment as a result of mental or physical disability;
- Legally resides with the retiree, the non-retiree parent or in a licensed special care home or facility; and
- Receives more than one-half of his or her financial support from the retiree.

To determine whether your child qualifies for this coverage, complete the Statement of Dependent Eligibility Beyond Limiting Age Due to Mental or Physical Disability form and submit to UnitedHealthcare. You can obtain this form by contacting UnitedHealthcare at (877) 228-4215 or on benefits.cat.com.

The Claims Administrator requires proof of the child's incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached age 26. Before the Claims Administrator agrees to this extension of coverage for the child, the Claims Administrator may require that a Physician chosen by the Claims Administrator examine the child. If approved, the length of approval is determined by the nature of the handicap as stated by the physician as it pertains to standard Social Security Insurance Bluebook eligibility for handicapped status.

Coverage will continue until the Enrolled Dependent child Reaches Age 65 as long as the Enrolled Dependent is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the Program. However, coverage will

not continue following the retiree's death unless the retiree has a surviving Spouse or Same-Sex Domestic Partner to provide one-half support to the disabled child. Following the retiree's death, coverage for such Enrolled Dependent will end in accordance with the section entitled *Survivor's Coverage* beginning on page 31.

The Claims Administrator may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might require a medical examination. However, the Claims Administrator generally will not ask for this information more than once a year. You should receive notification from UnitedHealthcare 60 days prior to extended coverage expiration date. You must complete and submit the request for continued coverage. If you do not provide proof of the child's incapacity and dependency within 31 days of the Claims Administrator's request as described above, coverage for that child will end.

REEMPLOYMENT OF RETIREES

The Program is intended to constitute a retiree only plan for purposes of Section 732(a) of ERISA and Section 9831 of the Internal Revenue Code. As a result, a retiree who also is an employee of Caterpillar or any of its Affiliates generally is ineligible for participation in the Program.

Notwithstanding any other provision of this SPD to the contrary, any retiree who is rehired by the Company or a Related Company in a supervisory position on or after April 15, 2017 and before December 31, 2018 to work at Building HH in East Peoria, Illinois, the Company's Aurora, Illinois facility or the Company's Joliet, Illinois facility and who subsequently terminates employment (i.e. re-retires) effective on or before January 1, 2019 shall be eligible for participation in the Program, provided the individual otherwise meets the applicable eligibility requirements.

TRANSFERS TO/FROM CATERPILLAR GLOBAL MINING

On July 9, 2011, Caterpillar Inc. acquired Caterpillar Global Mining LLC (formerly known as Bucyrus International, Inc.). As described above, certain retirees of Caterpillar Global Mining LLC and its subsidiaries are eligible for benefits under the Program. See the *Eligibility* section on page 9 in regard to the eligibility rules for Caterpillar Global Mining LLC retirees. This section illustrates how those eligibility requirements apply to individuals who transfer to, or transfer from, a position with Caterpillar Global Mining LLC or its subsidiaries.

Employment transfers between Caterpillar Global Mining LLC or its subsidiaries and Caterpillar Inc. or another Participating Company on or after the July 9, 2011 acquisition date do not affect your eligibility for retiree benefit coverage. Instead, you will continue to be subject to the eligibility rules applicable to the employee group into which you were hired or rehired. In other words, you cannot gain or lose eligibility for retiree benefit coverage by transferring employment. These rules are described in greater detail below:

- If you were:
  - hired before July 9, 2011 by Bucyrus International, Inc., or
  - hired on or after July 9, 2011, but before January 1, 2013, into a position in which you were designated by the Company as a Caterpillar Global Mining LLC employee,

  then your eligibility for retiree benefit coverage will be determined based on the rules applicable to Caterpillar Global Mining LLC employees, regardless of whether you subsequently transfer to Caterpillar Inc. or another Participating Company. If you were hired prior to January 1, 2005, then you may be eligible for medical expense benefits as set forth in item 2 of "Caterpillar Global Mining Retirees" in the *Eligibility* section beginning on page 9. If you were hired on or after January 1, 2005, you will not be eligible for medical expense benefits, regardless of whether you transfer to Caterpillar Inc. or another Participating Company prior to January 1, 2013. *Examples 2*, *4* and *5* below illustrate these rules.

- If you were hired into a position in which you were designated as an employee of Caterpillar Inc. or any Participating Company other than Caterpillar Global Mining LLC, then your eligibility for retiree benefit coverage will be determined based on the rules applicable to Caterpillar Inc. employees, as set forth in the *Eligibility* section beginning on page 9,

regardless of whether you subsequently transfer to Caterpillar Global Mining LLC after July 9, 2011. *Examples 1* and *3* below illustrate these rules.

The eligibility rules for individuals transferring between Caterpillar Global Mining LLC and Caterpillar Inc. or another Participating Company are further explained by the following examples:

Example 1. John was originally hired by Caterpillar Tractor Company (the predecessor to Caterpillar Inc.) on July 1, 1983. John held a variety of management positions in a variety of divisions with Caterpillar. Effective July 1, 2012, John transferred to a management position with Caterpillar Global Mining, and as a result of the transfer, his employer changed from Caterpillar Inc. to Caterpillar Global Mining LLC. Effective February 1, 2014, at the age of 62, John retired. Because John was designated as a Caterpillar Inc. employee, the rules applicable to Caterpillar Inc. retirees apply and, because John was hired prior to January 1, 2003, the specific eligibility rules described in item 2 of "Caterpillar Global Mining Retirees" in the *Eligibility* section beginning on page 9 apply. At the time John retired, he was age 62 with 30 years and seven months of Credited Eligibility Service. John clearly is eligible for retiree medical expense coverage and retiree life insurance benefits coverage under the Program. When John attains age 65, his medical coverage will convert from Traditional Healthcare Benefits to HRA Benefits because he is designated as a Caterpillar Inc. employee for purposes of the Program, regardless of his subsequent transfer to Caterpillar Global Mining LLC.

Example 2. Barbara was originally hired by Bucyrus International, Inc. on October 1, 2003. Barbara held a variety of management positions in the mining organization. Effective January 4, 2013 Barbara was transferred to a management position with Caterpillar Inc. As a result of the transfer, Barbara's employer changed from Caterpillar Global Mining LLC to Caterpillar Inc. Effective November 1, 2018, at the age of 55, Barbara retired from that management position with Caterpillar. Because Barbara was originally employed by Bucyrus International, Inc., the rules applicable to Caterpillar Global Mining LLC retirees apply and, specifically because Barbara was hired after January 1, 2003, the specific eligibility rules described in item 2(b) of "Caterpillar Global Mining Retirees" in the *Eligibility* section beginning on page 9 apply. At the time Barbara retired, she was age 55 with 15 years and 1 month of Credited Eligibility Service. Because Barbara was enrolled in coverage under the Employee Program on October 31, 2018, and because she had attained age 55 and completed at least 15 years of Credited Eligibility Service, Barbara is eligible for retiree medical expense coverage and retiree life insurance benefits coverage under the Program. When Barbara attains age 65, her medical coverage will cease and she will not be eligible for HRA benefits because she was designated as a Caterpillar Global Mining LLC employee for purposes of the Program, regardless of her subsequent transfer to Caterpillar Inc.

Example 3. Fred was originally hired by Caterpillar Inc. on March 1, 2005. Fred worked his way up from a salaried position in the mailroom and, effective June 1, 2016, was transferred to a management position with the Global Mining Division. As a result of the transfer, Fred's employer changed from Caterpillar Inc. to Caterpillar Global Mining LLC. For the next 15 years, Fred held a variety of positions with increasing responsibility with Caterpillar Global Mining. After a distinguished career, Fred retired on June 1, 2031. Because Fred was originally employed by Caterpillar Inc., he was designated as a Caterpillar Inc. employee for purposes of the Program and the rules applicable to Caterpillar Inc. retirees apply. Because Fred was hired on or after January 1, 2003 (but before January 1, 2013), the specific eligibility rules described in item 3 of "Caterpillar Global Mining Retirees" in the *Eligibility* section on page 9 apply. At the time Fred retired, he was age 60 with 26 years and three months of Credited Eligibility Service. Fred clearly is eligible for retiree medical expense coverage and retiree life insurance benefits coverage under the Program. When Fred attains age 65, his medical coverage will convert from Traditional Healthcare Benefits to HRA Benefits because he is designated as a Caterpillar Inc. employee, regardless of his subsequent transfer to Caterpillar Global Mining LLC.

Example 4. Donna was originally hired by Bucyrus International, Inc. on March 1, 1998. For the next several years, Donna held a variety of positions in the mining organization. Effective June 1, 2012, Donna was transferred to a management position in the Human Resources Division with Caterpillar Inc. As a result of the transfer, Donna's employer changed from Caterpillar Global Mining LLC to Caterpillar Inc. For the next 11 years, Donna held a variety of management positions in the Human Resources Division. After a distinguished career, Donna retired on June 1, 2023 at the age of 62. Because Donna was originally employed by Bucyrus International, Inc., the rules applicable to Caterpillar Global Mining LLC apply and, specifically because Donna was hired before January 1, 2003, the eligibility rules described in item 2(a) of "Caterpillar Global Mining Retirees" in the *Eligibility* section beginning on page 9 apply. At the time Donna retired, she was age 62 with 25 years and 3 months of Credited Eligibility Service. Because Donna was enrolled in coverage under the Employee Program on May 31, 2023, and because she had attained age 60 and completed at least 10 years of Credited Eligibility Service, Donna is eligible for retiree medical expense coverage and retiree life insurance benefits coverage under the Program. When Donna attains age 65, her medical coverage will cease

because she was designated as a Caterpillar Global Mining LLC employee for purposes of the Program, regardless of her subsequent transfer to Caterpillar Inc.

Example 5. Sue was originally hired by Caterpillar Global Mining LLC on December 1, 2011. After just one year of service there, effective December 1, 2012, Sue was transferred to a management position with Caterpillar Inc. As a result of the transfer, Sue's employer changed from Caterpillar Global Mining LLC to Caterpillar Inc. Sue retired from that management position on September 15, 2013 at the age of 63. Because Sue was originally employed by Caterpillar Global Mining LLC, she was designated as a Caterpillar Global Mining LLC employee for purposes of the Program. Sue is not eligible for retiree medical expense benefits, even though she transferred to Caterpillar Inc. prior to January 1, 2013. Sue will, however, be eligible for retiree life insurance benefits coverage under the Program.

Participation In The Program

HOW TO ENROLL

Life Insurance Benefits

No action is necessary on your part to enroll in retiree life coverage under the Program. The basic life coverage you had as an active employee continues in retirement as described in the *Life Insurance Benefits* section beginning on page 89. Notwithstanding the foregoing, a Solar Turbines Incorporated Retiree who retired prior to February 1, 2017, shall have his basic life insurance benefits provided in accordance with the rules that were in effect on December 31, 2016 in the Solar Turbines Incorporated Retiree Insurance Program.

If you retire after January 1, 2003, on your retirement date, you have the option of purchasing group life insurance that will extend your retiree life insurance coverage beyond the date that it expires as described in the *Life Insurance Benefits* section beginning on page 89. To extend your basic life insurance coverage, you must contact MetLife at the telephone number listed in the section entitled *Contact Information* beginning on page 121 within 31 days of the date of your retirement or, if later, within 31 days of notice from MetLife.

Voluntary Benefits

If you are under the age of sixty-five (65) and you were enrolled in accident insurance and/or legal insurance under the Employee Program, you will have such insurance automatically continued upon retirement. If you were not enrolled in such coverage under the Employee Program at the time of your retirement, you will have to wait until the next Annual Enrollment Period to enroll in coverage.

Annual Enrollment

There will be one Annual Enrollment Period each year, at which time you may elect the voluntary benefit coverage, if any, you want to enroll in for yourself and any eligible Dependents for the next plan year. If you do not make a new election for voluntary benefit coverage during the Annual Enrollment Period, your current plan year elections will carry over and you and any eligible Dependents will automatically be enrolled in the same voluntary benefit coverage for the subsequent plan year.

Mid-Year Changes Not Permitted

Once enrolled in voluntary benefit coverage, you may not change your election during the plan year, regardless of experiencing a change in status or other event that otherwise allows you to change your elections mid-year under the Company's Medical Premium Payment Plan (even though Retirees are not eligible to participate in such plan). Changes to your voluntary benefit coverage may only be made during the Annual Enrollment Period.

Healthcare Benefits

Traditional Healthcare Benefits (Retirees Age 64 And Younger)

If you are currently covered under the Traditional Healthcare Benefits of the Program, such coverage will continue under the Program in accordance with its terms. If you were covered as an employee under the medical benefits provisions of the Employee Program on the day preceding your retirement, your (and your Dependent's (if eligible) medical benefit coverage will automatically continue in retirement under the Program in accordance with its terms, unless you waive coverage.

If you waive your coverage under the Program, you may re-enroll in the Program for coverage during any subsequent Annual Enrollment Period or sooner pursuant to a qualifying change in status (described below). To enroll, you must show, on a form satisfactory to the Company, that you (and your Dependents) were covered under an employer-sponsored group health plan or comparable private insurance (including COBRA coverage) for the previous 12 months (or for the entire period since your retirement if such period is less than 12 months).

Annual Enrollment

Each year, you may elect Traditional Healthcare Benefits for the following calendar year (January 1 - December 31). Typically, this Annual Enrollment Period occurs in the fall of each year. The elections you make during the Annual Enrollment Period take effect on the following January 1, the start of the new plan year.

Prior to the Annual Enrollment Period, you will receive information that is designed to help you with the annual enrollment process. The information will define when the Annual Enrollment Period will occur, describe the enrollment procedure, how to access the options available to you and applicable costs and any significant changes to the available coverage since the last enrollment. Be sure to read the information carefully. This information may be provided in hard copy form, via the internet or otherwise, as determined by the Plan Administrator.

Note: If you do not enroll during the Annual Enrollment Period but you were enrolled during the prior plan year, your traditional medical, traditional dental, traditional vision, and traditional prescription drug coverage will remain in effect for the following plan year unless the plan administrator informs you otherwise, in which case you will be required to make an active enrollment. If you do not actually enroll during the Annual Enrollment Period and your current coverage option is no longer available, you will default into an alternative option selected by the Plan Administrator in its sole discretion. If you were not enrolled during the prior plan year, you will not be defaulted into any traditional medical, traditional dental, traditional vision, or traditional prescription drug coverage for the following plan year during the Annual Enrollment Period.

Enrollment Pursuant to a QMCSO

You or a state agency may enroll your Dependent child for benefit coverage pursuant to the terms of a valid QMCSO, provided any required contributions are made. This means you will be required to pay for such coverage. If you have not elected coverage for yourself, and you are ordered to cover your Dependent child, you will also automatically be enrolled in the Program. See the section entitled *Qualified Medical Child Support Order ("QMCSO")* beginning on page 13 for additional information.

Your Eligible Dependents

If you have properly enrolled your eligible Dependents in Traditional Healthcare Benefits, their coverage will begin on the date described in the following chart.

Effective Date of Dependents' Coverage	
If you…	**Your Dependent's Coverage is Effective…***
Are a retiree who enrolled your Dependents within the 31-day period immediately following the first day you were eligible for coverage,	On the date your coverage is effective.

Effective Date of Dependents' Coverage	
If you…	**Your Dependent's Coverage is Effective…***
Applied for Dependent coverage during an Annual Enrollment Period,	On his or her annual enrollment effective date.
Have a newborn child and applied for Dependent's coverage within 31 days of the newborn child's date of birth,	On the child's date of birth.
Adopted a child or have a child placed with you for adoption and applied for Dependent's coverage within 31 days of the custody** date,	On the custody date.
Acquire a Dependent due to a court order, decree, marriage, or other similar union (i.e. Same-Sex Domestic Partnership) and applied for Dependent's coverage within 31 days of such court order, decree, marriage or similar union.	On the date of such court order, decree, marriage or other similar union (i.e. Same-Sex Domestic Partnership).

* In order for your Dependent's coverage to be effective on the date indicated in this column, you must properly enroll such Dependent in the Program. If you do not properly enroll your Dependent within the required time period, you must wait until the next Annual Enrollment Period to enroll him or her (unless you experience a change in status).

** For purpose of this table, "custody" means the child has been placed with you for adoption and you are legally responsible for medical expenses incurred by the child.

Social Security numbers are required for enrollment. You are required to provide the Social Security number for each eligible dependent you wish to cover. Social Security numbers are not required to enroll an eligible dependent under six months of age. Please note that dependents age six months or older are required to have a Social Security number on file. Coverage will be terminated at the end of the plan year for dependents age six months and older if the Social Security number has not been provided.

COVERAGE OF SAME-SEX DOMESTIC PARTNERS

A Same-Sex Domestic Partner, for purposes of the Program is the sole, same-sex person who is in a civil union, domestic partnership, or similar legal relationship with the Employee, as recognized under the laws of the federal government or a state government of the U.S., including its territories and possessions and the District of Columbia (or a legally recognized equivalent government of another country), subject to the following rules:

- A retiree's relationship will be treated as a Same-Sex Domestic Partnership, regardless of whether the retiree and his or her Same-Sex Domestic Partner remain in the jurisdiction where the relationship was legally entered into. In the event more than one person meets this definition for a given retiree, then the Same-Sex Domestic Partner is the person who first met the criteria in this definition.

- Notwithstanding anything herein to the contrary, if a retiree has a spouse recognized for purposes of federal law, no person will qualify as the retiree's Same-Sex Domestic Partner unless such Employee's marriage to such spouse is first lawfully dissolved.

- A Same-Sex Domestic Partner will include a civil union partner under state law, a domestic partner, or other similar partner relationship with the retiree (including an opposite-sex partner), but solely to the extent mandated by applicable state insurance law or required by a contract between the Company and a state or local government entity.

- Though a Same-Sex Domestic Partner does not have a legal right to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), the Program will provide continuation coverage rights to your Same-Sex Domestic Partner that are similar to those provided to Spouses under COBRA.

- Under federal law, the value of health care coverage for a Same-Sex Domestic Partner and/or the children of a Same-Sex Domestic Partner is considered taxable income (also known as imputed income) unless the individual is considered your tax dependent for federal tax purposes. Generally, if your Same-Sex Domestic Partner and/or children of your

Same-Sex Domestic Partner meet the definition of a dependent for federal tax purposes (see Internal Revenue Code Section 152 Dependent Definition), you would not be subject to federal, state or local income tax on the value of those health benefits provided. If your Same-Sex Domestic Partner or children of your Same-Sex Domestic Partner qualify as your tax dependent for federal tax purposes, you should certify this tax dependent status when you enroll them by contacting the Caterpillar Benefits Center at (877) 228-4010 so income is not imputed to you for these benefits.

You may change elections related to your Same-Sex Domestic Partner under the Program under the same circumstances you could if you had a Spouse. For example, if you enter into a same-sex civil union or a domestic partnership so you have a new Same-Sex Domestic Partner, or your relationship with a Same-Sex Domestic Partner is legally dissolved, you would be eligible to make the same mid-year changes in your Program elections as you could if you married or divorced a spouse that is recognized under federal law, as applicable. Federal tax law limits how some of these mid-year changes can be handled, however, so in some of these situations, you may need to pay for Program benefits on an after-tax basis. Contact the Caterpillar Benefits Center at (877) 228-4010 if you have questions about changing your elections.

Changing Your Coverage

The circumstances under which you may change your Traditional Healthcare Benefits during the calendar year are described below. If none of those circumstances apply, you may not make a change in coverage during the calendar year.

As noted above, under certain circumstances, you may enroll in coverage, add or remove covered Dependents, or change coverage during the year. For example, you may make a prospective change to your coverage (and/or the coverage of your Dependents, if applicable), if:

- You experience a "change in status" - as later described in this section - that affects your or your Dependents' eligibility for benefits;
- You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as described in the *Special Enrollments During the Year* section beginning on page 21;
- The Claims Administrator receives a Qualified Medical Child Support Order (QMCSO) or other court order, judgment or decree requiring you to enroll a Dependent child;
- You, your Spouse or your Dependent becomes entitled to or loses Medicare or Medicaid coverage;
- You, your Spouse or your Dependent experiences a significant, unexpected and unforeseen increase (or decrease) in the cost of coverage;
- If there is a change in your Spouse's (or your Dependent's) coverage offered by their employer and the other employer's plan either (a) allows your Spouse (or Dependent) to make an election change under that plan; or (b) the plan offered by your Spouse's employer operates on a different 12-month period and does not conduct its annual enrollment at the same time as the Program;
- You, your Spouse or your Dependent child experience a significant reduction in coverage or a total loss of coverage;
- The Program adds a benefit package option or significantly improves coverage under an existing option; and
- You qualify for a special enrollment in a Qualified Health Plan as described in the *Special Enrollments in a Qualified Health Plan* section beginning on page 21.

In most cases an election change must be consistent with the event and all election changes must be made within 31 days of the event. The Plan Administrator will determine, in its sole discretion, if an event has occurred that permits a change under these rules.

Changes in Status

You may change certain benefit elections during the plan year if you experience a change in status. Depending on the event that you experience, you may change your benefit coverage under the Program. You also may be able to add or remove Dependents from coverage. A change in status is any of the following:

- You get married, divorced, or legally separated or you have your marriage annulled;

- Your Spouse or Dependent dies;
- Your Dependent becomes eligible for coverage or ineligible for coverage (*e.g.*, he or she reaches the eligibility age limit);
- You or your Spouse has a baby, you adopt or you have a child placed with you for adoption;
- You, your Spouse or your Dependents experience a change in employment status (*e.g.*, start or end employment, begin or return from an unpaid leave of absence, change work sites, change from part-time to full-time or vice versa) that leads to a loss of or gain in eligibility for coverage; or
- Your home residence changes and your previous coverage is no longer available or new coverage options become available.

Regardless of what type of change in status you have, any election change you make under the Program must be because of and consistent with the change in status.

If you experience a change in status or any other event described in this section, you must call the Caterpillar Benefits Center at (877) 228-4010 within 31 days after the event to change your coverage. In addition, you may be required to provide proof of your change in status or the other event. If you do not, you cannot change your coverage until the next Annual Enrollment Period, unless you once again experience a change in status.

Special Enrollments During the Year

Under HIPAA, you have the right to enroll yourself and your Dependents for the Program benefit coverage, even if you were not previously enrolled, if you acquire a new Dependent or if you or your Dependents lose coverage under another group health plan for any of the following reasons:

- You or your Dependents exhaust COBRA coverage under another employer's group health plan (other than due to failure to pay contributions or for cause);
- Employer contributions toward the other group health plan coverage terminates; or
- You or your Dependents lose eligibility under the other group health plan.

You must request a change in coverage within 31 days of the special enrollment event described above, and your election is effective as of the date of the event. If you don't request the change within 31 days, you lose special enrollment rights for that event.

You may also enroll a Dependent who is otherwise eligible under the Program, but not enrolled, (and you and any other eligible Dependents, if not otherwise enrolled) if either of the following conditions is met:

- Your eligible Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan under Title XXI of the Social Security Act and coverage under such a plan is terminated as a result of loss of eligibility for such coverage and you request coverage under the Program not later than 60 days after the date of termination of such coverage; or
- Your eligible Dependent becomes eligible for assistance, with respect to coverage under the Program, under a Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan) and you request coverage under the Program not later than 60 days after the date your Dependent is determined to be eligible for such assistance.

Coverage under the Program will become effective on the date the enrollment request is received by the Plan Administrator.

Special Enrollments in a Qualified Health Plan

You may revoke your coverage election under the Program if 1) you are eligible for a special enrollment period to enroll in a "qualified health plan" through an "exchange" pursuant to guidance issued by the Department of Health and Human Services and other applicable guidance; and 2) the revocation of your coverage election corresponds to the intended enrollment of you

or a Dependent in a qualified health plan through an exchange for new coverage that is effective no later than the day immediately following the last day of your coverage under the Program.

HRA Benefits (Retirees Age 65 And Older)

If you were covered as an employee under the Employee Program on the day preceding your retirement and at the time of your retirement you are age 65 or older, you are not eligible for Traditional Healthcare Benefits under the Program, but instead are eligible for HRA Benefits under the Program. Similarly, if you retired prior to age 65 and you are covered under the Program when you Reach Age 65, you are no longer eligible for Traditional Healthcare Coverage under the Program. Instead, you are eligible for the HRA Benefits of the Program. No employees, former employees, or retirees of Caterpillar Global Mining LLC are eligible for HRA Benefits. No one who retired as an hourly employee of Solar Turbines Incorporated is eligible for HRA Benefits.

To enroll in the HRA Benefits of the Program, you need to first enroll in available insurance coverage offered through Willis Towers Watson's Via Benefits. **Via Benefits** offers medical coverage that coordinates with Medicare. Via Benefits also offers dental and vision coverage. You must contact Via Benefits to enroll in such coverage. Please note that after you enroll in the available insurance coverage to establish your HRA Account, you are not required to enroll in available insurance coverage through Via Benefits in subsequent years to continue to receive HRA Benefits under the Program. You and your Spouse or Same-Sex Domestic Partner must enroll in HRA Benefits separately.

Cost Of Coverage

LIFE INSURANCE BENEFITS

You are not required to pay a premium for your basic retiree life insurance coverage. The Company pays the entire cost of such coverage. However, you may be required to pay a premium for your basic retiree life insurance in the future. You pay the entire cost of extended life coverage.

VOLUNTARY BENEFITS

The cost of voluntary benefit coverage is determined by the Claims Administrator. Voluntary benefit coverage is paid for on an after-tax basis.

TRADITIONAL HEALTHCARE BENEFITS

Depending upon your retirement date, you may be required to pay a premium for your Traditional Healthcare Benefits. Your premium may change at any time and if you didn't pay a premium in the past, you may be required to pay one in the future. The up-to-date premium information for each coverage option will be in your annual enrollment materials or you may contact the Plan Administrator for information.

Several factors are taken into consideration in determining the premium applicable to you and your Dependents, including your coverage choice (*e.g.*, retiree only, retiree and Spouse or Same-Sex Domestic Partner, retiree and children, or retiree, Spouse or Same-Sex Domestic Partner and children).

HRA BENEFITS

You currently are not required to pay a premium to receive HRA Benefits under the Program. You may be required to pay a premium, however, for any individual insurance coverage that you purchase with your HRA Benefits.

Coordination of Benefits

BENEFITS WHEN YOU HAVE COVERAGE UNDER MORE THAN ONE PLAN

The Program coordinates benefits with other plans that provide benefits to you. The following information describes how UnitedHealthcare will coordinate traditional medical benefits under the Program with those of any other plan that provides benefits to you. For information on coordination of benefits for traditional prescription drug, traditional dental, and traditional vision benefits, contact the applicable Claims Administrator listed on the *Plan Information* chart beginning on page 121. If you are enrolled in the Blue Cross Blue Shield National plan (BCBS), refer to the Blue Cross Blue Shield benefits booklet or to the phone number on the back of the identification card issued by BCBS for information on coordination of benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Don't forget to update your Dependents' Medical Coverage Information: Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

DETERMINING WHICH PLAN IS PRIMARY

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- The Program will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, the Program will pay benefits first;

- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:

    - the parents are married or living together whether or not they have ever been married and not legally separated; or
    - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;

- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:

    - the parent with custody of the child; then
    - the Spouse or Same-Sex Domestic Partner of the parent with custody of the child; then
    - the parent not having custody of the child; then
    - the Spouse or Same-Sex Domestic Partner of the parent not having custody of the child; then
    - plans for active employees pay before plans covering laid-off or retired employees;

- the plan that has covered the individual claimant the longest will pay first; and

- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, the Program will not pay more than it would have paid had it been the primary plan.

The following examples illustrate how the Program determines which plan pays first and which plan pays second:

- Let's say you and your Spouse both have family medical coverage through your respective employers or former employers. You are unwell and go to see a Physician. Since you're covered as a retiree under the Program, and as a Dependent under your Spouse's plan, the Program will pay benefits for the Physician's office visit first.

- Again, let's say you and your Spouse both have family medical coverage through your respective employers or former employers. You take your Dependent child to see a Physician. The Program will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

WHEN THE PROGRAM IS SECONDARY

If the Program is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Program determines the amount it would have paid based on the allowable expense.

- the Program pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Program would have paid had it been the only plan involved.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

DETERMINING THE ALLOWABLE EXPENSE IF THIS PLAN IS SECONDARY

If the Program is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the

primary plan and the Program do not have a contracted rate, the allowable expense will be the greater of the primary plan's reasonable and customary charges and the Program's Eligible Expenses.

When the provider is a Network provider for both the primary plan and the Program, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for the Program, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for the Program, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and the Program, the allowable expense is the greater of the primary plan's reasonable and customary charges and the Program's Eligible Expenses.

What is an allowable expense? For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

WHEN A COVERED PERSON QUALIFIES FOR MEDICARE

Determining Which Plan is Primary

To the extent permitted by law, the Program will pay benefits secondary to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Program pays benefits first and Medicare pays benefits second:

- individuals with active current employment status age 65 or older and their Spouses age 65 or older (however, Same-Sex Domestic Partners are excluded as provided by Medicare);
- individuals with end-stage renal disease, for a limited period of time; and
- disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When the Program is Secondary to Medicare

If the Program is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Program benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and the Program is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, benefits will be paid on a secondary basis under the Program and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider. When calculating the Program's secondary benefits in these circumstances, for administrative convenience the Claims Administrator in its sole discretion may treat the provider's billed charges as the allowable expense for both the Program and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Program and other plans. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under the Program and other plans covering the person claiming benefits. The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under the Program must give the Claims Administrator any facts needed to apply those rules and

determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the benefits payable, your claim for benefits will be denied.

OVERPAYMENT AND UNDERPAYMENT OF BENEFITS

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Program should have paid. If this occurs, the Program may pay the other plan the amount owed.
If the Program pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in benefits payable under any Company-sponsored benefit plans, including the Program. The Company also reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses.

If the Program overpays a health care provider, the Program reserves the right to recover the excess amount, by legal action if necessary.

REFUND OF OVERPAYMENTS

If the Program pays for benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Program if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment Caterpillar Inc. made exceeded the benefits under the Program; or
- all or some of the payment was made in error.

The refund equals the amount the Program paid in excess of the amount that should have been paid under the terms of the Program. If the refund is due from another person or organization, the Covered Person agrees to help the Program get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Program may reduce the amount of any future Benefits for the Covered Person that are payable under the Program. The reductions will equal the amount of the required refund. The Program may have other rights in addition to the right to reduce future benefits.

How Long Coverage Continues

Generally, your coverage under the Program continues while you are contributing your appropriate share of the cost. This Section describes how long your life and healthcare benefits will continue under the Program.

LIFE INSURANCE BENEFITS

If you retired on or before January 1, 2003, your retiree life insurance will continue while you participate in the Program. If, on the other hand, you retired after January 1, 2003, your retiree life will continue until the third anniversary of your retirement, unless you elect extended life coverage. In which case, your extended life coverage will continue for as long as you contribute the required premium.

Note: When your life insurance coverage ends or is reduced, you may obtain individual insurance coverage with the same insurance company without Evidence of Insurability. This is called a "conversion right." To convert to an individual policy, you must apply for conversion with the appropriate insurance company within 31 days after your coverage ends or is reduced. If your life insurance coverage ends and you die during the 31-day conversion period, your beneficiary receives the benefit that would have been paid if you converted to the individual policy. This is true regardless of whether or not you actually applied for conversion.

VOLUNTARY BENEFITS

Your voluntary benefits coverage will end for you and your Enrolled Dependents when you turn age sixty-five (65). Specifically, your voluntary benefits coverage will end on the first day of the month in which your 65th birthday occurs (or the first day of the month immediately preceding the month in which your 65th birthday occurs if your birthday occurs on the first day of the month).

Note: Voluntary benefits coverage is not subject to COBRA. As such, there is no COBRA coverage available for voluntary benefit coverage.

TRADITIONAL HEALTHCARE BENEFITS

Your Traditional Healthcare Benefits will continue so long as you are eligible to participate in the Program and you continue to pay any required premiums for coverage. In general, your Traditional Healthcare Benefits will end on the earlier of: (1) the date of your death; (2) the day you cease to pay the required premiums; or (3) when you Reach Age 65. Your Dependent's Traditional Healthcare Benefits will end on the earlier of: (a) the day your coverage ends; or (b) the day in which he or she ceases to be a Dependent. In the case of a Dependent who is your Spouse or Same-Sex Domestic Partner, his or her Traditional Healthcare Benefits also will cease when he or she Reaches Age 65. In the case of a Dependent who ceases to be a Dependent due to the attainment of age 26, Traditional Healthcare Benefits will end on the earlier of: (i) the day your coverage ends; or (ii) the first day of the month immediately following the month in which the Dependent turned age 26.

Your healthcare benefits will change when you Reach Age 65. Your Traditional Healthcare Benefits under the Program will be replaced with the HRA Benefits that are described in *Health Reimbursement Arrangement (HRA) Benefits* section on page 83. Healthcare benefits for your Spouse or Same-Sex Domestic Partner will also change when he or she Reaches Age 65. The Traditional Healthcare Benefits under the Program cease for your non-spouse Dependent upon the earlier of (1) the date your Dependent is no longer an eligible Dependent, or (2) the date your Dependent Reaches Age 65. Your Spouse's or Same-Sex Domestic Partner's Traditional Healthcare Benefits also will be replaced with HRA Benefits.

Hospital Confinement

If you (or your covered Dependent) are confined to a Hospital for an Inpatient Stay when your Traditional Medical Coverage under the Program ends, certain limited coverage will continue through the period of confinement. Coverage during the remaining period of your confinement will be limited to Covered Health Services that are directly related to the Sickness, Injury or other health condition that was the primary reason for the confinement (or a complication directly associated with such condition). However, this limited coverage may not be continued in the event the medical plan is terminated or otherwise amended to eliminate such coverage.

Coverage under the Program may be continued following certain events if you properly elect and pay for continuation coverage provided pursuant to COBRA. Refer to the subsection entitled *Continuation of Benefits (COBRA)* beginning on page 28 for more information on continuation coverage under COBRA.

CONTINUATION OF BENEFITS (COBRA)

If you and your Dependents have health care coverage (*e.g.*, medical, prescription drug, vision and dental) through the Company and that coverage ends, you may continue coverage for a specified period, depending on the reason coverage ends. An event that allows you to continue health care coverage after it would otherwise end is called a "qualifying event." Continuation coverage is available as required by law under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Although a Same-Sex Domestic Partner does not have a legal right to continuation coverage under COBRA, the Program will provide continuation coverage rights to Same-Sex Domestic Partners that are similar to those provided to spouses under COBRA.

When You and Your Dependents Elect COBRA

If you and your Dependents choose continuation coverage through COBRA, you and your Dependents are offered coverage on the same basis as other participants, except you or your affected Dependents pay the entire cost of coverage (i.e., the full group rate), plus two percent (2%). COBRA coverage is intended to extend prior coverage, rather than to create new classes of covered individuals. To be eligible for continuation coverage, you or your Dependents must be covered under the Program on the date before the qualifying event.

COBRA coverage takes effect on the date of the qualifying event if a timely election is made. It is your responsibility to notify the COBRA Administrator of a qualifying event (*e.g.*, divorce). Complete address and contact information for the COBRA Administrator can be found in the section entitled *Contact Information* beginning on page 121. In addition, you may add a newborn or an adopted child during the COBRA continuation period in accordance with the "special enrollment" rules outlined above.

Administration of COBRA

If you have any questions about COBRA or if you are required to notify the Company of any event to trigger the Company's COBRA obligations, contact the Plan Administrator. Upon any required notification by you, the Plan Administrator will contact the COBRA Administrator to send you any necessary paperwork. The Company has engaged an outside third-party as its COBRA Administrator to assist it with the sending and receiving of COBRA information, including the collection of COBRA premiums if elected by participants. The contact information for the COBRA Administrator is listed in the section entitled *Contact Information* beginning on page 121.

Snapshot of COBRA Continuation Coverage

The following is a general snapshot of who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues.

If:	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
You	Die	Your covered Dependents	36 months
	Become divorced or legally separated or legally dissolve Same-Sex Domestic Partner union	Your covered Dependents	36 months
	Become entitled to Medicare while on COBRA	Your covered Dependents	Up to 36 months*

If:	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
	Your former employer files for federal bankruptcy which results in a loss or substantial elimination of coverage within one year before or after the bankruptcy filing	You and your covered Dependent	For retirees, upon the retiree's death. For all other qualified beneficiaries, the earlier of: (1) the qualified beneficiary's death, or (2) 36 months after the retiree's death.
Your covered Dependent	Is no longer an eligible Dependent (due to age limit, divorce or legal separation or legal dissolution)	Your covered Dependent	36 months
	Is no longer an eligible Dependent because of your death	Your covered Dependent	36 months
	Becomes disabled within the first 60 days of COBRA continuation coverage	You and your covered Dependent	Up to 29 months*

*Includes months of COBRA coverage already used.

Important Notes

- If a second qualifying event occurs within the 18- or 29-month period, the COBRA continuation period for health care coverage may be extended up to 36 months from the date you lost coverage on account of the first qualifying event.
- Keep the Plan Administrator informed of any change in your or your covered Dependents' address so that you and your covered Dependents can receive the necessary information concerning your rights to COBRA continuation coverage.

COBRA Coverage for Disabilities

As shown in the chart above, COBRA coverage can be extended from 18 months up to 29 months if (another qualified beneficiary) is totally disabled the other qualified beneficiary becomes eligible for COBRA coverage or becomes disabled during the first 60 days of COBRA coverage. Monthly contributions for continuation coverage increase to 150% (from 102%) of the monthly amount for each of the 11 additional months of continuation coverage.

To be eligible for this extension, the individual must:

- Receive a determination of disability from the Social Security Administration ("SSA") that the individual was disabled on the date coverage ended, or become disabled during the first 60 days of COBRA coverage, and
- Notify the Plan Administrator within 60 days after the later of:
  - the date of the SSA's determination of disability; or
  - the date of the qualifying event.

If the SSA determines that the individual is no longer totally disabled, continuation of coverage will cease. The individual must notify the Plan Administrator within 30 days of any such finding. Coverage will terminate on the earlier of the first day of the month that is at least 30 days after the SSA's findings or at the end of the 29-month period.

COBRA Coverage for HRA Coverage

If the Company maintains an HRA Account for your Spouse and you and your Spouse divorce, such former Spouse is eligible for COBRA continuation coverage upon divorce. If your former Spouse elects COBRA continuation coverage, such coverage

will continue for a maximum period of 36 months. COBRA continuation coverage takes effect on the date of the divorce and continues until the earliest of the following:

- The end of the 36-month continuation period;
- The date the Company no longer provides group health coverage to any of its employees or retirees;
- The date your former Spouse fails to timely pay the monthly COBRA premium; or
- The date your former Spouse becomes a covered employee or dependent under another group health care plan (provided pre-existing condition exclusions or limitations under the new group health care plan do not apply to your Spouse).

Reporting a Qualifying Event

In order to be eligible for COBRA continuation coverage, you or your affected covered Dependent must notify the Plan Administrator either in writing or orally within 60 days after the date on which coverage is lost on account of any of the following qualifying events:

- You divorce or become legally separated;
- Your child no longer meets the definition of a Dependent (*e.g.*, due to age limit); or
- You (or your covered Dependent) are determined to have been disabled under the Social Security Act when coverage ended or at any time during the first 60 days of receiving COBRA continuation coverage.

When you or your affected covered Dependent contact the Plan Administrator, be sure to inform the Plan Administrator of the specific event, the date of the event, and who is affected.

The COBRA Administrator sends you and/or your affected covered Dependent a notice, including the cost of coverage, within 14 days of receiving this notification.

The Plan Administrator informs the COBRA Administrator within 30 days of the loss of your coverage on account of any of the following qualifying events:

- You become entitled to Medicare; or
- Your death.

The COBRA Administrator sends you and/or your affected covered Dependents a notice, including the cost of coverage, within 44 days after one of these qualifying events occur.

Deciding Whether to Continue Coverage

You have 60 days from the day coverage would otherwise end (or from the day the notice is sent to you, if later) to choose continuation coverage.

In order to continue your health care coverage, you or your covered Dependents must pay the full cost of coverage (i.e., the full group rate), plus a 2% fee for administrative costs (or a 50% administrative fee in the case of an 11-month extension due to disability). This is referred to as the COBRA premium. In order to continue coverage under the HRA Coverage, your former Spouse must pay the full cost of the HRA coverage each month, plus a 2% administrative fee. The cost of the HRA coverage is the amount allocated to the former Spouse's HRA Account (multiplied by a factor) each year, multiplied by 102%, and then divided by 12.

Your first payment (due within 45 days of your election) must include your COBRA contribution for the entire period from the date coverage ended through the month of the payment. Subsequent contributions are due on the first of the month, whether or not you receive a bill. If the COBRA Administrator does not receive your monthly contribution within 30 days of the first of the month, coverage is canceled as of the last day of the month in which you paid a contribution. If you do not choose to continue

coverage, you should make the appropriate election. In that case, your healthcare coverage ends on the day on which the qualifying event occurred.

When COBRA Coverage Ends

If you elect COBRA continuation coverage, it takes effect on the date of your qualifying event and continues until the earliest of the following:

- The end of the 18-month, 29-month or 36-month continuation period (for medical and dental);
- The date the Company no longer provides coverage to any of its employees;
- When there is a significant underpayment of a premium or when premiums for continuation of group coverage is not paid within the required time;
- The date you or your Dependents become covered under another group health care plan (provided pre-existing condition exclusions or limitations under the new group health care plan do not apply to you or your Dependents);
- The date you or your Dependents become entitled to Medicare; or
- With respect to the 11-month extension for disability, the date the person is no longer disabled (you must notify the Program within 30 days of a determination by the Social Security Administration that you or a covered Dependent is no longer disabled).

If the COBRA Administrator determines that your coverage is terminating before the end of the 18-month, 29-month or 36-month period (*e.g.*, when premiums are not being paid within the required time), you will be notified that your coverage is terminating and you will be provided with the reason why and the date your coverage is terminating.

Election Period

A qualified beneficiary has at least 60 days to elect to continue coverage. The election period ends on the later of:

- 60 days after the date coverage would have stopped due to the qualifying event; or
- 60 days after the date the qualified beneficiary is sent notice of the right to continue coverage.

Required Payments

As noted above, in order to continue your health care coverage, you or your covered Dependents must pay the applicable COBRA premium (102% of the full cost of coverage, or 150% of the full cost of coverage in the case of an 11-month extension due to disability). A qualified beneficiary has 45 days from the date of election to make the first required payment for the coverage. The first payment will include any required payment for the continued coverage before the date of the election.

Survivor's Coverage

If a retiree is covered under the Program at the time his or her death, the retiree's surviving Spouse or Same-Sex Domestic Partner may elect to continue healthcare benefits for him or herself and any surviving Dependent children that were covered under the Program at the time of death. Similarly, the surviving Spouse or Same-Sex Domestic Partner of an employee covered under the Employee Program at the time the employee's death, may elect to continue healthcare benefits under the Program for him or herself and any surviving Dependent children that were covered under the Employee Program at the time of death, provided such employee met the age and service requirements of the Program applicable to such employee on the day immediately preceding the date of the employee's death.

Survivor's coverage is charged at the retiree rate and continues for the life of the surviving Spouse or Same-Sex Domestic Partner, provided the surviving Spouse or Same-Sex Domestic partner continues to meet the Program's eligibility requirements and subject to the Plan Sponsor's sole discretionary right to change or discontinue the Program at any time. Please note that the medical benefits coverage under the Program for a surviving Spouse or Same-Sex Domestic Partner who has not Reached Age

65 at the time of your death, will change from Traditional Healthcare Coverage to HRA Benefits when he or she Reaches Age 65.

Survivor's coverage will end if the survivors stop making any required contributions for coverage. In addition, a surviving Spouse or Same-Sex Domestic Partner who is receiving this continued coverage may not at any time enroll any subsequent spouse or domestic partner for coverage.

Any period of continuation coverage shall be subject to the Plan Administrator's sole discretionary right to change or discontinue the Program at any time. Any such change or termination may affect the benefits available to your survivors.

Other Events Ending Your Coverage

When any of the following happen, you may receive written notice that coverage under the Program (*i.e.*, life and/or medical coverage, as applicable) has ended on the date the Plan Administrator identifies in the notice:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because you knowingly gave the Plan Administrator, the Claims Administrator or the COBRA Administrator false, material information. Examples include false information relating to another person's eligibility or status as a Dependent.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Failure to Pay	You failed to pay a required contribution.
Failure to Repay Applicable Taxes	The Company seeks repayment of the amount of participant FICA (and any other applicable taxes) attributable to Same-Sex Domestic Partner coverage that is paid by the Company on the participant's behalf and you fail to repay such amounts to the Company.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to the Plan Administrator's staff, the Claims Administrator's staff, the COBRA Administrator's staff or a Provider.
Any Other Material Violation	There was any other material violation of the terms of the Program.

TRADITIONAL MEDICAL COVERAGE

An Introduction To Your Traditional Medical Coverage

This Traditional Medical Coverage Section summarizes the medical coverage administered by UnitedHealthcare and provided under the Traditional Healthcare Benefits of the Program. You are encouraged to review the benefit limitations of this *Traditional Medical Coverage* section by reading the *What's Covered – Benefits* beginning on page 33 and *What's Not Covered – Exclusions* section beginning on page 51 that pertain to you.

Be aware that your Physician does not have a copy of this SPD and is not responsible for knowing or communicating your benefits.

If you are enrolled in the Blue Cross Blue Shield National plan (BCBS), BCBS provides your medical benefits. The general information in this SPD about eligibility, how to enroll, coverage termination, and the important legal information applies to you. The information regarding dental and vision benefits also applies to you. However, your specific medical benefits and information about coordination of benefits and claims and appeals are not described in this SPD. You will receive, under separate cover, information about the medical benefits provided by BCBS. If you have questions about your medical benefits, refer to the phone number on the back of the identification card issued by BCBS. Please note that it is the responsibility of BCBS to provide you with the necessary information about your specific medical benefits. If you do not receive that information, contact the Plan Administrator.

The benefits described in this *Traditional Medical Coverage* section do not apply to if you are a retiree or a retiree's Spouse or Same-Sex Domestic Partner who has Reached Age 65. Your healthcare benefits are described in the Section of the SPD titled *Health Reimbursement Arrangement (HRA) Benefits*.

Eligibility For Traditional Medical Coverage

You are eligible for Traditional Medical Coverage under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled *Eligibility* beginning on page 9 and any additional requirements described in this section. You and your Spouse each become ineligible for Traditional Medical Coverage when you each Reach Age 65.

What's Covered – Traditional Medical Coverage

ACCESSING BENEFITS

As a participant in the Program, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of benefits you receive and any benefit limitations that may apply. You are eligible for the Network level of benefits under the Program when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare or Caterpillar to provide those services. Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Program generally pays benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Caterpillar Network Plan

If you are enrolled in a Caterpillar Network plan, you can choose to receive either Network Benefits or Non-Network Benefits. You must use a Caterpillar Network facility or Physician to obtain Network Benefits. However, not all services or treatments are available through a Caterpillar Network facility. If you use a Physician or facility outside of the Network, the Eligible Expense standard will apply. In some cases, a Provider or facility will be subject to further restriction, and expenses incurred may not be eligible for reimbursement under the Program. Refer to the paragraph below entitled *Non-Covered Providers* beginning on page 55. If you use a Caterpillar Network Physician or facility, you will be reimbursed at the highest level of benefits. You are responsible for ensuring that your Provider is a Caterpillar Network Provider. A list of current Network Providers can be found at benefits.cat.com or you can call the Caterpillar HR Service Center Americas at (800) 447-6434. The Claims Administrator, in its sole discretion, may allow a Covered Person to use a UnitedHealthcare Network Provider and reimburse such Covered Person at the highest level of benefits.

UnitedHealthcare Network Plan

If you are enrolled in a UnitedHealthcare Network plan, you can choose to receive either Network Benefits or Non-Network Benefits. You must use a Network Physician, Network Hospital and Skilled Nursing Facility to obtain Network Benefits. If you use a non-Network Physician, Hospital or Skilled Nursing Facility, the Eligible Expense standard will apply. If you use a Network Physician, Network Hospital and Network Skilled Nursing Facility, you will be reimbursed at the highest level of benefits. You are responsible for ensuring that your Provider is a Network Provider. A list of current Network Providers can be found at www.myuhc.com or you can call the Claims Administrator at the telephone number shown on your ID card or in the section entitled *Contact Information* beginning on page 121. The Claims Administrator, in its sole discretion, may allow a Covered Person to use a Caterpillar Network Provider and reimburse such Covered Person at the highest level of benefits.

Non-Network Providers

If you are enrolled in a Caterpillar Network plan or a UnitedHealthcare Network plan, Eligible Expenses for Covered Health Services performed by non-Network Providers may be covered at the Network level for Eligible Expenses if no contracted Providers are available within 30 miles of your residence. Before receiving services, you must contact the Claims Administrator to confirm that the non-Network Provider services will be covered at the Network level. **Note that you must contact the Claims Administrator prior to each time you receive services.**

Out-of-Network Plan

If you are enrolled in an out-of-Network plan, depending on the geographic area in which you live, you may have access to some Network Providers. These Providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network Provider, your Co-payment and Co-insurance level will remain the same and you will be reimbursed consistent with these discounted rates. The portion that you owe may be less than if you received services from a non-Network Provider because the Eligible Expense may be a lesser amount. If you use a non-Network Provider, the Eligible Expenses standard will apply. A list of Network Providers can be found at www.myuhc.com or benefits.cat.com or you can call the Claims Administrator at the telephone number shown on your ID card or in the section entitled *Contact Information* beginning on page 121.

IDENTIFICATION CARD ("ID CARD")

You may be required to show your identification card ("ID card") when you request health care services from a Provider. If you do not show your ID card when requested, Providers have no way of knowing that you are enrolled in the Program.

ELIGIBLE EXPENSES

Eligible Expenses for Covered Health Services, incurred while the Program is in effect, are the amount that the Program will pay for benefits, as determined by the Plan Sponsor or its designee. In almost all cases the Plan Sponsor's designee is the Claims Administrator.

The Plan Sponsor has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Program.

Eligible Expenses are the amount the Claims Administrator determines that the Program will pay for benefits. For Network Benefits for Covered Health Services provided by a Network Provider, you are not responsible for anything except your cost sharing obligations (Co-payment, Co-insurance and Annual Deductible). For benefits for Covered Health Services provided by a non-Network Provider (other than Emergency services or services otherwise arranged by the Claims Administrator), you are responsible to work with the non-Network Physician or Provider to resolve any amount billed to you that is greater than the amount the Claims Administrator determines to be an Eligible Expense as described below. Eligible Expense are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines, as described in the SPD.

When Covered Health Services are received from a non-Network Provider, Eligible Expenses are an amount negotiated by the Claims Administrator, a specific amount required by law (when required by law), or an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Co-payment, Co-insurance or Annual Deductible. The Program will not pay excessive charges or amounts you are not legally obligated to pay.

ADVOCACY SERVICES FOR MEDICAL BENEFITS

The Claims Administrator provides advocacy services on your behalf with respect to non-Network Providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the telephone number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable Co-payment or Co-insurance. In addition, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Program and its participants (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

PERSONAL HEALTH SUPPORT

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents. Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is notified in advance of a treatment or service, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

NOTIFICATION REQUIREMENTS

Prior notification is suggested before you receive certain Covered Health Services. You are responsible for notifying Personal Health Support[SM] before you receive these Covered Health Services.

Services for which you should provide prior notification appear in this section under the section entitled *Notify Personal Health Support[SM]*? column in the *Benefits Information Grid* beginning on page 38.

To notify Personal Health Support[SM], call the telephone number shown on your ID card or in the section entitled *Contact Information* beginning on page 121. You should confirm with the Claims Administrator that the services you plan to receive are Covered Health Services, even if not indicated in the *Notify Personal Health Support[SM]*? column because, in some instances, certain procedures may not meet the definition of a Covered Health Service and are therefore excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy; and upper lid blepharoplasty.
- The Experimental or Investigational Services or Unproven Services exclusion.
- Any other limitation or exclusion of the Program.

If you are enrolled in Medicare on a primary basis (Medicare pays before the Program pays benefits), the notification requirements described in this SPD do not apply to you. You are not required to notify Personal Health Support[SM] before receiving Covered Health Services when Medicare is the primary payer. However, you should notify Personal Health Support[SM] if you will be receiving services not covered by Medicare (*e.g.*, skilled nursing home stays after Medicare is exhausted).

For certain Covered Health Services, Network Providers are responsible for obtaining prior authorization. Network Providers cannot bill you for services they fail to prior authorize as required.

2ND.MD SERVICES

Participants enrolled in a medical benefit administered by UnitedHealthcare have access to 2nd.MD, a virtual expert medical consultation and navigation service that connects participants with board-certified specialists to discuss a diagnosis or treatment plan. 2nd.MD services are provided by the Plan at no cost to the participant. For more information about 2nd.MD, please visit the website at https://benefits.cat.com/en/2nd-MD.html.

BENEFITS AT A GLANCE

The following table outlines your Annual Deductible, your Maximum Out-of-Pocket cost and provide an overview of Co-payments and Co-insurance that apply when you receive certain Covered Health Services.

Note: **The information in the table will change from time to time. You will be notified during annual enrollment (or at another appropriate time) regarding applicable deductibles, maximums, co-payments, and co-insurance.**

Medical Benefit Options														
Network Service Area	Medical Benefit Option	Annual Deductible		Maximum Out-of-Pocket				Program Level Co-insurance - Hospital (Reimbursement Percentage/Co-insurance Amount)		Program Level Co-insurance - Physician (Reimbursement Percentage/Co-insurance Amount)		Preventive (No Deductible Applies)	
		Network & Non-Network		Network		Non-Network							
		Individual	Family	Individual	Family	Individual	Family	Network	Non-Network	Network	Non-Network	Network	Non-Network
Reside in a Network Area	BCBS National	$500	$1,000	$2,000	$4,000	None	None	80%/20%	0%/100%	80%/20%	0%/100%	100%	0%
	UHC Choice Plus PPO	$800	$1,600	$3,000	$6,000	None	None	80%/20%	50%/50%	80%/20%	50%/50%	100%	50%
	UHC Consumer Choice	$1,500	$3,000	$3,000	$6,000	None	None	80%/20%	50%/50%	80%/20%	50%/50%	100%	50%
	UHC Consumer Max	$3,000	$6,000	$5,000	$10,000	None	None	80%/20%	50%/50%	80%/20%	50%/50%	100%	50%
Reside in a Out-of-Area	UHC Choice Plus PPO	$800	$1,600	$3,000/$6,000				80%/20%		80%/20%		100%	
	UHC Consumer Choice	$1,500	$3,000	$3,000/$6,000				80%/20%		80%/20%		100%	
	UHC Consumer Max	$3,000	$6,000	$5,000/$10,000				80%/20%		80%/20%		100%	

If you are not required to pay a premium for your coverage, your coverage is provided under Option A, which results in the lowest out-of-pocket expenses to you.

If you are enrolled in family coverage* under the PPO or BCBS plan option, no one Covered Person may have more than the individual Annual Deductible applied to the family Annual Deductible, and after the Annual Deductible is met, no one Covered Person may have more than the individual Maximum Out-of-Pocket amount applied to the family Maximum Out-of-Pocket amount.

If you are enrolled in family coverage* under a CDHP option, you must meet the entire family Annual Deductible (either by one Covered Person's expenses meeting the family Annual Deductible or by the combined expenses of multiple family members meeting the family Annual Deductible) before the Program will begin to pay benefits (except for preventive care). After the family Annual Deductible is met, you must meet the entire family Maximum Out-of-Pocket amount (either by one Covered Person's expenses meeting the family Maximum Out-of-Pocket or by the combined expenses of multiple family members meeting the family Maximum Out-of-Pocket) before the Program will begin to pay 100% of covered healthcare costs.

*Family coverage includes any coverage category other than Individual (e.g., Employee + Spouse, Employee + Child(ren), Employee + Family).

See the examples below. Examples are for illustrative purposes only. Actual dollar amounts could vary.

Example 1

Michael, his spouse, and his three children are enrolled in family coverage under the UHC Choice Plus PPO option.

Michael has surgery performed by a Network Provider, and his expenses total $1,000. Michael must pay the first $800 because that is the individual deductible applied to a single person within the family. Once Michael pays the deductible of $800, the Program's Co-insurance is applied. At this point, Michael will need to pay 20% of the remaining costs of $200. Michael will pay $40, and the Program will pay $160.

Later, one of Michael's kids has health expenses of $2,000. Because Michael has not yet met the family deductible under the plan option, he must pay 100% of the cost up to the $1,600 family deductible. (Remember, Michael already paid $800 towards the deductible due to his healthcare expenses.) Michael pays $800 of his child's healthcare expenses, and when this amount is combined with the $800 Michael has already paid for his own healthcare expenses, Michael has met the family deductible of $1,600. The Program's Co-insurance is applied, and Michael will pay 20% of the remaining $1,200 ($240), and the Program will pay 80% ($960). The Co-insurance will be applied to any Covered Health Services for the remainder of the plan year until

Michael meets the Maximum-Out-of-Pocket limit. Once the Maximum-Out-of-Pocket limit is reached, the Program will pay 100% of Covered Health Services.

Note: Under the PPO and BCBS options, prescription drug costs do not apply toward the Annual Deductible and Maximum Out-of-Pocket limit. Michael would need to pay any prescription drug co-pays and/or co-insurance for himself and his family even after reaching the Maximum Out-of-Pocket limit.

Example 2

Mia, her spouse, and her son are enrolled in family coverage under the UHC Consumer Max CDHP option.

Mia's son develops a serious illness and has to be hospitalized at a Network Hospital where his expenses total $5,000. Mia must pay the first $5,000 because she has not reached the family deductible of $6,000. (Note: There is no individual deductible that applies to individuals enrolled in family coverage under a CDHP option.)

Later, Mia's spouse also has healthcare expenses from a Network Physician of $2,000. Mia mist pay the first $1,000 to meet the family's $6,000 deductible. After she meets the deductible, she will need to pay 20% of the remaining expenses ($200) and the Program will pay 80% ($800). The Co-insurance will be applied to any Covered Health Services for the remainder of the plan year until Mia meets the Maximum Out-of-Pocket limit. Once the Maximum Out-of-Pocket limit is reached, the Program will pay 100% of Covered Health Services. (Note: Only expenses for Network Providers are applied to the Maximum Out-of-Pocket limit.)

Note: Under the CDHP options, prescription drug costs are applied towards the Annual Deductible and Maximum Out-of-Pocket limit. Mia would have to pay the full cost of prescription drugs until the Annual Deductible is met, and then pay the applicable Co-Payment or Co-insurance amounts until she reaches the Maximum Out-of-Pocket limit.

BENEFIT INFORMATION

Important Points to Remember

Benefits that are <u>not</u> Covered Health Services are sometimes listed in two places:

- The *Benefits Information* grid beginning on page 38
- The *What's Not Covered – Exclusions* section beginning on page 51

Benefits Information Grid

Note: See the *Description of Network and Non-Network Benefits* sections beginning on pages 58 and 61 to understand which Providers are considered Network Providers in the Caterpillar Network and which are considered Network Providers in the UnitedHealthcare Network.

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	**Non-Network**
1. Acupuncture Services Acupuncture services for pain therapy when both of the following are true: • Another method of pain management has failed. • The service is performed by a Provider in the Provider's office.	No	20% after deductible	50% after deductible
Acupuncture is also a Covered Health Service for the treatment of: • Nausea of Chemotherapy, or • Post-operative nausea, or • Nausea of early Pregnancy.			
2. Allergy Services **Testing** Covered Health Services include testing for allergy care in a Physician's office. **Drug Treatment for Allergy Care** Covered Health Services include drug treatment for allergy care in a Physician's office. Coverage for an office visit associated with the allergy treatment described herein shall be determined in accordance with the provisions described in Item 18 (Physician's Services).	No	20% after deductible	50% after deductible
3. Ambulance Services **Ground Ambulance:** Covered Health Services include transportation from place where injured or stricken by illness to the nearest Hospital or from a Hospital where medically required services are not available to the nearest Hospital where such services are available (such as a burn center or trauma center). **Air Ambulance:** Air ambulance transport is covered in the following circumstances: • Either: 1. Patient requires transport from one Hospital to another because the first Hospital does not have the required services and/or facilities to treat the patient; or 2. Ground transportation is not appropriate due to distance or need of rapid transit; and • Such method of transportation is deemed medically required by the attending Physician (*e.g.*, because of the individual's medical condition, land transportation cannot be used); and	No*****	20% after deductible	50% after deductible

• Such method of transportation is in fact an ambulance service and not a charter flight service. ***Note:** You are not required to notify Personal Health Support[SM]. However, for air ambulance, you should call to verify coverage is available.			
4. Chiropractic Services/Spinal Manipulations Covered Health Services include chiropractic therapy and/or adjustments for Sickness or Injury. X-rays and labs performed in the chiropractor's office are described in Item 21 (Professional Fees for Surgical and Medical Services). Massage therapy is **not** a Covered Health Service. Benefits for spinal treatment are limited to a maximum of $700 per Covered Person per calendar year. You are responsible for any amount exceeding this $700 calendar year maximum.	No	20% after deductible	50% after deductible
5. Durable Medical Equipment Durable Medical Equipment must meet all of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Can withstand repeated use. • Not of use to a person in the absence of disease or disability. The Claims Administrator is responsible for determining the coverage criteria for Durable Medical Equipment and has the final determination. If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include, but are not limited to: • Mechanical equipment Necessary for the treatment of chronic or acute respiratory failure or conditions (excluding air conditioners, humidifiers, dehumidifiers, air purifiers and filters). • Delivery pumps for tube feedings. • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen concentrator units and the rental of Necessary equipment to administer oxygen (including tubing and connectors). • Speech aid devices and tracheoesophageal voice devices required for treatment of severe treatment of severe speech impediment or lack of speech directly attributed to sickness or injury. The Program provides benefits for a single unit of Durable Medical Equipment (*e.g.*, one insulin pump) and covers the cost of repairing that unit. In some cases, benefits may be provided for the replacement of a type of Durable Medical Equipment. The Claims Administrator in its sole discretion may approve the purchase of such equipment if it can reasonably be assumed that the duration of need is such that the rental price would exceed the purchase price, or said item cannot be made available on a rental basis.	Yes, for items over $1,000*****	20% after deductible	50% after deductible

***Note:** It is strongly recommended that you contact Personal Health Support℠ if you have any questions on whether an item will be covered. You are required to contact Personal Health Support℠ for items over $1,000.			
6. Emergency Room Health Services Emergency Room Health Services are services required to stabilize or initiate treatment in an Emergency. Emergency Room Health Services must be received on an outpatient basis at a Hospital or Alternate Facility and billed by the Hospital or Alternate Facility. Network benefits are paid for Emergency Room Health Services, even if the services are provided by a non-Network Provider. If you are enrolled in the traditional PPO or BCBS plan option, an Emergency room Co-payment of $100 per visit applies. This Co-payment is in addition to amounts you owe for your Annual Deductible and Co-insurance. The Emergency room Co-payment is waived if you are admitted to the Hospital from the emergency room. Observation is not considered an admission. Benefits are payable for the Outpatient Observation of a patient. For this purpose, "Outpatient Observation" means a brief hospital stay which (1) is not for the convenience of the patient, the patient's family, or a Physician, or in connection with the patient's admission, (2) lasts up to 24 and 48 hours, and (3) consists solely of short term treatment, assessment and reassessment before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient or is instead able to be discharged from the hospital. ***Note:** Please remember that if you are admitted to a Hospital as a result of an Emergency, you should notify Personal Health Support℠ within two business days or the same day of admission, or as soon as reasonably possible.	No*****	20% after deductible for all Covered Persons plus $100 Co-pay for those enrolled in a traditional PPO or BCBS plan option	20% after deductible for all Covered Persons plus $100 Co-pay for those enrolled in a traditional PPO or BCBS plan option
7. Gender Dysphoria Treatment Consistent with current Program administration, Covered Health Services for the treatment of gender dysphoria will be payable if such treatment services are medically necessary as determined by the Claims Administrator**.** ***Note:** You are encouraged to contact the Claims Administrator to verify coverage prior to receiving treatment.	Yes*****	20% after deductible	50% after deductible
8. Habilitative Services Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met: ■ The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist. ■ The initial or continued treatment must be proven and not Experimental or Investigational. Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. The Program may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Program to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that			

continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Program may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated. For purposes of this benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living. Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.			
9. Hearing Care **Audiologist** Coverage is limited to charges by a licensed or certified audiologist for Physician-prescribed hearing evaluations to determine location of a disease within the auditory system. The Program covers tests and treatment due to illness and Injury only. An audiometric exam is covered in conjunction with medical illness. **Hearing Evaluation** Coverage is limited to one hearing evaluation every sixty (60) months for one or both ears. **Hearing Aid** Coverage is limited to one hearing aid per ear once every sixty (60) months. Duplicates or replacements for lost or stolen Hearing Aids are not covered.	No	20% after deductible	50% after deductible
10. Home Health Care A patient qualifies for coverage under the home health benefit when a skilled service is required in lieu of a coverable Inpatient Stay. Personal Health Support℠ will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.	Yes*****	20% after deductible	50% after deductible
Services must be both of the following: • Ordered by a Physician. • Provided by an agency that is licensed by the state as a Home Health Agency and is Medicare certified. If a patient qualifies for coverage under the home health benefit, the following services may be covered: 1. Registered Nurse 2. Licensed Practical Nurse 3. Home Health Aide or Certified Nursing Assistant 4. Physical Therapist/Occupational Therapist/Speech Therapist 5. Medical Social Worker 6. Intravenous medications and TPN 7. Intravenous supplies 8. Wound care supplies 9. Enteral feeding formula and supplies when the enteral feeds are needed due to an inborn error in metabolism 10. Dietician 11. Line maintenance supplies			

The total combined cost of services 1, 2 and 3 (the nursing component) cannot exceed the room and board cost of a Skilled Nursing Facility. The home health benefit is limited to 100 visits per Covered Person per calendar year where any visit up to 4 hours is considered 1 visit. The patient must be homebound. ***Note:** Please remember to notify Personal Health Support[SM] five business days before receiving services.			
11. Hospice Care Patient qualifies for hospice when a Physician certifies that he is terminally ill and hospice-appropriate. A patient is terminally ill if the medical prognosis is that the patient's life expectancy is six months or less if the illness runs its normal course. Services must be provided by an agency that is licensed by the state as a home health or Hospice Agency and is Medicare certified. If a patient qualifies for coverage under the hospice benefit, the following services may be covered in the home: 1. Registered Nurse 2. Licensed Practical Nurse 3. Home Health Aide or Certified Nursing Assistant 4. Medical Social Worker 5. IV medications and supplies related to the terminal condition 6. Wound care supplies The total combined cost of the nursing component (1, 2 and 3 above) cannot exceed the room and board cost of a Skilled Nursing Facility. The Claims Administrator may determine that the patient qualifies for room and board coverage in a Medicare-certified nursing facility. If the patient chooses to use a Medicare-certified nursing facility, services 1 - 6 above would not apply. Coverage for room and board is subject to a lifetime limit of 30 days. Durable Medical Equipment is covered under the regular Durable Medical Equipment benefit. For prescription drugs (other than IV), see the *Prescription Drug Benefits* section beginning on page 65 of this SPD. There is no coverage for bereavement counseling or chaplain services. ***Note:** Please remember to notify Personal Health Support[SM] five business days before receiving services.	Yes*****	20% after deductible	50% after deductible
12. Hospital – Inpatient Stay Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Reimbursement for a private room will be made up to the amount of the Semi-private Room rate unless confined to a private isolation room, which is allowable for certain medical conditions (*e.g.*, infectious hepatitis, spinal meningitis, severe burns). ***Note:** Please remember that if you are admitted to a Hospital, you should notify Personal Health Support[SM] within two business days or the same day of admission, or as soon as reasonably possible.	Yes*****	20% after deductible	50% after deductible
13. Infertility Services	No	20% after deductible	50% after deductible

Procedures for the diagnosis of infertility and procedures to correct a medical condition causing infertility, including semen analysis for men. **The following treatments and services related to those treatments are NOT covered:** • Artificial insemination. • Drug therapy. • In-vitro fertilization – gamete (GIFT) and zygote (ZIFT) intrafallopian transfer procedures. • Reversal of tubal ligation or vasectomy.			
14. Maternity Services Benefits for Pregnancy will be paid at the same level as benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. The Program will pay benefits for an Inpatient Stay of at least: • 48 hours for the mother and newborn child following a normal vaginal delivery. • 96 hours for the mother and newborn child following a cesarean section delivery.	No*****	20% after deductible	50% after deductible
If the mother agrees, the attending Provider may discharge the mother and/or the newborn child earlier than these minimum time frames. ***Note:** Please remember that if you are admitted to a Hospital, you should notify Personal Health Support℠ within two business days or the same day of admission, or as soon as reasonably possible.			
15. Mental Health Services Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, Alternate Facility, or 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. Service 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.	No	20% after deductible	50% after deductible

16. Nutritional Counseling Covered Health Services for Covered Persons with medical conditions that require a special diet when performed by a registered dietician while in an Inpatient Hospital setting. Some examples of such medical conditions include: • Diabetes mellitus. • Gestational Diabetes • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias.	No	20% after deductible	50% after deductible
17. Obesity Surgery Benefits under this section include surgical treatment of morbid obesity. Currently, the Program follows guidelines set by the Claims Administrator. Limitations: ▪ Benefits are limited to one surgery per lifetime per Covered Person. ▪ Repeat bariatric or lap band repair are covered only if the following guidelines are adhered to: ➢ For the original procedure, patient met all the screening criteria, including BMI requirements; ➢ The patient has been compliant with a prescribed nutrition and exercise program following the original surgery; and ➢ Significant complications or technical failure (i.e., break down of gastric pouch, slippage, breakage or erosion of gastric band, bowel obstruction etc.) of the bariatric surgery has occurred that requires take down or revision of the original procedure that could only be addressed surgically and Patient is requesting reinstitution of an acceptable bariatric surgical modality. ➢ If you are enrolled in a Caterpillar Network plan or a UnitedHealthcare Network plan, you are required to use a Network Hospital. This limitation applies even if your Network Provider refers you to a non-Network Provider or Hospital. No benefits will be paid if you use a non-Network Provider or Hospital unless you reside outside of a Network area and are enrolled in an out-of-Network plan. **Note:** It is important to contact the Claims Administrator to determine allowable coverage prior to services being rendered.	Yes	100% after deductible	50% after deductible
18. Oral Surgery Covered Health Services include dental treatment for dislocations, fracture care and certain incisions and excisions, or any other oral surgery deemed to be of a medical nature and medically appropriate; prosthetic devices prescribed for medical reasons; anesthetics administered in connection with covered oral surgery. Oral surgery will be covered as a Covered Health Service, rather than as a dental benefit, if anesthesia is	No*	20% after deductible	50% after deductible

required for a medical reason or the oral surgery is for a medical reason or for the treatment of injury to the face or jaw. Refer to the *Dental Benefits* section beginning on page 69 of this SPD for additional oral surgery coverage. If more than one procedure can meet your functional needs, benefits are available only for the most cost-effective procedure. The Plan Administrator will determine whether any specific oral-related charges are covered (if at all) under oral surgery or as Dental Benefits. ***Note:** You are not required to notify Personal Health Support[SM]; however, it is strongly recommended that you contact Personal Health Support[SM] to verify that the services you require are covered under this benefit.			
19. Outpatient Surgery, Diagnostic and Therapeutic Facility Services Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to Outpatient surgery, diagnostic and therapeutic services are described in Item 21 (Professional Fees for Surgical and Medical Services).	No	20% after deductible	50% after deductible
Covered Health Services received on an Outpatient basis at a Hospital or Alternate Facility, including: • Surgery and related services • Lab and radiology/X-ray services • Other diagnostic tests and therapeutic treatments (including intravenous cancer chemotherapy or other intravenous infusion therapy).			
20. Physician's Services Benefits for Physician's services include: • Evaluation and management services provided in the Physician's office, Hospital or other ambulatory facility. • Covered Health Services as a result of Sickness or Injury. • Injection services at a Physician's office and covered drugs injected at a Physician's office. • Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or work). Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card. Benefits for virtual visits do not include email, or fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities. **Not Covered:** • Routine/preventive health checkups (except as described below). • Routine immunizations, including well child immunizations. • Immunizations associated with employer-required travel. • Video consultations, including virtual visits, from a non-network Provider.	No	20% after deductible	50% after deductible

21. Preventive Care Services The Program covers only the following preventive care services**:** **Well Adult Preventive Care** – Benefits are payable for the following screening services: Colonoscopy Screening – Screening is limited to the following schedule: ▪ One annual Stool occult blood screening between ages 50 – 54 ▪ One colonoscopy screening at age 55 and over. Expenses incurred as a result of the screening colonoscopy and related to a diagnosed condition are subject to deductible and Co-insurance. Lipid and Blood Sugar Screening – Screening is limited to the following schedule: ▪ For males age 35 and over, one test every five (5) years ▪ For females age 45 and over, one test every five (5) years	No	0% no deductible applies	50% after deductible
Well Woman Preventive Care – Benefits are payable for one annual routine gynecological exam which includes a physician pelvic and breast exam. Benefits also are payable for a PAP smear every three years. In addition, benefits are payable for mammography testing as follows: Mammography Testing – Mammography testing is limited to the following schedule: ▪ One between ages 35 – 39 ▪ One every calendar year from age 40 and over **Well Child Preventive Care** – Benefits are payable in any plan year for routine pediatric office visits for Dependent children up to and including age six (6). The lifetime maximum is $800 per child. You are responsible for any amount exceeding the $800 lifetime maximum per child. Routine immunizations are not covered. **NOTE:** This section only describes preventive care services. Diagnostic services are covered at the appropriate Co-insurance level without age limits.			
22. Professional Fees for Surgical and Medical Services Professional fees for services, surgical procedures and other Medical Care received at a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, or Alternate Facility, or in a Physician's office include, but are not limited to: • Pathology. • X-ray/diagnostic interpretation. • Anesthesiology. • Radiation therapy.	No	20% after deductible	50% after deductible
23. Prosthetic Devices Prosthetic devices that replace a limb or body part including: • Artificial limbs. • Artificial eyes. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. • Ostomy and colostomy supplies. • Mandibular advancement devices used to treat sleep apnea.	No	20% after deductible	50% after deductible

• Orthotic appliances and devices when prescribed by a Physician and custom manufactured or custom fitted to an individual participant by a Physician. **The following orthotic appliances and devices are NOT covered:** • Foot orthotics and shoe orthotics except for custom-molded shoe inserts prescribed to treat a disease or illness of the foot; • Orthotic appliances for the treatment of flat feet; • Orthotic appliances for the treatment of sublaxation of the foot; • Any braces or orthotic appliances that can be obtained without a Physician's order; and • Any other orthotic appliance or device determined unnecessary by the Claims Administrator. It is recommended that you contact Personal Health Support[SM] if you have any questions on whether an item will be covered. If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of, a Physician. The Program provides benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of unusable prosthetic device. Duplicates and replacement of lost or stolen prosthetic devices are **not** covered.			
24. Reconstructive Procedures **Reconstructive Procedures** -- Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. Improving or restoring physiologic function means that the target organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored. **Cosmetic Procedures** -- Services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function such as breathing. The Program does not provide benefits for Cosmetic Procedures. Some services are considered cosmetic in some circumstances and reconstructive in others. This means there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations the purpose would be to improve appearance, and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision while on other occasions improvement in appearance is the primary purpose of the procedure. Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. For more information about benefits for mastectomy-related services, contact the Claims Administrator at the telephone number on your ID card or in the section entitled *Contact Information* beginning on page 121.	Yes*****	20% after deductible	50% after deductible

Cosmetic Procedures are always excluded from coverage. ***Note:** You should notify Personal Health Support℠ before receiving services. When you provide notification, Personal Health Support℠ can verify that the services are a reconstructive procedure rather than a Cosmetic Procedure.			
25. Rehabilitation Services – Outpatient Therapy Rehabilitation services must be performed by a licensed therapy Provider, under the direction of a Physician. Outpatient rehabilitation services for: • Physical therapy. • Occupational therapy. • Cardiac rehabilitation therapy. • Pulmonary rehabilitation therapy. Outpatient rehabilitation services for physical therapy, occupational therapy, cardiac rehabilitation therapy, and pulmonary rehabilitation therapy are limited to **60 visits** per type of therapy per Covered Person per calendar year. You are responsible for any amount exceeding this 60 visit per calendar year maximum.	No	20% after deductible	50% after deductible
26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Covered Health Services include services for an Inpatient Stay in a Skilled Nursing Facility or non-acute Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Services must be received from a Provider who is both Medicare certified and licensed by the state. In general, the intent of skilled nursing is to provide benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of Skilled Nursing, rehabilitation and Facility services which are less than those of a general acute Hospital but greater than those available in the home setting. The Covered Person is expected to improve to a predictable level of recovery. Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, benefits are NOT available when these services are required intermittently (such as physical therapy three times a week). Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence. ***Note:** Please remember to notify Personal Health Support℠ five business days prior to your admission.	Yes*****	20% after deductible	50% after deductible
27. Speech Therapy Covered Health Services for speech therapy services will be payable if such speech therapy services are: (i) medically necessary as determined by the Claims Administrator; (ii) prescribed by a Physician; and (iii) performed by a qualified speech therapist. For this purpose, a "qualified speech therapist" is an audiologist who (i) possesses a Master's or Doctorate Degree in Audiology and Speech Pathology from an accredited university, (ii) possesses a Certificate of Clinical Competence in Audiology	No	20% after deductible	50% after deductible

from the American Speech and Hearing Association, and (iii) where applicable, is licensed by the state. Speech therapy is limited to sixty (60) visits per Covered Person, per calendar year.			
28. Substance Abuse Services Substance Abuse Services include those received on an inpatient or outpatient basis in a Hospital, Alternate Facility, or 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.	No	20% after deductible	50% after deductible
29. Temporomandibular Joint Dysfunction (TMJ) Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenial defect, developmental defect, or oropathology. Please note that benefits are not available for charges for services that are dental in nature.	No	20% after deductible	50% after deductible
30. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a Designated Provider or a Caterpillar designated facility to receive full benefits. Designated Providers may change from time to time. For information on current Designated Providers, contact the Claim Administrator at the number on your ID card or in the section entitled *Contact Information* beginning on page 121. It is your responsibility to determine what facilities qualify as Designated Providers before you receive services or treatment. Generally, services by radiologists, anesthesiologists and pathologists are included in covered expenses and subject to limitations. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service and is not an Experimental or Investigational Service or an Unproven Service: • Bone marrow/peripheral stem cell transplants (not all bone marrow transplants meet the definition of a Covered Health Service). • Heart transplants. • Heart/lung transplants.	Yes*****	20% after deductible	50% after deductible

• Lung transplants. • Kidney transplants. • Pancreas transplants. • Kidney/pancreas transplants. • Liver transplants. • Cornea transplants (it is not required that a cornea transplant be performed at a designated facility). The Claims Administrator will determine if the transplant is a Covered Health Service. Organ or tissue transplant or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Personal Health Support℠ to be a proven procedure for the involved diagnoses. Under the Program, there are specific guidelines regarding benefits for transplant services. For information about these guidelines, contact Personal Health Support℠ at the telephone number on your ID card or in the section entitled *Contact Information* beginning on page 121. Covered organ transplants means transplantation of only procedures pre-approved by the Claims Administrator in its sole discretion and shall not include any transplantation of any non-human organs, or artificial devices. If the transplant is a Covered Health Service and it is: • Received at a Designated Provider or a Caterpillar designated facility, benefits will be payable at the appropriate Network level (after you meet your deductible). • Received at a non-Designated Provider, benefits will be payable at 50% of Eligible Expenses (after you meet your deductible). ***Note:** Personal Health Support℠ notification is required for all transplant services. You must notify Personal Health Support℠ within seven (7) business days before the scheduled date of any of the following: • The evaluation. • The donor search. • The organ procurement/tissue harvest. • The transplant. You should notify Personal Health Support℠ as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).			
31. Urgent Care Center Services Covered Health Services received at an Urgent Care Center as a result of Sickness or Injury are allowed. When services to treat urgent health care needs are provided in a Physician's office, benefits are available as described under Item 19 (Physician's Services) earlier in this section.	No	20% after deductible	50% after deductible

What's Not Covered – Exclusions

THE USE OF SECTION HEADINGS

To help you find specific exclusions more easily, this SPD uses headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you and your covered Dependents.

PLAN EXCLUSIONS

The Program will not pay or approve benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician; or
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in the *What's Covered – Benefits* section beginning on page 33 or through an amendment to this SPD.

Alternative Treatments

- Acupressure;
- Aromatherapy;
- Hypnotism;
- Rolfing;
- Naturalist or Naturopath; and
- Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Comfort or Convenience

- Television;
- Telephone;
- Beauty/Barber service;
- Guest service;
- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
    - Air conditioners;
    - Air purifiers and filters;
    - Dehumidifiers;
    - Humidifiers;
    - Home Remodeling; and
    - Seat Lift Chair;
- Devices and computers to assist in communication and speech except for speech aid devised and tracheo-esophageal voice devices for which benefits are provided; and
- Home remodeling to accommodate a health need (*e.g.*, ramps and swimming pools).

Dental

Refer to the *Dental Benefits* section beginning on page 69 of this SPD because benefits may be payable under that section.

- Dental care;
- Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:

  - Periodontal treatment and endodontic services;
  - Extraction (including wisdom teeth), restoration and replacement of teeth; and
  - Services to improve dental clinical outcomes;
- Dental braces;
- Dental implants or any treatment to improve the ability to chew or speak;
- Dental x-rays, supplies and appliances, including hospitalization and anesthesia, except for
  - Charges for hospitalization and anesthesia where dental services are administered in a Hospital due to an underlying Injury, illness, mental condition or age that precludes such dental services from being delivered adequately and safely in an office setting;
  - Transplant preparation,
  - Initiation of immunosuppressive, direct treatment of an acute traumatic Injury, cancer or cleft palate; and
  - Oral surgery (see Item 17, Oral Surgery, of the *Benefits Information Grid* beginning on page 38 for coverage information)
- Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly.

Drugs

Refer to the *Prescription Drug Benefits* section beginning on page 65 of this SPD because benefits may be payable under that section.

- Prescription drug products for Outpatient use that are filled by a prescription order or refill;
- Self-injectable medications;
- Non-injectable medications given in a Physician's office except as required in an Emergency; and
- Over-the-counter drugs and treatments.

Experimental or Investigational Services or Unproven Services

Experimental or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service or an Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

Foot Care

- Except when needed for severe systemic disease:
  - Routine foot care (including the cutting or removal of corns and calluses); and
  - Nail trimming, cutting, or debriding;
- Hygienic and preventive maintenance foot care. Examples include the following:
  - Cleaning and soaking the feet;
  - Applying skin creams in order to maintain skin tone; and
  - Other services that are performed when there is not a localized illness, Injury or symptom involving the foot;
- Treatment of flat feet;
- Treatment of subluxation of the foot;

- Shoe orthotics, except for certain custom orthotics prescribed by a Physician on or after January 1, 2012 as described under Item 22 (Prosthetic Devices) of the *Benefits Information Grid* beginning on page 38; and
- Special shoes unless they are an integral part of a leg brace or scoliosis appliance as described under Item 22 (Prosthetic Devices) of the *Benefits Information Grid* beginning on page 38.

Medical Supplies and Appliances

- Devices used specifically as safety items or to affect performance in sports-related activities;
- Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Elastic stockings;
  - Ace bandages;
  - Gauze and dressings; and
  - Syringes;
- Orthotic appliances that straighten or reshape a body part for cosmetic reasons (including some types of braces); and
- Tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment as described under Item 5 (Durable Medical Equipment) of the *Benefits Information Grid* beginning on page 38.

Mental Health/Substance Abuse

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis;
- 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.
- Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice;
- 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*;
- Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents;
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangement;
- Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that are any of the following:
  - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
  - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; and
  - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective;
- Pastoral counselors;
- Treatment provided in connection with autism and autism spectrum disorders, including Intensive Behavioral Therapies; and

- Treatment provided in connection with tobacco dependency.

Non-Covered Providers

Any services, treatments, items or supplies received from a Non-Covered Provider are excluded under the Program. This means that any expenses incurred from a Non-Covered Provider are not covered under the Program and will not be paid or approved for reimbursement in any amount. In addition, amounts paid by you to a Non-Covered Provider will not count towards your Annual Deductible or Maximum Out of Pocket.

Just as it is your responsibility to determine - before incurring any expenses - whether your Provider is a Network Provider, it is also your responsibility to determine whether a Provider (who may previously have been a Network or a non-Network Provider) is or has become a Non-Covered Provider under the Program. You may obtain a list of all Non-Covered Providers from the website at benefits.cat.com.

Nutrition

- Megavitamin and nutrition-based therapy;
- Except as described in Item 15 (Nutritional Counseling) of the *Benefits Information Grid* beginning on page 38, nutritional counseling for either individuals or groups, including weight-loss programs, health clubs and spa programs; and
- Enteral feedings and other nutritional and electrolyte formulas, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, low cholesterol), oral vitamins, and oral minerals except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism.

Physical Appearance

- Cosmetic Procedures. (See the *Definitions* section beginning on page 123 of this SPD for the definition of Cosmetic Procedures.) Examples include:
    - Pharmacological regimens, nutritional procedures or treatments;
    - Tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); and
    - Scar or keloid removal or revision procedures except when:
        (i) The scar or keloid was caused by an accidental Injury or a covered surgical procedure; or
        (ii) The scars were a result of acne or other severe scarring disorders;
- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Item 22 (Reconstructive Procedures) of the *Benefits Information Grid* beginning on page 38;
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation;
- Weight-loss programs whether or not they are under medical supervision. Weight-loss programs for medical reasons are also excluded;
- Wigs regardless of the reason for the hair loss;
- Non-surgical treatment of obesity;
- Surgical treatment of obesity unless the patient is morbidly obese as defined in accordance with guidelines established by the Claims Administrator, in its sole discretion. If a patient qualifies, surgical treatment will be covered only once per lifetime;

- Services received from a personal trainer; and
- Liposuction.

Providers

- Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other Provider;
- Services that are self-directed to a freestanding or Hospital-based diagnostic facility; and
- Services ordered by a Physician or other Provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other Provider:
  - Has not been actively involved in your Medical Care prior to ordering the service, or
  - Is not actively involved in your Medical Care after the service is received.

  This exclusion does not apply to mammography testing.

Reproduction

- Fees, payments and associated expenses for surrogate parenting;
- Health services and associated expenses for elective abortion;
- Reversal of voluntary sterilization;
- Fees or direct payment to a donor for sperm or ovum donations;
- Monthly fees for maintenance or storage of frozen embryo;
- Contraceptive supplies and services. (Refer to the *Prescription Drug Benefits* section of this SPD.);
- Artificial insemination;
- Drug therapy; and
- In-vitro fertilization – Gamete (GIFT) and zygote (ZIFT) intrafallopian transfer procedures.

Services Provided under Another Plan

- Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation;
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you; and
- Health services for a Covered Person who is on active military duty.

Transplants

- Health services for organ and tissue transplants, except those described under Item 29 (Transplantation Services) of the *Benefits Information Grid* beginning on page 38;
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person;
- Health services for transplants involving mechanical or animal organs;
- Any solid organ transplant that is performed as a treatment for cancer; and
- Any multiple organ transplant not listed as a Covered Health Service under Item 29 (Transplantation Services) of the *Benefits Information Grid* beginning on page 38.

Travel

- Travel or transportation expenses, even though prescribed by a Physician.
- Immunizations required for travel.

Vision

Refer to the *Vision Benefits* section beginning on page 77 of this SPD because benefits may be payable under that section.

- Eye examinations;
- Lenses (glasses and contacts);
- Eye exercise therapy;
- Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery; and
- Contact lens solution.

All Other Exclusions

- Health services and supplies that do not meet the definition of a Covered Health Service. (See the *Definitions* section beginning on page 123 of this SPD.);
- Vaccinations and immunizations that are routine, preventative or associated with Employer-required travel;
- Physical, psychiatric or psychological exams, testing, or treatments that are otherwise covered under the Program when:
    - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
    - Related to judicial or administrative proceedings or orders;
    - Conducted for purposes of medical research; and
    - Required to obtain or maintain a license of any type;
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
- Health services received after the date your coverage ends, including health services for medical conditions arising before the date your coverage ends;
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Program;
- In the event that a Provider waives Co-payments or Co-insurance for a particular health service, no benefits are provided for the health service for which the Co-payments or Co-insurance are waived;
- Charges in excess of Eligible Expenses or in excess of any specified limitation;
- Growth hormones;
- Custodial Care;
- Domiciliary care;
- Private duty nursing;
- Respite care;
- Rest cures;

- Psychosurgery;
- Treatment of benign gynecomastia (abnormal breast enlargement in males) when considered cosmetic. Treatment of gynecomastia is covered based upon medical criteria;
- Medical and surgical treatment of excessive sweating (hyperhidrosis);
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;
- Appliances for snoring except mandibular advancement devices for documented sleep apnea;
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing;
- Any charges higher than the actual charge. The actual charge is defined as the Provider's lowest routine charge for the service, supply or equipment;
- Any charge for services, supplies or equipment advertised by the Provider as free;
- Any charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical incompetence;
- Any charges prohibited by federal anti-kickback or self-referral statutes;
- Any additional charges submitted after payment has been made and your account balance is zero;
- Any Outpatient facility charge in excess of payable amounts under Medicare;
- Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services;
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies; and
- Chelation therapy, except to treat heavy metal poisoning.

Description of Network and Non-Network Benefits (Reside in a Caterpillar Network Area)

NETWORK BENEFITS

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are any of the following:

- Provided by a Network Physician or other Network Provider.
- Emergency Room Health Services.
- Covered Health Services that are described as Network Benefits in the *What's Covered – Benefits* section beginning on page 33.

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	You are not responsible for anything except your cost sharing obligations (Co-payment, Co-insurance and Annual Deductible). See the *What's Covered – Benefits* section beginning on page 33.	You are responsible to work with the Non-Network Physician or Provider to resolve any amount billed to you that is greater than the amount the Claims Administrator determines to be an Eligible Expense. See the *What's Covered – Benefits* section beginning on page 33.
Who Should File Claims?	You are responsible for ensuring that a claim has been filed; however, a Provider may file claims on your behalf. See the *Filing a Claim for Benefits* section beginning on page 97.	You are responsible for ensuring that a claim has been filed; however, a Provider may file claims on your behalf. See the *Filing a Claim for Benefits* section beginning on page 97.
Outpatient Emergency Room Health Services	Emergency Room Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means if you seek Emergency care at a non-Network facility, you are not required to pay any difference between Eligible Expenses and the amount the Provider bills.	

Provider Network

The Claims Administrator or its affiliate, or the Company or its Affiliate, arranges for health care Providers to participate in a Network. You must receive Covered Health Services from a Caterpillar Network Provider in order to receive Network Benefits. A Provider outside of the Caterpillar Network is considered a non-Network Provider and will be paid at the non-Network level (with the exception of Emergency Room Health Services). However, if you are outside of the Caterpillar Network, the Claims Administrator, in its sole discretion, may permit you to use a UnitedHealthcare Network Provider and still receive Network benefits.

These Network Providers have agreed to discount their charges for Covered Health Services. Network Providers are independent practitioners. They are not employees of the Program or employees of the Claims Administrator. It is your responsibility to select your Provider. If you use a Network Provider, your Co-insurance amount will generally be less than it would be if you use a non-Network Provider. Since the total amount of Eligible Expenses may be less when you use a Network Provider, the portion that you owe will be less.

The credentialing process confirms public information about the Providers' licenses and other credentials but does not assure the quality of the services provided. The Plan Administrator or its designee may provide general information on the quality of Providers based on certain publicly available information about the Providers. Such general information is not a guarantee of the quality of services received from a Provider, and the Program, the plan sponsor, and the Plan Administrator are not liable for the quality of services received from a Provider. The Plan Administrator or its designee may also provide general information on the estimated cost of services at certain Providers. Such estimates are provided for convenience and initial planning purposes only and should not be relied on as the actual cost of the services. You should always confirm the actual cost of a service with a Provider before receiving treatment. The Program, the plan sponsor, and the Plan Administrator are not liable for any costs incurred because a participant relied on an estimate and did not verify the actual cost with the treating Provider.

You have access to the directory of Illinois Caterpillar Network Providers on benefits.cat.com. The Network of Providers is subject to change. Before obtaining services, you should always verify the Network status of a Provider. A Provider's status may change. You can verify the Provider's status by calling the Claims Administrator at the number on your ID card or in the *Contact Information* section beginning on page 121, or by using the benefits.cat.com website.

It is possible that you might not be able to obtain services from a particular Network Provider, or you might find that a particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to you, you must choose another Network Provider to get Network Benefits.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some products. Refer to your Provider directory or contact the Claims Administrator for assistance.

There are no discounts for services, treatments, items or supplies that are not covered by the Program.

Designated Providers and Other Providers

If you have a medical condition that Personal Health Support[SM] believes needs special services, they may direct you to a Designated Provider or other Provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Personal Health Support[SM] may direct you to a non-Network facility or Provider.

In both cases, benefits will be paid only if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other Provider chosen by Personal Health Support[SM].

NON-NETWORK BENEFITS

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by non-Network Physicians or non-Network Providers. Non-Network Benefits are also payable for Covered Health Services that are provided at non-Network facilities. However, if you are traveling or on vacation, office-based services for a non-Emergency situation may be payable at the Network level. Facility-based services will be subject to Program guidelines.

If there is no Network Provider within a 30-mile radius of your home zip code, you may be eligible to receive benefits for certain Covered Health Services paid at the Network level for Eligible Expenses. You may check a Provider's status in your area by visiting www.myuhc.com or by calling the Claims Administrator at the number on the back of your ID card or in the section entitled *Contact Information* beginning on page 121. All benefits that fall under this category must be approved prior to receipt of care for each occurrence and are subject to any plan limitations or exclusions set forth in this SPD.

EMERGENCY ROOM HEALTH SERVICES

The Program provides benefits for Emergency Room Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Room Health Services, even if the services are provided by a non-Network Provider.

If you are confined in a non-Network Hospital after receiving Emergency Room Health Services, Personal Health Support[SM] must be notified within two business days or on the same day of admission if reasonably possible. Personal Health Support[SM] may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date Personal Health Support[SM] decides a transfer is medically appropriate, Non-Network Benefits will be available if the continued stay is determined to be a Covered Health Service.

If you are admitted as an inpatient to a Hospital within 24 hours of receiving treatment for the same condition as an Emergency Room Health Service, you will not have to pay the emergency room Co-payment for Emergency Room Health Services.

Note: The emergency room Co-payment for covered Emergency Room Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an Inpatient in the Hospital. In this case, the emergency room Co-payment will apply. The emergency room Co-payment information can be found under Item 6 (Emergency Room Health Services) of the *Benefits Information Grid* beginning on page 38.

Description of Network and Non-Network Benefits (Reside in a UnitedHealthcare Network Area)

NETWORK BENEFITS

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are any of the following:

- Provided by a Network Physician or other Network Provider.
- Emergency Room Health Services.
- Covered Health Services that are described as Network Benefits in the *What's Covered – Benefits* section beginning on page 33.

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	You are not responsible for anything except your cost sharing obligations (Co-payment, Co-insurance and Annual Deductible). See the *What's Covered – Benefits* section beginning on page 33.	You are responsible to work with the Non-Network Physician or Provider to resolve any amount billed to you that is greater than the amount the Claims Administrator determines to be an Eligible Expense. See the *What's Covered – Benefits* section beginning on page 33.
Who Should File Claims?	You are responsible for ensuring that a claim has been filed; however, a Provider may file claims on your behalf. See the *Filing a Claim for Benefits* section beginning on page 97.	You are responsible for ensuring that a claim has been filed; however, a Provider may file claims on your behalf. See the *Filing a Claim for Benefits* section beginning on page 97.
Outpatient Emergency Room Health Services	Emergency Room Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means if you seek Emergency care at a non-Network facility, you are not required to pay any difference between Eligible Expenses and the amount the Provider bills.	

Provider Network

The Claims Administrator or its affiliate, or the Company or its Affiliate, arranges for health care Providers to participate in a Network. You must receive Covered Health Services from a UnitedHealthcare Network Physician, Network Hospital or Skilled Nursing Facility in order to receive Network Benefits. A Physician, Hospital or Skilled Nursing Facility outside of the UnitedHealthcare Network is considered a non-Network Provider and will be paid at the non-Network level (with the exception of Emergency Room Health Services). However, the Claims Administrator, in its sole discretion, may permit you to use a Caterpillar Network Provider and still receive Network benefits.

These Network Providers have agreed to discount their charges for Covered Health Services. Network Providers are independent practitioners. They are not employees of the Program or employees of the Claims Administrator. It is your responsibility to select your Provider. If you use a Network Provider, your Co-insurance amount will generally be less than it would be if you use a non-Network Provider. Since the total amount of Eligible Expenses may be less when you use a Network Provider, the portion that you owe will be less.

The credentialing process confirms public information about the Providers' licenses and other credentials but does not assure the quality of the services provided. The Plan Administrator or its designee may provide general information on the quality of Providers based on certain publicly available information about the Providers. Such general information is not a guarantee of the quality of services received from a Provider, and the Program, the plan sponsor, and the Plan Administrator are not liable for the quality of services received from a Provider. The Plan Administrator or its designee may also provide general information on the estimated cost of services at certain Providers. Such estimates are provided for convenience and initial planning purposes only and should not be relied on as the actual cost of the services. You should always confirm the actual cost of a service with a Provider before receiving treatment. The Program, the plan sponsor, and the Plan Administrator are not liable for any costs incurred because a participant relied on an estimate and did not verify the actual cost with the treating Provider.

You have access to the directory of UHC Network Providers on www.myuhc.com. You can request a directory of UHC Network Providers at no cost to you. The Network of Providers is subject to change. Before obtaining services, you should always verify the Network status of a Provider. A Provider's status may change. You can verify the Provider's status by calling the Claim Administrator at the number on your ID card or in the *Contact Information* section beginning on page 121, or by using the www.myuhc.com website. (For an Illinois Caterpillar Network Provider, visit the benefits.cat.com website.)

It is possible that you might not be able to obtain services from a particular Network Provider, or you might find that a particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to you, you must choose another Network Provider to get Network Benefits.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some products. Refer to your Provider directory or contact the Claims Administrator for assistance.

There are no discounts for services, treatments, items or supplies that are not covered by the Program.

Designated Providers and Other Providers

If you have a medical condition that Personal Health Support[SM] believes needs special services, they may direct you to a Designated Provider or other Provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Personal Health Support[SM] may direct you to a non-Network facility or Provider.

In both cases, benefits will be paid only if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other Provider chosen by Personal Health Support[SM].

NON-NETWORK BENEFITS

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by non-Network Physicians or non-Network Providers. Non-Network Benefits are also payable for Covered Health Services that are provided at non-Network facilities. However, if you are traveling or on vacation, office-based services for a non-Emergency situation may be payable at the Network level. Facility-based services will be subject to Program guidelines.

If there is no Network Provider within a 30-mile radius of your home zip code, you may be eligible to receive benefits for certain Covered Health Services paid at the Network level for Eligible Expenses. You may check a Provider's status in your area by visiting www.myuhc.com or by calling the Claims Administrator at the number on the back of your ID card or in the section entitled *Contact Information* beginning on page 121. All benefits that fall under this category must be approved prior to receipt of care for each occurrence and are subject to any plan limitations or exclusions set forth in this SPD.

EMERGENCY ROOM HEALTH SERVICES

The Program provides benefits for Emergency Room Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Room Health Services, even if the services are provided by a non-Network Provider.

If you are confined in a non-Network Hospital after receiving Emergency Room Health Services, Personal Health Support[SM] must be notified within two business days or on the same day of admission if reasonably possible. Personal Health Support[SM] may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date Personal Health Support[SM] decides a transfer is medically appropriate, Non-Network Benefits will be available if the continued stay is determined to be a Covered Health Service.

If you are admitted as an inpatient to a Hospital within 24 hours of receiving treatment for the same condition as an Emergency Room Health Service, you will not have to pay the emergency room Co-payment for Emergency Room Health Services.

Note: The emergency room Co-payment for covered Emergency Room Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an Inpatient in the Hospital. In this case, the emergency room Co-payment will apply. The emergency room Co-payment information can be found under Item 6 (Emergency Room Health Services) of the *Benefits Information Grid* beginning on page 38.

Obtaining Benefits (Reside Outside a Network Area)

IF YOU OBTAIN SERVICES FROM A NETWORK PROVIDER

The Claims Administrator or its affiliate or the Company or its Affiliate arranges for health care Providers to participate in a Network. These Network Providers have agreed to discount their charges for Covered Health Services. If you use a Network Provider, your Co-insurance amount will generally be less than it would be if you use a non-Network Provider. The Co-insurance level will remain the same, but because the total amount of Eligible Expenses may be less when you use a Network Provider, the portion that you owe will be less.

Network Providers are independent practitioners. They are not employees of the Program or employees of the Claims Administrator. It is your responsibility to select your Provider.

The credentialing process confirms public information about the Providers' licenses and other credentials but does not assure the quality of the services provided. The Plan Administrator or its designee may provide general information on the quality of Providers based on certain publicly available information about the Providers. Such general information is not a guarantee of the quality of services received from a Provider, and the Program, the plan sponsor, and the Plan Administrator are not liable for the quality of services received from a Provider. The Plan Administrator or its designee may also provide general information on the estimated cost of services at certain Providers. Such estimates are provided for convenience and initial planning purposes only and should not be relied on as the actual cost of the services. You should always confirm the actual cost of a service with a Provider before receiving treatment. The Program, the plan sponsor, and the Plan Administrator are not liable for any costs incurred because a participant relied on an estimate and did not verify the actual cost with the treating Provider.

You have access to the directory of UHC Network Providers on www.myuhc.com. You can request a directory of UHC Network Providers at no cost to you. You also have access to the directory of Illinois Caterpillar Network Providers on benefits.cat.com. The Network of Providers is subject to change. Before obtaining services, you should always verify the Network status of a Provider. A Provider's status may change. You can verify the Provider's status by calling the Claims Administrator at the number on your ID card or in the *Contact Information* section beginning on page 121, or by using one of the above web sites.

It is possible that you might not be able to obtain services from a particular Network Provider or you might find that a particular Network Provider may not be accepting new patients.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some products. Refer to your Provider directory or contact the Claims Administrator for assistance.

There are no discounts for services, treatments, items or supplies that are not covered by the Program.

DESIGNATED PROVIDERS AND OTHER PROVIDERS

If you have a medical condition that Personal Health Support[SM] believes needs special services, they may direct you to a Designated Provider or other Provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Personal Health Support[SM] may direct you to a non-Network facility or Provider.

In both cases, benefits will be paid only if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other Provider chosen by Personal Health Support[SM].

EMERGENCY ROOM HEALTH SERVICES

The Program provides benefits for Emergency Room Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

If you are confined in a Hospital after you receive Emergency Room Health Services, Personal Health Support[SM] must be notified within two business days or on the same day of admission if reasonably possible.

If you are admitted as an inpatient to a Hospital within 24 hours of receiving treatment for the same condition as an Emergency Room Health Service, you will not have to pay the emergency room Co-payment for Emergency Room Health Services.

Note: The emergency room Co-payment for covered Emergency Room Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the Hospital. In this case, the emergency room Co-payment will apply. The emergency room Co-payment information can be found under Item 6 (Emergency Room Health Services) of the *Benefits Information Grid* beginning on page 38.

TRADITIONAL PRESCRIPTION DRUG COVERAGE

Eligibility For Traditional Prescription Drug Coverage

You are eligible for Traditional Prescription Drug Coverage under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled *Eligibility* beginning on page 9 and any additional requirements described in this section.

The benefits described in this *Traditional Prescription Drug Coverage* section do not apply to you if you are a retiree age 65 or older or a retiree's Spouse or Same-Sex Domestic Partner age 65 or older. Your healthcare benefits are described in the section of the SPD titled *Health Reimbursement Arrangement (HRA) Benefits.*

Overview Of Traditional Prescription Drug Coverage

Your prescription drug coverage applies to prescription drug expenses that meet the following criteria:

- The expenses are incurred for products listed on the Caterpillar Drug Formulary (the "Formulary");
- The expenses are prescribed on or after the effective date of coverage; and
- The prescription is the subject of a written order of a Physician (or his or her legally licensed agent) who is acting within the scope of his or her license.

You may obtain a copy of the Formulary at benefits.cat.com or by contacting Magellan Rx Management at (877) 228-7909. Please note that the Formulary is reviewed periodically, and additions or deletions may be made from time to time. It is your responsibility to refer to the Formulary or contact Magellan Rx Management to determine if your particular prescription drug will be covered under the Program. Note that certain lancets, strips, and glucometers used for diabetic testing are included in the Formulary. As such, these diabetic testing supplies are covered as part of the Program prescription drug benefit described in this section.

Benefits under the Program will be paid as follows for each covered prescription and each covered refill (retail):

- 100% of the charge, less the applicable deductible (if applicable), Network Co-payment or Network Co-insurance, if dispensed by a Network Pharmacy;
- 100% of the charge, less the applicable deductible (if applicable), out-of-Network Co-payment or out-of-Network Co-insurance, if dispensed by an out-of-Network Pharmacy; or
- For prescription drugs purchased at a Non-Network Pharmacy, you will pay 100% of the prescription drug cost at the pharmacy. You will then need to submit the Caterpillar Prescription Drug Expense Claim Form to Magellan Rx Management for reimbursement.

BCBS NATIONAL AND UHC CHOICE PLUS PPO PLAN OPTIONS

If you are enrolled in a PPO or BCBS plan option, your prescription drug coverage Maximum Out-of-Pocket is a separate limit that is integrated with your applicable medical benefits coverage Maximum Out-of-Pocket. The total amount of your prescription drug coverage Maximum Out-of-Pocket will depend on your medical benefits coverage Maximum Out-of-Pocket and your applicable expenses.

UHC CONSUMER CHOICE OR UHC CONSUMER MAX (CDHP) PLAN OPTIONS

If you are enrolled in a CDHP, your expenses for prescription medications covered under the Program count toward your Annual Deductible. This means you pay the full cost of prescription medications until your Annual Deductible is met. Certain preventive medications are covered before you meet your Annual Deductible. If your medication is listed on the Caterpillar Inc. Consumer-Directed Health Plan (CDHP) Preventive Drug List (the "Preventive Drug List"), you pay the Co-pay or Co-insurance amount, regardless of whether your Annual Deductible has been met. The Preventive Drug List for Consumer-Directed Health Plans is available at benefits.cat.com under the U.S. RX tab or you can call Magellan Rx Management at (877) 228-7909. Please note that the Preventive Drug List is reviewed periodically, and additions or deletions may be made from time to time. It is your responsibility to refer to the Preventive Drug List or contact Magellan Rx Management to determine if a prescription drug is a Preventive Drug under the Program.

If you are enrolled in family coverage, the Annual Deductible for the entire family must be met before the Program will begin to pay benefits. Amounts you pay for both prescription drug expenses and medical expenses will be considered when determining whether your Annual Deductible has been satisfied. Amounts paid as part of your Annual Deductible will also count towards your annual Maximum Out-of-Pocket if filled using a Network Pharmacy. Prescription drug claims filled by an Out-of-Network or Non-Network Pharmacy will not count towards your annual Maximum Out-of-Pocket. If you are enrolled in family coverage, the entire family Maximum Out-of-Pocket must be met before expenses for covered prescription drugs are payable at 100% during the remainder of the calendar year when obtained through a Network Pharmacy.

Prescription Drug Co-Payments/Co-Insurance

The Co-payment or Co-insurance amounts for drugs purchased at a Network Pharmacy are as follows:

- No Co-payment or Co-insurance for each prescription drug designated as "Tier 0";
- $10 Co-payment for each prescription drug designated as "Tier 1" ($5 Co-payment if filled by a select network pharmacy);
- 20% Co-insurance for each prescription drug designated as "Tier 2," subject to a minimum of $35 and a maximum of $70;
- 50% Co-insurance for each prescription drug designated as "Tier 3" or a Compounded Drug, subject to a minimum of $85 and a maximum of $135;
- 50% Co-insurance for each prescription drug designated as "Tier 4," subject to a minimum of $110 and a maximum of $210;
- the total cost charged by the Network Pharmacy *if that amount is less* than the Co-payment for Tier 1, or less than the Co-insurance minimum amount for Tier 2, Tier 3, a Compounded Drug or Tier 4.

By having your prescription filled at a Network Pharmacy, you will pay no more than the required Co-payment or Co-insurance for each prescription or refill as listed above. If you have your prescription filled at a pharmacy that is not in the Network (i.e. an Out-of-Network Pharmacy or non-Network Pharmacy), your coverage under the Program will be reduced. For a list of the prescription drugs covered by the Program and the designation of each such prescription drug, please refer to benefits.cat.com. You may also obtain a list of Network pharmacies at benefits.cat.com or by calling Magellan Rx Management at (877) 228-7909.

The Co-payment or Co-insurance amounts for drugs purchased at an Out-of-Network or Non-Network Pharmacy for up to a 30-day supply are as follows:

- $25 Co-payment for each prescription drug designated as "Tier 0" or "Tier 1";
- 30% Co-insurance for each prescription drug designated as "Tier 2," subject to a minimum of $60 and a maximum of $130;
- 50% Co-insurance for each prescription drug designated as "Tier 3," a Compounded Drug or "Tier 4," subject to a minimum of $160 and a maximum of $260;

- the total cost charged by the Out-of-Network or Non-Network Pharmacy *if that amount is less* than the Co-payment charged for "Tier 1", or less than the Co-insurance minimum amount charged for "Tier 2," "Tier 3," a Compounded Drug or "Tier 4."

MAIL SERVICE PROGRAM

- Prescription drugs can be purchased through the mail from AllianceRx Walgreens Pharmacy Home Delivery. You can elect to obtain by mail maintenance prescription drugs that you take on a regular basis, are stabilized on a given dosage and are covered under the Program.
- These medications will be delivered to your home either by U.S. Postal Service or United Parcel Service (UPS). Prescriptions can be shipped overnight for an additional charge to you.
- Maintenance drugs are available through the mail service program for up to a 90-day supply at the following Co-payments or Co-insurance:
    - No Co-payment or Co-insurance for each prescription drug designated as "Tier 0";
    - $30 Co-payment for a prescription drug designated as "Tier 1";
    - 20% Co-insurance for each prescription drug designated as "Tier 2," subject to a minimum of $105 and a maximum of $210;
    - 50% Co-insurance for each prescription drug designated as "Tier 3" or a Compounded Drug, subject to a minimum of $255 and a maximum of $405;
    - Mail order is not available for prescription drugs designated as "Tier 4."
- If you have questions about the mail service program, contact AllianceRx Walgreens Pharmacy Home Delivery at (866) 840-1222 (TTY for deaf: (800) 925-0178) 24 hours a day, seven days a week. Order forms and instructions are available at benefits.cat.com under the "U.S. RX" tab.

BENEFIT LIMITATIONS

Your prescription drug benefits are limited as follows:

- Prescription drugs must meet approved indications established by the Claims Administrator.
- The Claims Administrator may require the use of a generic drug, if available.
- The Claims Administrator may limit quantities.
- Certain prescription drug products require prior authorization for coverage. (A list of these products is available at benefits.cat.com under the "U.S. RX" tab, or you can call Magellan Rx Management at (877) 228-7909.
- When there are several drugs in a given class that are considered equally effective, the most cost-effective drug may be required as a first step. This is referred to as "Step Therapy." Step Therapy may be required for coverage through the prior authorization process.
- The Claims Administrator may require, as a condition to reimbursement, that you obtain all or a defined group of drugs or services from a single participating Provider or pharmaceutical vendor.
- Multiple prescription drugs, when packaged as a unit, may require a Co-payment or Co-insurance payment for each prescription drug.
- Drugs purchased outside of the United States will be covered only if your Primary Residence is outside of the United States. However, the Claims Administrator may approve payment of prescription drugs purchased outside of the United States when you are traveling outside the United States.

The following are common examples of prescription drug charges that are <u>not covered under the Program</u>:

- Administration charges;

- Any refill dispensed after one year from the date of the Physician's latest order;
- Charges for any covered prescription drugs for which payment is otherwise provided under the other benefits of the Program;
- Charges for prescription drugs incurred prior to the date coverage became effective under the Program;
- Charges for which the cost of the prescription drug is less than the Co-payment or Co-insurance amount;
- Charges for quantities exceeding the amount specified by the Provider;
- Drugs purchased as replacement prescriptions (i) resulting from loss, theft or breakage, or (ii) for drugs not otherwise in your possession when you are traveling;
- More than a 30-day supply at any one time of any covered prescription non-maintenance drug, except when the mail service program is utilized (as described above) and except in the case of extended travel outside the United States in accordance with rules and procedures established by the Claims Administrator; and
- Drugs which are experimental, investigational, unproven or cosmetic in nature.

SPECIAL RULE FOR DRUGS PURCHASED OUTSIDE OF THE UNITED STATES

Prescription drugs purchased outside of the U.S. are generally not payable under the Program unless:

- your Primary Residence is outside the U.S. and therefore you purchase prescription drugs outside the U.S.; or
- your Primary Residence is inside the U.S. and the Claims Administrator approves payment of prescription drugs purchased outside the U.S. when you are traveling outside of the U.S., provided that the applicable Co-payment will apply to any such approved purchases.

MEDICARE PART D

If you are eligible for Medicare, you are not required to enroll in Medicare Part D.

Your prescription drug coverage under the Program is, on average, better than standard Medicare Part D prescription drug coverage. This means you can keep this coverage and not pay more for Medicare Part D if you later decide to enroll in Part D. However, under certain circumstances, Medicare Part D may be a better choice for you. You should evaluate very carefully which prescription drug coverage is right for you. Refer to the *Important Notice from Caterpillar About Your Prescription Drug Coverage and Medicare* which is provided to you annually.

For up-to-date information regarding prescription drug coverage under the Program, please visit the website at benefits.cat.com.

TRADITIONAL DENTAL COVERAGE

Eligibility For Traditional Dental Coverage

You are eligible for Traditional Dental Coverage under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled *Eligibility* beginning on page 9 and any additional requirements described in this section.

The benefits described in this *Traditional Dental Coverage* section do not apply if you are a retiree age 65 or older or a retiree's Spouse or Same-Sex Domestic Partner age 65 or older. Your healthcare benefits are described in the section of the SPD titled *Health Reimbursement Arrangement (HRA) Benefits.*

Overview Of Traditional Dental Coverage

The Plan Sponsor shall reimburse you for Eligible Expenses subject to the terms, conditions, exclusions and limitations of the Program and as described below.

Only Necessary dental services are Covered Dental Services under the Program. The Program will not cover expenses that are not Necessary Covered Health Services. The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

IDENTIFICATION ("ID") CARD

Dental ID cards are not required for services to be rendered. Cigna is available 365 days a year, 24 hours a day to verify dental coverage at 1-800-244-6224.

Cigna Dental ID cards are available by contacting Cigna Dental at 1-800-244-6224. Printable Dental ID cards are available at MyCigna.com and viewable ID cards are available on the MyCigna app. (App download is free at available app stores.)

EXTENDED COVERAGE

A 60-day temporary extension will be granted to a Covered Person for dentures or other prosthetic devices ordered prior to the date coverage is terminated, provided the dentures or other prosthetic device is supplied before the end of the 60-day period.

Procedures For Obtaining Dental Benefits

COVERED DENTAL SERVICES

You are eligible for Covered Dental Services listed in the *Covered Dental Services* section of this SPD if such Covered Dental Services are Necessary and are provided by or under the direction of a Dentist or other Provider. All dental coverage is subject to the terms, conditions, exclusions and limitations of the Program.

PRE-DETERMINATION OF BENEFITS

If the charge for a Covered Dental Service is expected to exceed $200 or if a dental exam reveals the need for fixed bridgework, you must notify the Claims Administrator of such treatment before treatment begins. If requested, the Dentist must provide the Claims Administrator with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Claims Administrator will decide if the proposed treatment is a Covered Dental Service under the Program and estimate the amount of payment. The estimate of benefits payable will be sent to the Dentist and will be subject to all terms, conditions, and provisions of the Program. If a treatment plan is not submitted, the Covered Person will be responsible for payment of any dental treatment not approved by the Claims Administrator. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Predetermination of benefits is not an agreement to pay for expenses. The predetermination process lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment.

Schedule Of Dental Benefits

The following *Schedules* outline (i) the Levels of Reimbursement, (ii) the Deductibles that you are required to pay for Covered Dental Services and (iii) any maximum benefit that may apply. Covered Dental Services are described more completely in the *Covered Dental Services* section beginning on page 71.

Benefits are subject to satisfaction of applicable waiting periods and the Annual Deductible. **All reimbursements for Covered Dental Expenses will apply toward your Annual Maximum Benefit, except orthodontic services to which a separate Lifetime Maximum Benefit applies.**

Benefit Description	**Level Of Reimbursement After The Annual Deductible**
Preventive Dental Services	100% of Eligible Expenses. Annual Deductible does not apply.
Basic Dental Services	
Minor Restorative	80% of Eligible Expenses
Endodontics	80% of Eligible Expenses
Periodontics	80% of Eligible Expenses
Oral Surgery	80% of Eligible Expenses
Adjunctive Services	80% of Eligible Expenses
Major Dental Services	50% of Eligible Expenses
Orthodontic Services	50% of Eligible Expenses. Annual Deductible does not apply.

Deductible/Annual Maximum	**Amount**
Annual Individual Deductible	$50
Annual Family Deductible	$100
Annual Maximum Benefit	$1,500 per Covered Person
Lifetime Orthodontic Maximum Benefit	$1,500 per Covered Person age 21 or younger

Covered Dental Services

Covered Dental Services described in this section are covered when such services are:

- Necessary (refer to the *Definitions* section beginning on page 123 of this SPD);
- Provided by or under the direction of a Dentist or other appropriate Provider as specifically described;
- The least costly, clinically accepted treatment; and
- Not excluded as described in the *General Exclusions* section beginning on page 75.

Covered Dental Services are subject to satisfaction of the Annual Deductible and applicable waiting periods as described in the *Schedule of Dental Benefits* beginning on page 70.

Preventive Dental Services (100% of Eligible Expenses)

Benefit Description	Special Limitations
Bite-Wing Radiographs	Limited to one series of films per calendar year.
Complete Series or Panorex Radiographs	Limited to one time per 60 consecutive months.
Dental Prophylaxis	Limited to two times per calendar year.
Emergency Palliative Treatment	Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit. Subject to deductible.
Fluoride Treatments	Limited to Covered Persons under the age of 20 years and limited to two treatments per calendar year. Treatment should be done in conjunction with dental prophylaxis.
Individual Periapical Radiographs	Done in conjunction with diagnosis of a specific condition requiring treatment.
Intraoral Occlusal Radiographs	Done in conjunction with diagnosis of a specific condition requiring treatment.
Oral Examinations	Limited to two times per calendar year. Covered as a separate benefit only if no other service was done during the visit other than dental prophylaxis and x-rays.
Periodontal Maintenance	Limited to two times per calendar year, following active and adjunctive periodontal therapy (within the prior 24 months, exclusive of gross debridement). Covered in combination with regular prophlaxis. Annual Deductible does not apply.
Sealants	Limited to one treatment per Covered Persons under the age of 14 every three calendar years on unrestored primary and posterior permanent teeth only.
Space Maintainers that replace prematurely lost teeth	Limited to Covered Persons under the age of 19 years for the replacement of prematurely lost teeth. One per lifetime.

Basic Dental Services (80% of Eligible Expenses)

Benefit Description	Special Limitations
Minor Restorative Services	
Amalgam Restorations	
Composite Resin Restorations	If a tooth can be restored with a less expensive material such as amalgam, appropriate payment for that procedure will be made toward the charge for another type of restoration selected by you and your Dentist. The balance of the treatment charge will not be payable under the Program.
Cosmetic Bonding	For participants aged 8 - 19 years only. Limited to front teeth five through twelve on the upper dental arch, and teeth 21 through 28 on the lower dental arch if required due to severe tetracycline staining, severe fluorosis, hereditary opalescent dentin, or ameleogenesis imperfecta, not more than once in any period of 36 consecutive months. Requires preauthorization prior to commencement of services.
Pin Retention	Not covered in addition to cast restoration.
Endodontics	
Apexification Apicoectomy and Retrograde filling Hemisection Root Canal Therapy Root Resection Therapeutic Pulpotomy	
Periodontics	
Hard or Soft Tissue Surgery Crown Lengthening* Gingivectomy* Osseous Graft* Osseous Surgery*	*Only one of these procedures per quadrant or site per 36 months.
Provisional Splinting	
Scaling and Root Planning	

Benefit Description	Special Limitations
Oral Surgery Alveoloplasty Biopsy Certain excisions Frenectomy Incision and Drainage Removal of a Benign Cyst Removal of Exostosis Root Recovery Root Removal Simple Extraction Surgical Extraction of Erupted Teeth and Roots Surgical Extraction of Impacted Teeth	Refer to the *Traditional Medical Coverage* section beginning on page 33 of this SPD for additional coverage for Oral Surgery (*e.g.*, treatment of fractures and reduction of dislocation). Refer to *Major Dental Services* beginning on page 73 for implants.
Adjunctive Services	
Analgesia Desensitizing Medicament General Anesthesia Intraveinous Sedation and Analgesia Injection of antibiotics Occlusal Adjustment	Coverage for Analgesia is limited to participants aged 0 – 6 years, or patients with behavioral problems or physical disabilities. Coverage for General Anesthesia only when administered in connection with oral surgery or other Covered Dental Services. Pretreatment estimate is suggested to determine medical necessity.
Occlusal Guards	Covered only if prescribed to control habitual grinding.
Sedative Fillings	Covered as a separate benefit only if no other service, other than x-rays and exam, were done on the same tooth during the visit.

Major Dental Services (50% of Eligible Expenses)

Benefit Description	**Special Limitations**
Crowns **Gold Inlay or Onlay** **Porcelain Onlays** **Post & Cores for Single Tooth Crown (only for teeth that have had root canal therapy)**	Limited to one per tooth every 60 consecutive months. Covered only when a filling cannot restore the tooth. However, if a tooth can be restored with a less expensive material such as full cast metal, appropriate payment for that procedure will be made toward the charge for another type of restoration selected by you and your Dentist. The balance of the treatment charge will not be payable under the Program.
Fixed Bridges	Limited to one time per 60 consecutive months. This includes bridgework done in connection with periodontal treatment and other diseases of the gums and tissues of the mouth. Covered only when a less expensive product cannot restore the teeth. Preauthorization recommended prior to treatment.

Benefit Description	Special Limitations
Dentures – Full	Limited to one time per 60 consecutive months. Includes precision attachments for dentures. Includes adjustments during the six-month period following installation. If the patient and Dentist decide on personalized restoration or specialized techniques as opposed to standard dental procedures, dental expense benefits will be allowed for the appropriate amount for standard denture service toward such elected treatment. The balance of the treatment charge will not be payable under the Program.
Dentures – Partial	Limited to one time per 60 consecutive months. Includes adjustments during the six-month period following installation. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, dental expense benefits will cover the applicable percentage of the cost of such procedure toward a more elaborate or precision appliance that the patient and Dentist may choose to use and the balance of the cost will not be payable under the Program.
Implants	Limited to one time per 60 consecutive months. Covered only when a less expensive procedure cannot restore the tooth. Preauthorization recommended prior to treatment.
Orthodontic Treatment	Limited to Covered Person age 21 or younger, subject to orthodontic lifetime maximum.
Provisional Splinting	
Re-cement Bridges	
Re-cement Crowns	
Re-cement Inlays	
Relining Dentures	Limited to relining done more than 6 months after the initial insertions.
Repairs to Full Dentures, Partial Dentures, Bridges	

Orthodontic Services

OVERVIEW

Orthodontic Services are services or supplies furnished by a Dentist to a Covered Person age 21 or younger (unless due to accidental Injury or as an alternative to orthognathic surgery) in order to diagnose or correct misalignment of the teeth or the bite.

PREDETERMINATION OF BENEFITS

If a dental exam reveals the need for orthodontia, you should notify the Claims Administrator of such treatment before treatment begins. If requested, the Dentist must provide the Claims Administrator with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Claims Administrator will decide if the proposed treatment is a Covered Dental Service under the Program and estimate the amount of payment. The estimate of benefits payable will be sent to the Dentist and will be subject to all terms, conditions and

provisions of the Program. If a treatment plan is not submitted, the Covered Person will be responsible for payment of any dental treatment not approved by the Claims Administrator. Pre-determination of benefits is not an agreement to pay for expenses. The predetermination process lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment.

ORTHODONTIC MAXIMUM

Not more than $1,500 per lifetime will be payable for covered orthodontia services for a Covered Person age 21 or younger. This maximum is determined separately from the Annual Maximum Benefit for Covered Dental Expenses.

LEVEL OF REIMBURSEMENT

The Program will reimburse for 50% of Eligible Expenses. The Annual Deductible does not apply.

Note: The extended coverage provision described in *Extended Coverage* in the *Overview of Traditional Dental Coverage* section beginning on page 69 does not apply to Orthodontic Services.

Dental Coverage – General Exclusions

Except as may be specifically provided in the *Covered Dental Services* section beginning on page 69 or through an amendment to this SPD, the following are not Covered Dental Services. However, the Claims Administrator may, in its sole discretion amend this list of general exclusions.

- Dental services that are not Necessary.
- Hospitalization or other facility charges. (Refer to the *Traditional Medical Benefits* section beginning on page 33 of this SPD for possible coverage.)
- Any dental procedure performed solely for cosmetic/aesthetic reasons (*i.e.*, procedures that improve physical appearance.)
- Reconstructive Surgery regardless of whether or not the surgery is incidental to a dental disease, Injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. Appropriate payment will be made toward the cost of procedures necessary to eliminate oral diseases and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension to restore occlusion will be considered optional and their cost will not be payable under the Program.
- Any dental procedure not directly associated with dental disease.
- Any procedure not performed in a dental setting.
- Procedures that are considered to be Experimental or Investigational Services or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental or Investigational Service or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be an Experimental or Investigational Service or Unproven Service in the treatment of that particular condition.
- Drugs or medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit. (Refer to the *Prescription Drug Benefits* section beginning on page 65 of this SPD for possible coverage.)
- Services for injuries or conditions covered by workers' compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue. (Refer to Item 17 (Oral Surgery) of the *Benefits Information Grid* beginning on page 38 in the subsection, *Benefit Information*, of the section of this SPD entitled *What's Covered – Benefits* for possible coverage under the oral surgery benefit.)

- Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision. (Refer to Item 17 (Oral Surgery) of the *Benefits Information Grid* beginning on page 38 in the subsection, *Benefit Information*, of the section of this SPD entitled *What's Covered – Benefits* for possible coverage under the oral surgery benefit.)
- Replacement of complete or partial dentures, fixed bridgework, or crowns previously submitted for payment under the Program within 60 consecutive months of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
- Replacement of complete or partial dentures, crowns, or fixed bridgework if damage or breakage was directly related to Provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient noncompliance, the patient is liable for the cost of replacement. The patient is liable for the cost of replacement of lost, missing or stolen appliances and prosthetic devices.
- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint. (Refer to Item 17 (Oral Surgery) of the *Benefits Information Grid* beginning on page 38 in the subsection, *Benefit Information*, of the section of this SPD entitled *What's Covered – Benefits* for possible coverage under the oral surgery benefit.)
- Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.
- Expenses for dental procedures begun prior to the Covered Person's eligibility with the Program.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO). Appropriate payment will be made toward the cost of procedures Necessary to eliminate oral diseases and to replace missing teeth. Appliances or restorations Necessary to increase vertical dimension to restore occlusion will be considered optional and their cost will not be payable under the Program.
- Full-mouth radiograph series in excess of once every 60 consecutive months. Panoramic radiographs in excess of once every 60 consecutive months, except when taken for diagnosis of third molars, cysts or neoplasms.
- Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
- Occlusal guards (except if prescribed to control habitual grinding), including those specifically used as safety items or to affect performance primarily in sports-related activities.
- Dental services otherwise covered under the Program, but rendered after the date individual coverage under the applicable plan terminates, including dental services for dental conditions arising prior to the date individual coverage terminates, except those conditions covered under the *Extended Coverage* section beginning on page 69. If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination.
- Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- Orthodontic Services for patients age 22 and older unless due to accidental Injury or as an alternative to Orthogenetic surgery.
- Diagnostic casts, bacteriologic studies and caries susceptibility tests.
- Interim partial dentures only covered for persons under the age of 19.
- Charges for plaque control, fissure sealants, dietary instruction, and any other dental health care instructions.
- Charges by the Dentist for completing and filing claim forms on the patient's behalf.
- Replacement or repair of a broken orthodontic appliance.
- General Analgesia, except as described in the *Basic Dental Services* chart above.
- Charges set forth as exclusions in any other sections of the Program.

TRADITIONAL VISION COVERAGE

Eligibility for Traditional Vision Coverage

You are eligible for Traditional Vision Coverage under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled *Eligibility* beginning on page 9 and any additional requirements described in this section.

The benefits described in this *Traditional Vision Coverage* section do not apply if you are a retiree age 65 or older or a retiree's Spouse or Same-Sex Domestic Partner age 65 or older. Your healthcare benefits are described in the section of the SPD titled *Health Reimbursement Arrangement (HRA) Benefits.*

Overview of Traditional Vision Coverage

The Plan Sponsor shall reimburse you for eligible vision expenses subject to the terms, conditions, exclusions and limitations of the Program and as described below.

IDENTIFICATION ("ID") CARD

You do not need to show an ID card when you obtain vision services.

Schedule of Vision Benefits

SCHEDULE OF VISION BENEFITS

The following *Schedules* outline the vision benefits that are available from Network and non-Network Providers. The *Schedules* list your applicable co-payment or reimbursement amount for various services, as well as any other benefits that are available.

VISION SERVICES FROM A NETWORK PROVIDER

Benefit Description	Your Co-payment Amount
Comprehensive Eye Exam	$20 Co-payment. Limited to one exam per calendar year.
Contact Lens Exam	Up to $60 Co-payment Limited to one exam per calendar year.
Diabetes Eyecare Plus Program (related to Type 1 and Type 2 diabetes)	$20 Co-payment. Subject to restrictions.
Lenses only	$20 Co-payment for one pair of single vision, bifocal, trifocal or lenticular lenses. Limited to one pair of lenses per calendar year.

Lenses and frames	$20 Co-payment for one pair of single vision, bifocal, trifocal or lenticular lenses per calendar year. Up to $160 allowance for one pair of frames every other calendar year.
Frames only	$20 Co-payment and up to $160 allowance for one pair of frames every other calendar year.
Elective contact lenses	Up to $140 allowance per calendar year (in lieu of lenses and frames).
Medically necessary contact lenses	$20 Co-payment per calendar year for an annual supply (in lieu of lenses and frames). Limited to a Covered Person whose vision cannot be corrected through glasses.

VISION SERVICES FROM A NON-NETWORK PROVIDER

Benefit Description	Your Reimbursement Amount
Comprehensive Eye Exam	Up to $45 reimbursement Limited to one exam per calendar year.
Lenses only	One pair of lenses reimbursed at: (i) Up to $30 for single vision lenses (ii) Up to $50 for bifocal lenses (iii) Up to $65 for trifocal lenses (iv) Up to $100 for lenticular lenses Limited to one pair of lenses per calendar year.
Frames	Up to $70 reimbursement for one pair of frames every other calendar year.
Elective contact lenses	Up to $105 reimbursement per calendar year (in lieu of lenses and frames).
Medically necessary contact lenses	Up to $210 reimbursement per calendar year for an annual supply (in lieu of lenses and frames). Limited to a Covered Person whose vision cannot be corrected through glasses.

Vision Coverage – General Exclusions

The following are not covered under the Program as part of your vision benefits. The Claims Administrator may, in its sole discretion, amend this list of general exclusions.

- Eye exercise therapy;
- Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery;
- Contact lens solution; and
- Replacements for lost or broken glasses.

HEALTH SAVINGS ACCOUNT

If you are a participant in one of the CDHP options and otherwise are an eligible retiree, you may open and contribute to a Health Savings Account (HSA). An HSA allows you to save on a pre-tax basis for future medical expenses. If you are not enrolled in a CDHP option, you are not eligible to open and contribute to an HSA.

Unlike the CDHP options, your HSA is not an employee welfare benefit plan, is not subject to ERISA and is not required to be summarized in an SPD. Nevertheless, some of the important features of the HSA option are described here.

LEGAL RESPONSIBILITY

It is your legal responsibility (and not the Company's) to make sure that any contributions to your HSA (including the Company's contributions) do not exceed IRS maximum allowable amount for your coverage level. Also note that special rules apply if both you and your Spouse are eligible to contribute to HSAs.

QUESTIONS?

If you have questions about your HSA, you can get additional information at www.healthequity.com/caterpillar or contact the Claims Administrator, HealthEquity, at 1-844-311-9732.

How Your HSA Works

Your HSA is an individual custodial account that you establish directly with a bank or other financial institution. You may use the balance in your HSA for reimbursement of qualified medical expenses (as set forth in Internal Revenue Code Section 223). Your contributions to your HSA may be made with pre-tax funds and your qualifying withdrawals will be tax-free. Because your contributions are pre-tax, you may save federal income taxes, state income taxes in certain states, and FICA (Social Security and Medicare) taxes.

Who is Eligible?

Under current IRS rules, you are eligible to open and contribute to an HSA under Internal Revenue Code Section 223 for any month, if on the first day of such month you:

- Have elected coverage under one of the CDHP options;
- Are not enrolled in and/or covered by any health plan that is not a high-deductible health plan, unless it is a type of permitted limited coverage, such as a Limited Purpose FSA;
- Are not and your spouse is not enrolled in the Health Reimbursement Arrangement (HRA) Benefits under the Program or any other HRA that does not qualify for one of the exceptions permitted by the IRS;
- Cannot be claimed by another taxpayer (except your Spouse) as a dependent on his or her individual income tax return; and
- Are not eligible for and enrolled in Medicare.

WHEN YOU HAVE COVERAGE UNDER YOUR SPOUSE'S HEALTH PLAN

You should be aware that coverage under your Spouse's health plan could make you ineligible to contribute to an HSA. This will be the case if:

- your Spouse enrolls you as a dependent under a health plan that is not a high-deductible health plan; or
- your Spouse contributes to his or her employer's general purpose flexible spending account (FSA).

Refer to IRS Publication 969, "Health Savings Accounts and Other Tax Favored Health Plans" for information about the special rules that affect contributions to your HSA. The publication is available from the IRS by calling 1-800-829-3676. Or, you can download a copy of the publication from the IRS Web site at www.irs.gov.

MEDICARE

IMPORTANT: Read This If You Are Enrolled in Medicare

You cannot make any HSA contributions if you are eligible for and enrolled in Medicare.

Establishing Your HSA

When you enroll in a CDHP option, you may establish an HSA. For your convenience, the Company has entered into an agreement with HealthEquity to provide HSA administration services. The Company will pay your account set-up and maintenance fees. However, any other banking fees that you might incur (e.g., overdraft fees), and any fees assessed by your HSA custodian are your responsibility. Also, you are only eligible to receive a Company contribution to your HSA if you set up your account with HealthEquity.

Contributions to Your HSA

When you enroll in a CDHP option and establish your HSA with HealthEquity, the Company will make contributions to your account. You can also make tax-free contributions to your HSA, up to the IRS maximum allowable amount. If you open your HSA at another bank or financial institution without going through Health Equity, you may still make contributions to your HSA, but you will not receive the Company contribution. And, you are free at any time to move any or all of your HSA funds from one bank to another authorized bank or other financial institution. You should verify that any contributions you make will be in compliance with the rules regarding HSAs.

AMOUNT OF CONTRIBUTIONS

Federal tax law limits the amount that you and/or anyone else, including the Company, can contribute to your HSA on a tax-favored basis each year. The annual HSA contributions (your contributions plus the Company's contributions) cannot exceed the IRS maximum allowable amount. For 2017, the IRS maximum allowable amount is $3,400 if you are enrolled in retiree-only coverage, and $6,750 if you are enrolled in any other coverage tier. It is your legal responsibility (and not the Company's) to make sure that any contributions that are made to your HSA (including the Company's contributions) do not exceed the IRS maximum allowable amount.

CATCH UP CONTRIBUTIONS

In addition to making contributions up to the IRS maximum allowable amounts stated above, if you are age 55 or older, you may also elect to make an annual catch-up contribution to your HSA ($1,000 each year).

TIMING OF CONTRIBUTIONS

Company contributions are made as soon as administratively practicable after your coverage in a CDHP option is effective. Note that if you enroll in a CDHP option on or after October 1, the Company will not make any contributions to your HSA for that plan year. The Company will not make any contributions to your HSA for any plan years in which you failed to establish or maintain an HSA with HealthEquity.

CONTRIBUTIONS ARE VESTED

Any contributions that you or the Company make to your HSA are fully vested and are not forfeitable. They remain in your HSA for your use in future years.

Withdrawals from Your HSA

You must keep track of and request reimbursement on your own from your HSA for the payments you make for qualified medical expenses. A list of what constitutes qualified medical expenses is available in IRS Publication 502 which is available from any regional IRS office or at www.irs.gov. Reimbursements and all other matters relating to maintaining your HSA are not part of the Program and are to be handled by you and your bank or other financial institution.

The financial institution with which you establish your HSA will provide you with instructions on how to request reimbursement or withdraw money from your HSA for qualified medical expenses.

If you establish your HSA with HealthEquity, you will have access to information about your HSA online at www.healthequity.com/caterpillar. You will also be given a debit card to pay for qualified medical expenses.

Reimbursements from your HSA for qualified medical expenses for you or your dependents are not taxable under federal law, even if at the time of the reimbursement you are no longer eligible to contribute to the HSA. However, reimbursements for expenses that are not qualified medical expenses result in taxable income to you, regardless of when the reimbursement is made, and may be subject to an additional 20% penalty.

WHO IS MY DEPENDENT?

Please be aware that the definition of "dependent" for purposes of the Program is broader than the definition for your HSA. The IRS only permits you to seek reimbursement for qualified medical expenses that you, your Spouse or your qualified dependent incur. For HSA purposes, your qualified dependent is defined under Internal Revenue Code Section 152 (which generally includes your children up to age 19, or 24 if a full-time student). Please consult with your tax adviser to determine whether your dependent's expenses qualify for reimbursement through your HSA.

When Participation Ends

The Company contributions to your HSA will be automatically canceled when your coverage under a CDHP option ends. If you otherwise fail to satisfy the HSA eligibility requirements, you should notify the Plan Administrator immediately and your HSA Company contributions will be canceled. If you make contributions to your HSA when

you are no longer eligible, you may incur tax penalties. If the Company makes a contribution to your HSA and you were never eligible, or if the Company makes a contribution that results in you exceeding the IRS maximum allowable amount, the Company reserves the right to recoup the contribution it made on your behalf.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) BENEFITS

When you Reach Age 65, you are no longer eligible to participate in the Traditional Healthcare Benefits of the Program (*i.e.*, Traditional Medical Coverage, Traditional Prescription Drug Coverage, Traditional Dental Coverage, and Traditional Vision Coverage). If you have an eligible Spouse or Same-Sex Domestic Partner, your Spouse or Same-Sex Domestic Partner also is no longer eligible to participate in the Traditional Healthcare Benefits of the Program when he or she Reaches Age 65. Upon Reaching Age 65, you and your eligible Spouse or Same-Sex Domestic Partner are eligible to enroll in the HRA Benefits of the Program. If you elect to enroll in the HRA Benefits of the Program, the Company will establish an HRA Account in your name and in your Spouse's or Same-Sex Domestic Partner's name, if eligible. The HRA Benefits of the Program reimburse you and your Spouse or Same-Sex Domestic Partner for eligible healthcare expenses up to the amount in your HRA Account or your Spouse's or Same-Sex Domestic Partner's HRA Account. The HRA Benefits are intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code.

HRA Eligibility

You are eligible to enroll in the HRA Benefits of the Program if you meet the following requirements:

- you are eligible to participate in the Program;
- you Reach Age 65; and
- you are no longer eligible for Traditional Healthcare Benefits under the Program because you Reach Age 65.

Your Spouse or Same-Sex Domestic Partner is eligible to enroll in the HRA Benefits of the Program if he/she meets the following requirements:

- your Spouse or Same-Sex Domestic Partner is an eligible Spouse or Same-Sex Domestic Partner; and
- your Spouse or Same-Sex Domestic Partner is no longer eligible for Traditional Healthcare Benefits under the Program (or the Caterpillar Inc. Retiree Group Insurance Plan (RGIP) if you are a Joliet IAM Retiree, a Mapleton Patternmakers IAM Retiree, or St. Paul IAM Retiree) because he or she Reaches Age 65.

Your Spouse or Same-Sex Domestic Partner is also eligible to enroll in the HRA Benefits of the Program if he or she is age 65 or older at the time of your death, if you were eligible to retire prior to your death and if you were enrolled in the medical benefit portion of the Employee Program immediately prior to your death.

Note: No employees, former employees, or retirees of Caterpillar Global Mining LLC or its subsidiaries, or hourly employees of Solar Turbines Incorporated, are eligible for the HRA Benefits of the Program.

HRA Participation

HOW TO ENROLL

To enroll in the HRA Benefits, you need to first enroll in available insurance coverage offered through Via Benefits. Via Benefits offers medical coverage that coordinates with Medicare. Via Benefits also offers dental and vision coverage. You must contact Via Benefits to enroll in such coverage. Please note that after you enroll in the available insurance coverage to establish your HRA Account, you are not required to enroll in available insurance coverage through Via Benefits in subsequent years to continue to receive HRA Benefits under the Program.

WHEN HRA PARTICIPATION ENDS

Upon your death, no additional amounts will be credited to your HRA Account. Only those claims submitted within 6 months of the date of death for expenses incurred prior to your death will be reimbursed. Your death will not affect your Spouse's HRA Account.

Upon the death of your Spouse or Same-Sex Domestic Partner, no additional amounts will be credited to your Spouse's or Same-Sex Domestic Partner's HRA Account. Only those claims submitted within 6 months of your Spouse's or Same-Sex Domestic Partner's date of death for expenses incurred prior to his or her date of death will be reimbursed. Your Spouse's or Same-Sex Domestic Partner's death will not affect your HRA Account.

If you divorce your Spouse or have a similar dissolution of the arrangement with your Same-Sex Domestic Partner, coverage under the HRA Benefits of the Program ends for your Spouse or Same-Sex Domestic Partner. Your Spouse is eligible to elect COBRA continuation coverage or your Same-Sex Domestic Partner is eligible to elect continuation coverage that generally mirrors COBRA continuation coverage. If your Spouse fails to elect COBRA continuation coverage or your Same-Sex Domestic Partner fails to elect the continuation coverage offered, no additional amounts will be credited to your Spouse's or Same-Sex Domestic Partner's HRA Account.

The Value Of Your HRA Account

The maximum amount that may be allocated to your HRA Account and the maximum amount that may be allocated to your Spouse's or Same-Sex Domestic Partner's HRA Account each plan year is $3,000. This maximum amount may be changed (i.e., increased, decreased or reduced to $0), subject to the discretion of the Company.

The amount credited to your HRA Account and the amount credited to your Spouse's or Same-Sex Domestic Partner's HRA Account will be the maximum amount, subject to Caterpillar's discretionary right to make changes to the Program, if:

- you retired prior to January 1, 2011, or
- you retire on or after January 1, 2011 and you are age 65 and have completed 30 or more years of Healthcare Benefit Service at the time of your retirement, or
- you are a Joliet IAM Retiree, Mapleton Patternmakers IAM Retiree, or St. Paul IAM Retiree who retired prior to January 1, 2017, or
- you are a Solar Retiree who was hired prior to January 1, 2014 and who retired prior to January 1, 2019, or
- you are a UAW Retiree who retired prior to January 2, 2019 (January 2, 2020 for UAW Retirees from the Company's facility in Aurora), or
- you are a rehired retiree, as described in the *Reemployment of Retirees* section, who qualified for the maximum amount as a retiree prior to reemployment by the Company.

If you are not eligible for the maximum amount as described above, the amount allocated to your HRA Account and the amount allocated to your Spouse's or Same-Sex Domestic Partner's HRA Account will be the sum of:

- 4% times each full year of age between 50 and 65 times the maximum dollar amount; and
- 4% times each full year of Healthcare Benefit Service earned by you between 20 and 30 years of Healthcare Benefit Service times the maximum dollar amount.

For example, you retire in 2011 at the age of 62 with 22 years of Healthcare Benefit Service. Your maximum HRA Account contribution when you Reach Age 65, lose Traditional Healthcare Benefits under the Program and elect to

participate in the HRA Benefits of the Program, will be $1,440 (4% x 12 full years of age between 50 and 65 x $3,000) plus $240 (4% x 2 years of Healthcare Benefit Service between 20 and 30 years of credited service x $3,000), or $1,680.

If you are the Spouse or Same-Sex Domestic Partner of another eligible retiree, the maximum benefit available to both you and your Spouse or Same-Sex Domestic Partner as retirees is determined based on your respective retirement dates, ages and years of Healthcare Benefit Service. This rule does not apply to Solar Retirees.

The applicable amount will be allocated to your HRA Account and your Spouse's or Same-Sex Domestic Partner's HRA Account at the beginning of each year. If you enroll in HRA Benefits after the beginning of the year, a pro-rata portion of the applicable maximum amount will be allocated to your HRA Account and your Spouse's or Same-Sex Domestic Partner's HRA Account based on the number of full calendar months remaining in the year. The amount in your HRA Account is the amount that is available for reimbursement of medical care expenses.

Using Your HRA Account To Pay Healthcare Expenses

Your (and your covered Spouse's or Same-Sex Domestic Partner's) HRA Account is used to reimburse you for eligible healthcare expenses that you or your Spouse or Same-Sex Domestic Partner incur during the plan year. A healthcare expense is incurred at the time the service is furnished, not when the service is invoiced or paid.

ELIGIBLE HEALTHCARE EXPENSES

Eligible healthcare expenses are those expenses incurred by you, your Spouse, or your Same-Sex Domestic Partner for healthcare that would be considered deductible medical expenses for federal income tax purposes (Section 213 of the Internal Revenue Code).

Below is a partial list of typical healthcare expenses eligible for reimbursement from your HRA Account. Generally, eligible healthcare expenses are those that could be taken as a tax deduction on your federal income tax return if the amount of your healthcare expenses meets certain limits.

Medical Expenses

- Deductible, Co-payment and Co-insurance amounts;
- Medical insurance premiums, including Medicare premiums;
- Drug Co-pays;
- Excess over Eligible Expenses;
- Routine physical exams;
- Routine lab and x-rays performed for medical reasons;
- Cardiac rehabilitation classes;
- Drug abuse treatment centers;
- Stop-smoking programs (excluding non-prescription items);
- Weight-loss programs under a Physician's direction to treat a disease;
- Radial keratotomy;
- Menstrual care products;

- Personal protective equipment ("PPE"), such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19; and
- Over-the-counter drugs such as:
  - Pain relievers;
  - Cold/Sinus medicines;
  - Antacids;
  - Allergy medicines;
  - Cough Syrup;
  - Laxatives;
  - Hemorrhoid medicine;
  - Sore muscle medicines;
  - Nicotine patches and gum;
  - Athletes foot medicine;
  - Medical ointments;
  - Medicated shampoo;
  - Dietary Supplements;
  - Vitamin Supplements; and
  - Nutritional Supplements.

Vision Expenses

- Routine eye examinations;
- Eye glasses, including tinting; and
- Contact lenses, including all necessary supplies and equipment.

Hearing Expenses

- Routine hearing examinations;
- Hearing Aids and repairs; and
- Cost and repair of special telephone equipment for the deaf.

Dental Expenses

- Deductible, Co-payment and Co-insurance amounts;
- Dentures and fillings;
- Dental education programs (*e.g.*, plaque control and oral hygiene instruction); and
- Orthodontic services to the extent not covered under the Program.

A complete description of and a definitive list of what constitutes eligible expenses is available in IRS Publication 502 which is available from any regional IRS office or at www.irs.gov.

Expenses may be reimbursed from your HRA Account only if you are not reimbursed for the expenses through insurance or any other health plan. If only a portion of the expense has been reimbursed through insurance, your HRA Account may reimburse the remaining portion of the expense. For example, if another health plan pays for a

medical procedure, but you are responsible for payment of a co-pay and deductible, you may be reimbursed from your HRA Account for the amount of the applicable co-pay and deductible.

If you do not use all of the amount in your HRA Account during a plan year, the unused amounts remain in your account and can be used in subsequent plan years as long as you remain eligible to participate in the HRA Benefits offered under the Program. There is no limit on how much you can accumulate in your HRA Account.

INELIGIBLE EXPENSES

You cannot receive reimbursement from your HRA Account for any expenses that are not considered tax deductible by the IRS.

In no event will the following expenses be eligible for reimbursement:

- expenses incurred prior to the date coverage under the HRA Benefits began;
- expenses incurred after the date coverage under the HRA Benefits ends; and
- expenses that have been reimbursed by another plan or for which you are seeking reimbursement under another plan.

Reimbursement Procedure

To be reimbursed for eligible expenses from your HRA Account, you must submit an HRA Claim Form to the Claims Administrator. The Claims Administrator may require you to furnish a bill, receipt, cancelled check or other written evidence of payment or evidence of your obligation to pay the expenses. The Claims Administrator will reimburse you for eligible expenses, up to the balance in your HRA Account. Any portion of a claim for reimbursement that exceeds the balance in your HRA Account will be denied.

Forfeiture Of HRA Account

If your (or your covered Spouse's or Same-Sex Domestic Partner's) HRA Account is not depleted sooner, the HRA Account will be forfeited upon the occurrence of any of the following events:

- Upon your death, your HRA Account will be forfeited after payment of claims filed within 6 months of death.
- Upon the death of your covered Spouse, your Spouse's HRA Account will be forfeited after payment of claims filed within 6 months of death.
- Upon the death of your covered Same Sex Domestic Partner, your Same-Sex Domestic Partner's HRA Account will be forfeited after payment of claims filed within 6 months of death.
- Upon your re-employment with the Company, as described in the section titled Reemployment below.
- Upon divorce, the HRA Account of your Spouse will be forfeited unless your Spouse elects COBRA continuation coverage. If your Spouse elects COBRA continuation, the HRA Account of your Spouse will be forfeited when COBRA continuation coverage ends and after payment of claims filed within 6 months following the end of COBRA coverage.
- Upon the dissolution of your domestic partnership or similar arrangement, the HRA Account of your Same-Sex Domestic Partner will be forfeited unless your Same-Sex Domestic Partner elects continuation coverage. If your Same-Sex Domestic Partner elects continuation coverage, the HRA Account of your Same-Sex Domestic Partner will be forfeited when continuation coverage ends and after payment of claims filed within 6 months following the end of continuation coverage.

Reemployment

If you are reemployed by the Company and you become ineligible for participation in the Program as a result of your reemployment, no additional contributions will be made to your HRA Account or your Spouse's or Same-Sex Domestic Partner's HRA Account during your reemployment. (See the "Reemployment of Retirees" section of the *Eligibility and Participation* section on page 9 for more information regarding eligibility for the Program during reemployment.) Only those medical expenses incurred prior to the date you were reemployed will be eligible for reimbursement under the HRA Coverage. You and your Spouse or Same-Sex Domestic Partner may submit claims for reimbursement up to 6 months after your date of reemployment. Any amounts remaining in your HRA Account after all timely claims have been processed will be forfeited. Upon your subsequent retirement or other termination of employment, you will be treated as a new retiree for purposes of the HRA Coverage to the extent you are eligible upon your subsequent retirement.

If your Spouse or Same-Sex Domestic Partner is employed by the Company and becomes eligible for medical benefits under the Program, no additional amounts will be allocated to your Spouse's or Same-Sex Domestic Partner's HRA Account. However, you will continue to receive contributions to your HRA Account. Only those eligible medical expenses incurred prior to the date of your Spouse's or Same-Sex Domestic Partner's employment will be eligible for reimbursement from your Spouse's or Same-Sex Domestic Partner's HRA Account. Your Spouse or Same-Sex Domestic Partner may submit claims for reimbursement up to 6 months after the date of employment. Any amounts remaining in your HRA Account after all timely claims have been processed will be forfeited. Upon your Spouse's or Same-Sex Domestic Partner's subsequent separation of employment, your Spouse or Same-Sex Domestic Partner will resume participation in the HRA Coverage as the spouse or domestic partner of an eligible retiree. However, if your Spouse or Same-Sex Domestic Partner retires from the Company, your Spouse or Same-Sex Domestic Partner will be treated as a new eligible retiree for purposes of the Program's HRA Benefits.

NOTE: An eligible Spouse or Same-Sex Domestic Partner of a Solar Retiree, upon subsequent separation of employment, may either: (1) resume participation in the HRA coverage as the Spouse or Same-Sex Domestic Partner of an eligible retiree; or (2) become a new eligible retiree in his or her own right for purposes of the Program's HRA benefits.

LIFE INSURANCE BENEFITS

An Introduction To Your Life Insurance Benefits

This *Life Insurance Benefits* section of the SPD summarizes the various life insurance benefits available under the Program.

Eligibility For Life Insurance Benefits

You are eligible for Life Insurance Benefits under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled *Eligibility* beginning on page 9 and any additional requirements described in this section.

BASIC LIFE INSURANCE AT RETIREMENT

Except as otherwise provided below in regards to certain Caterpillar Global Mining LLC retirees, or Solar Turbines Incorporated retirees who retired prior to February 1, 2017, and excluding UAW Retirees and Post-2018 Mapleton Patternmakers IAM Retirees, if you retire and are covered by the Program, the Company will provide reduced basic life insurance benefits for a period following your retirement, as described below.

If you retired on or before January 1, 2003 (other than those that retired from Caterpillar Paving Products Inc.), the amount of basic life insurance will be determined as follows:

- If you were a management employee and your retirement date occurred on or before January 1, 2003, or if you are a non-management employee and your retirement date occurred on or after July 1, 1996 but on or before January 1, 2003, your basic life insurance coverage will continue but it will be reduced by 2% per month until the amount of coverage equals 50% of the amount of your basic life insurance coverage in effect on the day before your retirement date.

- If you were a non-management employee and your retirement date occurred on or after January 1, 1991 but prior to July 1, 1996, and
    - you retire on or before your 65th birthday, your basic life insurance coverage will continue until the first day of the month following your 65th birthday. At that time, your basic life insurance coverage amount will be reduced by 2% per month until the amount of coverage equals one and a half percent (1½%) of the amount of your basic life insurance coverage in effect on the day before your retirement date, multiplied by the number of years of credited service you earned under a pension plan sponsored by the Company in which you participate as of your date of retirement; or
    - you retire after your 65th birthday, your basic life insurance coverage will continue but it will be reduced by 2% per month until the amount of coverage equals one and a half percent (1½%) of the amount of your basic life insurance coverage in effect on the day before your retirement date, multiplied by the number of years of credited service you earned under a pension plan sponsored by the Company in which you participate as of your date of retirement.

Whether you retire before or after your 65th birthday, your basic life insurance coverage will not be reduced to an amount that is less than $3,000.

If you retire after January 1, 2003 (after January 1, 2004 for retirees from Caterpillar Paving Products Inc.), your basic life insurance coverage will continue in the amount in effect on the day before your retirement date until the first

anniversary of your retirement (up to a maximum of $500,000). On the first anniversary of your retirement, your basic life insurance coverage will be reduced to 50% of the amount in effect during the first year of your retirement. Your basic life insurance coverage will terminate on the third anniversary of your retirement.

Note: For Rehired Retirees (as defined in Appendix A), the first anniversary of your retirement for purposes of life insurance benefits will be calculated from your original retirement date.

OPTIONAL LIFE INSURANCE AT RETIREMENT

If you were a management or non-management employee and you retired on or after January 1, 1991 but prior to July 1, 1996, your optional life insurance coverage, if any, will be terminated as of your retirement date.

If you were a management or non-management employee who retired on or after July 1, 1996, you may continue your optional life insurance coverage, if any, provided you pay the required contribution. Your optional life insurance coverage will be reduced by 50% on your 70th birthday or, if later, your retirement date.

EXTENDED RETIREE COVERAGE

If you retire after January 1, 2003, on your retirement date, you will have the option of purchasing group life insurance that will extend your basic life insurance coverage beyond the third anniversary of your retirement date. If you elect to continue your coverage, your benefits will continue at the amount in effect on the day preceding the termination of your coverage. You will be required to pay the full group rate for the life insurance coverage, as determined by the Insurance Carrier. To extend your basic life insurance coverage, you must contact MetLife at the telephone number listed in the section entitled *Contact Information* beginning on page 121 within 31 days of the date of your retirement or, if later, within 31 days of notice from MetLife. You may extend your basic life insurance coverage without providing Evidence of Insurability if you were eligible to retire as of January 1, 2003 or if you carry optional life insurance coverage at the time you actually retire. In all other cases, you will be required to provide satisfactory Evidence of Insurability to extend your basic life insurance coverage.

NAMING A BENEFICIARY

A Beneficiary is someone who receives benefits in the event of your death.

When you enroll, you must name a Beneficiary. To designate a Beneficiary, go to the website at www.metlife.com/mybenefits and complete the form online. Alternatively, you may obtain a Beneficiary designation form by calling MetLife at the telephone number listed in the section entitled *Contact Information* beginning on page 121. You may complete and submit your Beneficiary designation form to MetLife at the address listed in the section entitled *Contact Information* beginning on page 121. You can name one or more Beneficiaries. If you name more than one Beneficiary, you need to designate what portion of the entire benefit should be paid to each. If you fail to name a percentage when naming multiple Beneficiaries, the benefit is paid in equal shares to each then living Beneficiary. You also need to indicate the Beneficiary's relationship to you. Please note that you need to make separate beneficiary designations for your basic and optional life insurance benefits.

CHANGING A BENEFICIARY

Because family situations may change, you should review your Beneficiary designations from time to time. You may change your Beneficiary at any time by submitting a new Beneficiary designation form. You do not need the Beneficiary's consent to make this change. If your form is accepted by MetLife, in its sole discretion, your new designation takes effect on the date you sign the form, even if you are not alive on the date your form is received. A beneficiary change form can be obtained by calling MetLife at the telephone number listed in the section entitled *Contact Information* beginning on page 121 or by completing the form on-line at metlife.com/mybenefits.

IF YOU DO NOT NAME A BENEFICIARY

If you do not name a Beneficiary (or if your Beneficiary dies before, at the same time as or within 24 hours of your death) the benefit is paid in one lump sum to those below in the following order:

- Your surviving legal Spouse/Same-Sex Domestic Partner, or if none,
- Your surviving legal child(ren) (in equal shares), or if none,
- Your surviving parent(s) (in equal shares), or if none,
- Your surviving sibling(s) (in equal shares), or if none, then to
- Your estate.

GVUL COVERAGE

If your life insurance is provided through a group variable universal life policy, you will be provided with additional information regarding your Life Insurance Benefits upon request.

Life Insurance Benefits for Certain Former Salaried Employees of Caterpillar Global Mining LLC

This section summarizes the various life insurance benefits available for retirees who were salaried employees of Caterpillar Global Mining LLC immediately prior to retirement, and were eligible for basic life insurance coverage under the Caterpillar Global Mining Legacy Salaried Employees Welfare Plan as of December 31, 2013.

BASIC LIFE INSURANCE AT RETIREMENT

Your basic life insurance coverage will continue in the amount in effect on the day before you retire. The minimum amount of such coverage shall be $1,500 and the maximum amount of such coverage shall be $5,000.

ACCELERATED LIFE INSURANCE BENEFITS

Accelerated life insurance benefits will be paid to you if: (i) basic life insurance coverage is in effect, (ii) you or your legal representative request accelerated life insurance benefits while such basic life insurance coverage is in effect, and (iii) you meet the following requirements while such basic life insurance coverage is in effect:

- The amount of your basic life insurance benefit to be accelerated equals or exceeds $1,500;
- The amount of your basic life insurance benefit to be accelerated has not been assigned; and
- The Claims Administrator receives (A) a completed accelerated benefit claim form, (B) satisfactory written evidence that, due to injury or sickness, you are expected to die within twenty-four (24) months, and (C) if requested by the Claims Administrator, satisfactory written evidence of your examination by a Physician chosen and paid for by the Claims Administrator.

Accelerated life insurance benefits will be paid only once and will reduce your basic life insurance benefit, and will also reduce the amount of life insurance you may convert to an individual policy of life insurance.

Accelerated life insurance benefits will not exceed 75 percent of your basic life insurance amount.

NAMING A BENEFICIARY

A Beneficiary is someone who receives benefits in the event of your death.

When you enroll, you must name a Beneficiary. To designate a Beneficiary, go to the website at www.metlife.com/mybenefits and complete the form online. Alternatively, you may obtain a Beneficiary designation form by calling MetLife at the telephone number listed in the section entitled *Contact Information* beginning on page 121. You may complete and submit your Beneficiary designation form to MetLife at the address listed in the section entitled *Contact Information* beginning on page 121. Your Beneficiary designation shall become effective only if a properly executed and dated Beneficiary designation form is filed with the Claims Administrator within thirty days after the execution date. Once received by the Claims Administrator, a properly executed and dated designation form shall be effective as of the execution date. You can name one or more Beneficiaries. If you name more than one Beneficiary, you need to designate what portion of the entire benefit should be paid to each. If you fail to name a percentage when naming multiple Beneficiaries, the benefit is paid in equal shares to each then living Beneficiary. You also need to indicate the Beneficiary's relationship to you. If a Beneficiary is a minor or incompetent, then Claims Administrator will pay the Beneficiary's guardian.

CHANGING A BENEFICIARY

Because family situations may change, you should review your Beneficiary designations from time to time. You may change your Beneficiary at any time by submitting a new Beneficiary designation form in accordance with the rules and procedures established by the Claims Administrator. You do not need the Beneficiary's consent to make this change. If your form is accepted by MetLife, in its sole discretion, your new designation takes effect on the date you sign the form, even if you are not alive on the date your form is received. A beneficiary change form can be obtained by calling MetLife at the telephone number listed in the section entitled *Contact Information* beginning on page 121 or by completing the form on-line at metlife.com/mybenefits. A valid Beneficiary change will cancel all prior Beneficiary designations filed with the Claims Administrator; provided, however, that no Beneficiary change shall apply to any payment made in good faith before the Claims Administrator records such change.

IF YOU DO NOT NAME A BENEFICIARY

If you do not properly name a Beneficiary or if there is no surviving Beneficiary as of your death, the benefit is paid in one lump sum to those below in the following order:

- Your surviving legal Spouse, or if none,
- Your surviving legal child(ren) (in equal shares), or if none,
- Your surviving parent(s) (in equal shares), or if none,
- Your surviving sibling(s) (in equal shares), or if none, then to
- Your estate.

ASSIGNMENT OF BENEFITS

You may assign your life insurance benefits and rights under the Program by filing a properly executed assignment form with the Claims Administrator. Such assignment will not be effective until the Company acknowledges the assignment, and the assignment form is delivered to the Claims Administrator for recording. Notwithstanding the foregoing, the Claims Administrator will recognize an irrevocable assignment under a group life insurance policy that is replaced by your insurance policy under the Program if you file a properly executed affirmation that is signed by you, the assignee(s) and the Company, and delivered to the Company for recording.

CONVERSION RIGHTS

In the event that your basic life insurance coverage terminates or is reduced as further described in your insurance policy, the Claims Administrator, in its sole discretion, may issue you an individual policy of life insurance, without evidence of insurability, if you make a timely written application to the Claims Administrator (as further described below) and timely pay all premiums due for such individual policy.

- If you are given written notice of the option to convert your life insurance coverage to an individual policy within fifteen days before or after the date your life insurance coverage is terminated or reduced, you must timely apply for conversion on or after such date and no later than thirty-one (31) days after such date.
- If you are given written notice of the option to convert your life insurance coverage to an individual policy more than fifteen (15) days after the date your life insurance coverage is terminated or reduced, you must timely apply for conversion on or after such date and no later than the earlier of (i) fifteen (15) days after such date of such written notice, or (ii) ninety-one (91) days after the date of the termination or reduction.

Life Insurance Benefits for Certain Solar Turbines Incorporated Retirees

This section summarizes the various life insurance benefits available for retirees who were salaried or hourly employees of Solar Turbines Incorporated immediately prior to retirement before February 1, 2017, and were eligible for basic life insurance coverage under the Solar Turbines Incorporated Retiree Insurance Program as of December 31, 2016.

BASIC LIFE INSURANCE AT RETIREMENT

If you retired before February 1, 2017, your basic life insurance coverage will reduce from two (2) times your annual base salary to one (1) times your annual base salary, up to a maximum of $1 million. For the purposes of basic life insurance coverage, annual base salary is your regular pay, excluding overtime, premium pay, bonuses, and other special compensation in effect on your retirement date. For retirees who were on sales incentive and service incentive plans prior to retirement, annual base salary means 100% of the relevant Target Total Cash Compensation (TTCC).

Your basic life insurance coverage will continue as follows:

- If you were a salaried employee hired prior to January 1, 2014, your basic life insurance coverage will continue for three (3) years from your date of retirement.
- If you were a salaried employee who retired before January 1, 2003, under the current terms of the Program, your basic life insurance coverage will continue for your life.
- If you were an hourly employee hired prior to January 1, 2016, your basic life insurance coverage will continue until you are Medicare eligible, or you reach age 65, whichever occurs first.

OPTIONAL LIFE INSURANCE AT RETIREMENT

Your optional life insurance coverage, if any, will be terminated as of your retirement date.

ACCELERATED LIFE INSURANCE BENEFITS

Accelerated life insurance benefits will be paid to you if: (i) basic life insurance coverage is in effect, (ii) you or your legal representative request accelerated life insurance benefits while such basic life insurance coverage is in effect, and (iii) you meet the following requirements while such basic life insurance coverage is in effect:

- The amount of your basic life insurance benefit to be accelerated equals or exceeds $5,000, with a maximum of $100,000;
- The amount of your basic life insurance benefit to be accelerated has not been assigned; and
- The Claims Administrator receives (A) a completed accelerated benefit claim form, (B) satisfactory written evidence that, due to injury or sickness, you are expected to die within twenty-four (24) months, and (C) if requested by the Claims Administrator, satisfactory written evidence of your examination by a Physician chosen and paid for by the Claims Administrator.

Accelerated life insurance benefits will be paid only once and will reduce your basic life insurance benefit, and will also reduce the amount of life insurance you may convert to an individual policy of life insurance.

Accelerated life insurance benefits will not exceed 25 percent of your basic life insurance amount.

NAMING A BENEFICIARY

A Beneficiary is someone who receives benefits in the event of your death.

When you enroll, you must name a Beneficiary. To designate a Beneficiary, go to the website at www.metlife.com/mybenefits and complete the form online. Alternatively, you may obtain a Beneficiary designation form by calling MetLife at the telephone number listed in the section entitled *Contact Information* beginning on page 121. You may complete and submit your Beneficiary designation form to MetLife at the address listed in the section entitled Contact Information beginning on page 121. You can name one or more Beneficiaries. If you name more than one Beneficiary, you need to designate what portion of the entire benefit should be paid to each. If you fail to name a percentage when naming multiple Beneficiaries, the benefit is paid in equal shares to each then living Beneficiary. You also need to indicate the Beneficiary's relationship to you. Please note that you need to make separate beneficiary designations for your basic and optional life insurance benefits.

CHANGING A BENEFICIARY

Because family situations may change, you should review your Beneficiary designations from time to time. You may change your Beneficiary at any time by submitting a new Beneficiary designation form. You do not need the Beneficiary's consent to make this change. If your form is accepted by MetLife, in its sole discretion, your new designation takes effect on the date you sign the form, even if you are not alive on the date your form is received. A beneficiary change form can be obtained by calling MetLife at the telephone number listed in the section entitled *Contact Information* beginning on page 121 or by completing the form on-line at metlife.com/mybenefits.

IF YOU DO NOT NAME A BENEFICIARY

If you do not name a Beneficiary (or if your Beneficiary dies before, at the same time as or within 24 hours of your death) the benefit is paid in one lump sum to those below in the following order:

- Your surviving legal Spouse/Same-Sex Domestic Partner, or if none,
- Your surviving legal child(ren) (in equal shares), or if none,
- Your surviving parent(s) (in equal shares), or if none,

- Your surviving sibling(s) (in equal shares), or if none, then to
- Your estate.

CONVERSION RIGHTS

In the event that your basic or optional life insurance coverage terminates or is reduced as further described in your insurance policy, the Claims Administrator, in its sole discretion, may issue you an individual policy of life insurance, without evidence of insurability, provided you make a written application to the Claims Administrator and pay premiums due for such individual policy within 30 days following your retirement date.

VOLUNTARY BENEFITS

An Introduction To Your Voluntary Benefits

This *Voluntary Benefits* section of the SPD summarizes the various voluntary benefits available under the various insurance policies of the Program.

Eligibility for Voluntary Benefits

You are eligible for Voluntary Benefits under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled *Eligibility For The Program* beginning on page 9 and you are a retiree or Enrolled Dependent, other than a surviving Spouse of a retiree.

Overview of Voluntary Benefits

The following voluntary benefits are available under the Program:

- *Accident Insurance:* Accident insurance provides a cash benefit in the event of a covered non-occupational injury or accident.
- *Legal Insurance:* Legal insurance provides professional legal assistance on a range of covered legal matters.

For more information on the voluntary benefits, including exclusions and how to file a claim, visit www.YourChoiceVoluntaryBenefits.com/us or refer to the applicable insurance policy issued by the insurance company.

GENERAL ADMINISTRATION

Filing A Claim For Benefits

Plan/Benefit	Information Needed	Where to Send Your Claim	Deadline* and Initial Decision
Traditional Medical Coverage	• Retiree's name and address • The patient's name, age and relationship to the retiree • The member and group numbers stated on your ID card • An itemized bill from your Provider that includes: - Patient diagnosis code - Date(s) of service - Procedure code(s) and descriptions of service(s) rendered - Charge for each service rendered - Provider of service name, address and tax identification number • The date the Injury or Sickness began • A statement indicating whether you are enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s) and a copy of the related Explanation of Benefits ("EOB") if they are the primary carrier(s).	UnitedHealthcare Insurance Company P.O. Box 740800 Atlanta, GA 30374-0800 Customer Service & Personal Health Support Notification: (866) 228-4215 www.myuhc.com	Deadline: One year following the date the expenses were incurred. An expense is incurred on the date you receive the service. Claims filed after this deadline will not be paid. Initial Decision: • Urgent Care claim: Within 72 hours after claim is filed • Pre-service claim (not urgent): Within 15 days after claim is filed** • Post-service claim: Within 30 days after claim is filed**

	Plan/Benefit	Information Needed	Where to Send Your Claim	Deadline* and Initial Decision
	Traditional Prescription Drug Coverage	A receipt that provides: • Date Filled • Days Supply • Drug Name and Strength • Price • Patient Name • Rx No. • Quantity Caterpillar Prescription Drug Expense Claim Form	Magellan Rx Management Attn: Claims Department 11013 W. Broad St. Suite #500 Glen Allen, VA 23060 Fax: (800) 424-7644 Phone: (877) 228-7909	Deadline: One year following the date the expenses were incurred. An expense is incurred on the date you receive the service. Claims filed after this deadline will not be paid. Initial Decision: • Urgent Care claim: Within 72 hours after claim is filed • Pre-service claim (not urgent): Within 15 days after claim is filed** • Post-service claim: Within 30 days after the claim is filed**
	Traditional Dental Coverage	A claim form with the following information: • Retiree name and address • Patient's name and age • Subscriber and health plan Group Numbers stated on your ID card • The name, address and tax identification number of the Provider of the service(s) • Date(s) of service • Itemized bill which includes the ADA codes or description of each charge • A statement indicating whether you are enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s) and the effective date of the coverage. Claim forms are available on the internet at benefits.cat.com or can be obtained by calling the Claims Administrator.	CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037 myCigna.com	Deadline: One year following the date the expenses were incurred. An expense is incurred on the date you receive the service. Claims filed after this deadline will not be paid. Initial Decision: • Urgent Care claim: Within 72 hours after claim is filed • Pre-service claim (not urgent): Within 15 days after claim is filed** • Post-service claim: Within 30 days after the claim is filed**

	Plan/Benefit	Information Needed	Where to Send Your Claim	Deadline* and Initial Decision
	Traditional Vision Coverage	A claim form with the following information: • Your name, address and date of birth • Patient's name and date of birth • The name and phone number of the Provider of the service(s) • Date(s) of service • Claim information • Itemized receipt(s) Claim forms are available at benefits.cat.com or can be obtained by calling VSP.	VSP P.O. Box 385018 Birmingham, AL 35238-5018 (800) 877-7195 VSP.com	Deadline: One year following the date expenses were incurred. An expense incurred on the date you received the service. Claims filed after the deadline will not be paid. Initial Decision: Urgent Care claim: Within 72 hours of claim is filed Pre-service claim (not urgent): Within 15 days after claim is filed** Post-service claim: Within 30 days after claim is filed.**

	Plan/Benefit	Information Needed	Where to Send Your Claim	Deadline* and Initial Decision
	HRA Benefits	HRA Claim Form and proof of the expenses incurred or services rendered, as described in the *HRA Benefit Claims* subsection beginning on page 108.	Your Spending Account P.O. Box 785040 Orlando, FL 32878-5040	Deadline: 90 days following the calendar year in which expenses were incurred. In the event of death, claims must be filed on or before the 6-month anniversary of your date of death for reimbursement from your HRA Account. Claims must be filed on or before the 6-month anniversary of your Spouse's or Same-Sex Domestic Partner's date of death for reimbursement from your Spouse's or Same-Sex Domestic Partner's HRA Account. If you are re-employed by the Company, claims for expenses incurred prior to re-employment must be filed on or before the 6-month anniversary of your date of re-employment. Claims must be filed on or before the 6-month anniversary of the end of COBRA continuation coverage. Initial Decision: Within 30 days after claim is filed**
	Life Insurance Benefits	Call the Plan Administrator at (888) 228-1811	MetLife P.O. Box 14406 Lexington, KY 40511 metlife.com/mybenefits	Initial Decision: Within 90 days after claim is filed.***

* If you wait any longer than these deadlines, you are not eligible for benefits under the plan relating to those expenses.
** Plus extension of up to 15 days in special circumstances.
*** Plus extension of up to 90 days in special circumstances.
**** Plus two extensions of up to 30 days each in special circumstances.

TRADITIONAL MEDICAL COVERAGE CLAIMS

If a Provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. Claims must be furnished to the Claims Administrator within one calendar year from the date the expense was incurred. An expense is incurred on the date you receive the service. Claims filed after this deadline will not be paid. The time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

If you provide written authorization to allow direct payment to a Provider, all or a portion of any Eligible Expenses due to a Provider may be paid directly to the Provider instead of being paid to you. Direct payments to a Provider do

not constitute a waiver of any anti-assignment provision. The Program will not reimburse third parties who have purchased or been assigned benefits by Physicians or other Providers.

If You Receive Covered Health Services from a Network Provider

The Plan Sponsor pays Network Providers directly for your Covered Health Services. Except as described below, if a Network Provider directly bills you for any Covered Health Service, contact the Claims Administrator. However, you are responsible for meeting any applicable Annual Deductible and for paying Co-payments and Co-insurance to a Network Provider at the time of service, or when you receive a bill from the Provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network Provider, you are responsible for requesting payment from the Claims Administrator. You must file the claim in a format that contains all of the information required, as described in the above chart.

Payment of Benefits

The Claims Administrator will make a benefit determination as set forth below. Benefits will be paid to you unless you provide written authorization to allow direct payment to a Provider.

TRADITIONAL PRESCRIPTION DRUG COVERAGE CLAIMS

If Dispensed by a Network Pharmacy

- Present your Prescription Drug ID Card at the pharmacy;
- The Network Pharmacy will bill the Program for prescriptions covered under the Program; and
- You will be charged the deductible, if applicable, or the Co-pay or Co-insurance amount for each prescription or refill received.

If Dispensed by an Out-of-Network Pharmacy

- Coverage under the Program will be reduced for claims filled using an Out-of-Network pharmacy;
- Present your Prescription Drug ID card at the pharmacy;
- The Out-of-Network Pharmacy will bill the Program for all prescriptions covered under the Program; and
- You will be charged the deductible, if applicable, or the Co-pay or Co-insurance amount for each prescription or refill received.

If Dispensed by a Non-Network Pharmacy

- Pay the entire cost of all prescription drug expenses;
- Obtain a receipt which provides the information described in the chart beginning on page 97;
- Complete the Caterpillar Prescription Drug Expense Claim Form available under the U.S. RX tab at benefits.cat.com or by calling Magellan Rx Management at (877) 228-7909;
- Submit claim form and receipt to Magellan Rx Management (via the fax number or address on the claim form);

- Magellan Rx Management will process the claim, applying the appropriate deductible, Co-pay or Co-insurance to each prescription or refill received; and
- If there are benefits payable, a check will be mailed to you at the address listed in the Magellan Rx Management system.

For up-to-date information regarding the Company's prescription drug benefit, visit the website at *benefits.cat.com.*

TRADITIONAL DENTAL COVERAGE CLAIMS

Subject to your written authorization, all or a portion of any Eligible Expenses due may be paid directly to the Provider of the Covered Dental Service instead of being paid to you. Direct payments to a Provider do not constitute a waiver of any anti-assignment provision.

TRADITIONAL VISION COVERAGE CLAIMS

Subject to your written authorization, all or a portion of any Eligible Expenses due may be paid directly to the Provider of the vision services. Direct payments to a Provider do not constitute a waiver of any anti-assignment provision.

HRA BENEFIT CLAIMS

To be reimbursed from your HRA Account you need to submit a reimbursement form, called an HRA Claim Form, for the expenses you, your Spouse, your Same-Sex Domestic Partner or your eligible Dependents incur. An HRA Claim Form is available from the Claims Administrator.

You must include with the HRA Claim Form proof of the expenses incurred. Proof can be a bill, invoice or an Explanation of Benefits ("EOB") from any group medical or dental plan that you are covered under. An EOB will be required if the expenses are for services usually covered under group medical and dental plans, for example, charges by surgeons, doctors and Hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical or dental plans.

You may submit a reimbursement form at any time up to 90 days following the end of the plan year. Only expenses incurred while you or your Spouse or Same-Sex Domestic Partner are enrolled in the HRA Coverage may be reimbursed from the HRA Account. An expense is considered incurred when services are provided, not when you are billed or when you pay for care. Reimbursement from your HRA Account will be made up to the balance in your HRA Account.

LIFE BENEFIT CLAIMS

The Claims Administrator has the initial authority to decide whether an individual is eligible for life insurance benefits under the Program. To make a claim for life insurance benefits, contact the Claims Administrator MetLife at the telephone number listed in the section entitled *Contact Information* beginning on page 121.

Benefit Determination

INITIAL DECISION

The *Filing A Claim for Benefits* chart beginning on page 97 above describes the deadlines for the Claims Administrator's initial decision.

As explained in the chart, the following rules apply to expedite initial decisions under the Company's group health plans (including the Program), depending on the type of claim involved.

Post-Service Claims

Post-service claims are those claims that are filed for payment of benefits after Medical Care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims (Pre-Determination)

Pre-service claims are those claims that require notification or approval prior to receiving Medical Care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action (Urgent Pre-Determination)

Urgent Care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claim Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

CLAIMS ADMINISTRATOR'S DECISION

You will receive an initial decision, in writing, from the Claims Administrator. If your request for benefits is denied, the written notice contains:

- The specific reasons for the denial;
- The specific provisions of the plan upon which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim for benefits and an explanation of why such material or information is necessary; and
- An explanation of how you may appeal the denial, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review.

In the case of health benefits, the written denial notice also informs you of:

- Any specific rule, guideline or protocol that was relied upon or a statement that such rule, guideline or protocol was relied upon and that you may request a copy of it free of charge;
- If the adverse determination is based on a medical necessity or experimental treatment exclusion, an explanation of the scientific or clinical judgment or a statement that you may request such explanation free of charge; and
- In the case of an Urgent Care claim, a description of the expedited review process.

You have the right to request and receive reasonable access to and copies of relevant documents, records and other information in the Company's possession free of charge. Relevant documents, records and other information are those that:

- Were relied upon in making the benefit determination;
- Were submitted, considered, or generated in the course of making the benefit determination;
- Demonstrate compliance with the Program's administrative processes or safeguards; or
- In the case of health benefits, constitute a statement of the Program's policy or guideline regarding the benefit for your diagnosis, whether relied upon or not.

Special Rule When Decision is Based on Medical Judgment

When a denial on appeal is based on a medical judgment, the Program consults with a health care professional with appropriate training, who will be identified upon request. Such health care professional will be someone who was neither consulted in connection with the initial denial of a claim that is the subject of the appeal, nor the subordinate of any such individual.

Note: If a claim for benefits is denied, there is a process for having your claim further reviewed. This review and appeals process is outlined in this *Further Review and Appeals* section beginning on page 105. You must follow this process in order to pursue a claim in court.

Further Review and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about your benefits.
- You are notified that a claim has been denied and you wish to appeal such determination.

REQUESTS FOR REVIEW

Type of Benefit	**Send requests for review to the Claims Administrator at:**
Program Eligibility	Request a Claim Initiation Form by contacting the Caterpillar Benefits Center at (877) 228-4010
Traditional Medical Coverage	UnitedHealthcare Insurance Company Attn: Caterpillar Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 (866) 228-4215
Traditional Prescription Drug Coverage	Magellan Rx Management Attn: Claims Department 11013 W. Broad St. Suite #500 Glen Allen, VA 23060 Fax: (800) 424-7644 Phone: (877) 228-7909
Traditional Dental Coverage	CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037 (800) 244-6224
Traditional Vision Coverage	VSP Member Appeals 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195
HRA Benefits	Willis Towers Watson's Via Benefits 10975 S. Sterling View Dr., Suite 1A South Jordan, UT 84095 (866) 766-6087

Type of Benefit	Send requests for review to the Claims Administrator at:
Life Insurance Benefits	MetLife P.O. Box 14406 Lexington, KY 40511 metlife.com/mybenefits (888) 228-1811

TRADITIONAL MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION COVERAGE CLAIMS

What to Do First

If your question or concern is about a benefit determination, you should contact the Claims Administrator. The Claims Administrator's telephone number is listed in the *Plan Information* chart beginning on page 121.

If you and the Claims Administrator agree that the claim needs to be reviewed and cannot resolve the issue to your satisfaction over the phone, the Claims Administrator will forward the claim to the appropriate area for review. You should receive a response from the Claims Administrator within ten business days. You may submit your question in writing. However, if you are not satisfied with a benefit determination as described in the *Filing a Claim for Benefits* section beginning on page 97 you may appeal it as described below without first contacting the Claims Administrator. If you first contact the Claims Administrator and later wish to send your appeal in writing, the Claims Administrator can provide you with the appropriate address.

If you are appealing an Urgent Care claim denial, please refer to the *Urgent Claim Appeals that Require Immediate Action* section beginning on page 103 and contact the Claims Administrator immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination, you can ask the Claims Administrator, in writing, to formally request an appeal.

If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card;
- The date(s) of medical service(s);
- The Provider's name;
- The reason you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment as well as a copy of the Explanation of Benefits.

You should write "APPEAL" at the top of your letter and send your appeal to the Claims Administrator at the address listed in the above chart. Your first appeal request should be submitted to the Claims Administrator within 180 days after you receive the claim denial.

A qualified individual who was not involved in the decision being appealed will be appointed to respond to the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent medical claim information. Upon request, and free of charge,

you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

For appeals of pre-service claims (as defined in the section entitled *Benefit Determination* beginning on page 102), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims (as defined in the section entitled *Benefit Determination* beginning on page 102), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see *Urgent Claim Appeals That Require Immediate Action* beginning on page 103.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request should be submitted to the Claims Administrator in writing within 60 days from receipt of the first level appeal decision. Note that for claims related to Program eligibility or dental benefits, there is one level of appeal. For dental claims, your appeal request should be submitted to the Claims Administrator within 180 days after you receive a claim denial. You will be notified by the Claims Administrator of the decision within 30 days from the receipt of an appeal for a post-service medical necessity determination. You will be notified by the Claims Administrator of the decision within 60 days of receipt of an appeal for any other post-service coverage determination. For eligibility claims, you will be notified by the Claims Administrator of the decision within 30 days from the receipt of an appeal.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Program for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your provider.

Urgent Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.
- For urgent claim appeals, the Plan Administrator has delegated its sole discretionary authority to the Claims Administrator to interpret and administer the provisions of the Program. The Claims Administrator's decisions are conclusive and binding.

Notice of Denial of Appeal

If a claim for benefits is denied in whole or in part, you or your authorized representative will be given a written notice of the denial, which will be written in a manner to be understood by you and which will include:

- The specific reason(s) for the adverse determination;
- The specific plan provisions on which the determination was based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and make copies of, all records, documents and other information relevant to the claim;
- A statement that you have the right to obtain, upon request and free of charge, a copy of the internal rules or guidelines relied upon in making the determination;
- A statement describing any voluntary appeal procedures offered under the plan and your right to bring a civil action under Section 502(a) of ERISA following the denial of your appeal;
- A statement that if your claim was denied based on a medical necessity or experimental treatment exclusion, you have a right to obtain, free of charge, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to your medical condition; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

HRA BENEFIT CLAIMS

How to Appeal an HRA Claim Decision

If you or any person claiming through you, wishes to have a denied claim reviewed, a written request must be sent to the person and address identified on the notice of claim denial letter for the receipt of requests for review of denied claims within 180 days from the date the claimant received the notice of denial of the claim or within 180 days from the date the claim was deemed denied.

- You may contact the Claims Administrator in an attempt to resolve the complaint in an informal manner.
- If you are not satisfied with any attempts at informal resolution, you must submit a written request for review of a denied claim or a written notice of the complaint or dispute to the Claims Administrator's address in accordance with the time frames set out above. You may submit supporting documentation or information to be considered. You must submit any requested additional information or documents.
- A written notice of the final decision will usually be sent to you within 60 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute.

If a claim for benefits is denied in whole or in part, you or your authorized representative will be given a written notice of the denial, which will be written in a manner to be understood by you and which will include:

- The specific reason(s) for the adverse determination;
- The specific plan provisions on which the determination was based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and make copies of, all records, documents and other information relevant to the claim;
- A statement that you have the right to obtain, upon request and free of charge, a copy of the internal rules or guidelines relied upon in making the determination;
- A statement describing any voluntary appeal procedures offered under the plan and your right to bring a civil action under Section 502(a) of ERISA following the denial of your appeal;
- A statement that if your claim was denied based on a medical necessity or experimental treatment exclusion, you have a right to obtain, free of charge, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to your medical condition; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

GENERAL ADMINISTRATION INFORMATION

Important Legal Provisions

PLAN DOCUMENT

This SPD presents an overview of your benefits under the Program. In the event of any discrepancy between this SPD and the official plan documents, the plan documents shall govern. Specifically, when this SPD inadvertently says anything that grants or provides greater rights or benefits to participants than the plan documents, the plan documents govern.

CLERICAL ERROR

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage or entitlements. The terms of the Program may not be amended by oral statements by the Company, the Plan Administrator, the Claims Administrator, or any other person. In the event an oral statement conflicts with any term of the Program, the Program's terms will control. It is your responsibility to confirm the accuracy of statements made by the Company or its designees, including the Claims Administrator, in accordance with the terms of this SPD and other plan documents.

PLAN ADMINISTRATION

The Plan Administrator has the sole and complete discretionary authority to determine eligibility and entitlement to plan benefits and to construe the terms of the Program, including the making of factual determinations. The Plan Administrator shall have the sole discretionary authority to grant or deny benefits under the Program. Benefits under the Program will be paid only if the Plan Administrator decides, in its sole discretion, that the applicant is entitled to them. The decisions of the Plan Administrator shall be final and conclusive with respect to all questions relating to the Program.

The Plan Administrator may delegate to other persons responsibilities for performing certain duties of the Plan Administrator under the terms of the Program and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the Program. The Plan Administrator shall be entitled to rely upon the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful.

The Plan Administrator has delegated to the Claims Administrators listed in the *Plan Information* chart beginning on page 121 the authority described in this *Plan Administration* section, including the authority to determine eligibility and entitlement to benefits and to construe the terms of the Program. The Plan Administrator may adopt uniform rules for the administration of the plans from time to time, as it deems necessary or appropriate.

In addition, in certain circumstances, for purposes of overall cost savings or efficiency, the Company may, in its sole discretion, offer benefits under the Program for services that would otherwise not be Covered Health Services. The fact that it does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

AMENDMENT AND TERMINATION

The Company reserves the sole discretionary right to modify, amend or terminate the Program, in whole or part, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by its Board of Directors or their designee and duly authorized on behalf of the Company. This right applies to every aspect of the Program, including but not limited to, benefit coverage levels, services covered and excluded, prescriptions covered and excluded, or any aspect of any network associated with the Program whether or not specifically stated with respect to any particular aspect.

If the Program is modified, amended or terminated, you will be notified of the effect of such change on your benefits or coverage and/or the benefits and coverage of (or available to) your Dependents. No consent of any employee or any other person will be necessary for the Company to modify, amend or terminate the Program.

COMPANY AUDIT

The Company and the Plan Administrator reserve the right to audit any aspect of the Program, including but not limited to eligibility, enrollment and claims. In connection with any such audit, the Plan Administrator may request from you, your Spouse, your Same-Sex Domestic Partner or your covered Dependent child(ren) information relating to eligibility, enrollment or claims. Failure to provide any requested information may affect your (or your Spouse's or your Same-Sex Domestic Partner's or your Dependent's) coverage or benefits under the Program.

REPRESENTATIONS CONTRARY TO THE PLAN

No employee, director, or officer of the Company has the authority to alter, vary, or modify the terms of the Program except by means of a duly authorized written amendment. No verbal or written representations contrary to the terms of the Program are binding upon the Program, the Plan Administrator or the Company.

NO ASSIGNMENT

Except as permitted by this SPD or the Plan Administrator:

- No individual has any transmissible interest in any benefit under the Program or any power to anticipate, alienate, assign, sell, transfer, dispose of, pledge or encumber the same;
- The Program will not recognize an assignment of any benefit under the Program, either in whole or in part; and
- No benefit will be subject to attachment, garnishment, execution following judgment or other legal process.

Except as may be required by law, your benefits under the Program are not subject to the claims of your creditors. Except as permitted by the Plan Administrator or as required by law, a participant may not assign his or her rights under the Program to a Provider. Direct payments to a Network Provider by the Program do not constitute a waiver of any anti-assignment provisions. Medical Providers are not third-party beneficiaries under the Program. A participant may appoint an authorized representative to act on his or her behalf solely with respect to an appeal of an adverse benefit determination or an inquiry concerning an adverse benefit determination. The designation of an authorized representative, however, does not constitute an assignment of a claim and does not provide the authorized representative withstanding to file a lawsuit on his or her own behalf.

A participant may not assign and/or transfer to anyone his or her right to file a lawsuit against the Program, the plan sponsor, any participating subsidiary, the Plan Administrator, any Program fiduciary, any party-in-interest with respect to the Program, or anyone else with respect to the Program.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS ("QMCSOS")

The Program's procedures for handling qualified medical child support orders ("QMCSOs") are available without charge upon request by calling the Caterpillar Benefits Center at (877) 228-4010.

NO CONTRACT OF EMPLOYMENT

Your participation in the plans does not grant you employment with the Company or rights to benefits except as specified under the terms of the Program. Nothing in the Program or this SPD confers any right of employment on any person.

PARTICIPATING COMPANIES

Participating Companies include those subsidiaries or affiliates of Caterpillar Inc. that adopt the Program with the approval of Caterpillar Inc.

IMPLIED PROMISES

No rights accrue to any employee, retiree, Dependent or Beneficiary by reason of any misstatement in, or omission from, this SPD, or by the operation of the Program.

CHANGE OF ADDRESS

It is important that you notify the Claims Administrator (and the Company) of any change in your address so you will be assured of receiving future benefit communications that the plans may send to you. You also should ensure that your Beneficiary's address is kept current. If your address changes, you may update your records under the Program by contacting the Caterpillar Benefits Center at (877) 228-4010 and, if you have Reached Age 65, you must also contact Via Benefits at (866) 766-6087 as well as your individual insurance carrier.

SEVERABILITY

If any provision of the Program is found, held or deemed by a court of competent jurisdiction to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the Program shall continue in full force and effect.

RECOVERY OF PAYMENTS MADE BY MISTAKE

You will be required to return any benefits, or portion thereof, paid under the Program by mistake of fact or law. If you fail to promptly repay any such benefits, the Claims Administrator may recover the amount by making the appropriate deduction(s) from your future benefit payments.

FORFEITURE OF UNCLAIMED OR ABANDONED BENEFIT PAYMENTS

If you receive a medical, vision, prescription drug, or dental benefit payment by check, you must cash the check within twelve (12) months of the date it is issued. A benefit payment check that is not cashed within this designated time period or that is otherwise unclaimed or abandoned shall be forfeited.

REFUND OF OVERPAYMENTS

If a Program pays benefits for expenses incurred on your account, you or any other person or organization that was paid, must make a refund to the Program if either of the following apply:

- All or some of the expenses were not paid by the participant or did not legally have to be paid by the participant.
- All or some of the payment the Program made exceeded the benefits under the plan.

The refund equals the amount the Program paid in excess of the amount the plan should have paid under the Program. If the refund is due from another person or organization, the participant agrees to help the plan get the refund when requested.

If you, or any other person or organization that was paid, does not promptly refund the full amount, the Program may reduce the amount of any future benefits that are payable under the Program. The reductions will equal the amount of the required refund. The Program may have other rights in addition to the right to reduce future benefits.

SUBROGATION

The following provisions apply to benefits administered by UnitedHealthcare. If you are enrolled in the Blue Cross Blue Shield National plan, please refer to the benefits booklet provided by Blue Cross Blue Shield for their subrogation provisions.

The Program has a right to subrogation and reimbursement. References to “you” or “your” in this section includes you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Program has paid benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Program is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Program has paid that are related to the Sickness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Program 100% of any benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.

- The plan sponsor in a workers' compensation case or other matter alleging liability.

- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.

- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Program in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

    - Notifying the Program, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.

    - Providing any relevant information requested by the Program.

    - Signing and/or delivering such documents as the Program or its agents reasonably request to secure the subrogation and reimbursement claim.

    - Responding to requests for information about any accident or injuries.

    - Making court appearances.

    - Obtaining the Program's or its agents' consent before releasing any party from liability or payment of medical expenses.

    - Complying with the terms of this section.

Failing to cooperate with these subrogation provisions is considered a breach of contract. As such, the Program has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Program has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Program due to you or your representative not cooperating with the Program or its designee. If the Program incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Program has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Program.

The Program has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Program's first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The Program's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Program is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the

Program's recovery without the Program's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

Regardless of whether you have been fully compensated or made whole, the Program may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Program may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Program's subrogation and reimbursement rights.

Benefits paid by the Program may also be considered to be benefits advanced.

If you receive any payment from any party as a result of Sickness or Injury, and the Program alleges some or all of those funds are due and owed to the Program, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

By participating in and accepting benefits from the Program, you agree that (i) any amounts recovered by you from any third party shall constitute Program assets (to the extent of the amount of Program benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Program (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Program to enforce its reimbursement rights.

The Program's rights to recovery will not be reduced due to your own negligence.

By participating in and accepting benefits from the Program, you agree to assign to the Program any benefits, claims or rights of recovery you have under any automobile policy – including no-fault benefits, personal injury protection ("PIP") benefits and/or medical payment benefits – other coverage or against any third party, to the full extent of the benefits the Program has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in the Program and accepting benefits under the Program, you acknowledge and recognize the Program's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

The Program may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the Program in any way to pay you part of any recovery it might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Program is governed by a six-year statute of limitations.

You may not accept any settlement that does not fully reimburse the Program, without its written approval.

The Plan Administrator and its designee have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Program's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Program is not extinguished by a release of claims or settlement agreement of any kind.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Program for 100% of its interest unless the Program provides written consent to the allocation.

The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Program, the provisions of this section continue to apply, even after you are no longer covered.

In the event that you do not abide by the terms of the Program pertaining to reimbursement, the Program may terminate benefits to you, your dependents, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Program has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Program due to your failure to abide by the terms of the Program. If the Program incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Program has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Program.

The Program, the Plan Administrator and its designee(s) administering the terms and conditions of the Program's subrogation and reimbursement rights have such powers and duties as are necessary to discharge their duties and functions, including the exercise of their discretionary authority to (1) construe and enforce the terms of the Program's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Program.

REIMBURSEMENT TO THE PLAN

If you or your covered Dependent is injured as a result of the act of a third party and you or your covered Dependent's legal representative files a claim for benefits, that same person must, as a condition of receipt of plan benefits, reimburse the Program for money received from the third party, or its insurer, to the extent of the amount paid by the Program on the claim. The right of reimbursement provides the Program with priority over any funds paid by a third party or insurer, without regard to whether you or your covered Dependent has been made whole. The Program will be reimbursed from your future benefits, to the extent necessary.

PLAN FUNDING

The Program

The Program may be funded through a group policy issued by an Insurance Carrier, by the Company through a self-insured plan that may or may not be funded through and paid out of a trust that is intended to be a tax-exempt organization under Section 501(c)(9) of the Internal Revenue Code, or through a combination of these means. The Program requires you to contribute to the cost of certain coverage.

The following chart shows which benefits under the Program are self-insured by the Company and which are fully insured.

	Self-Insured	**Fully Insured**
Benefits	Medical Prescription Drug Dental Vision Care	Life insurance benefits

	Self-Insured	Fully Insured
Definition	As claims are made, covered benefits are paid from the Company's general assets. In addition, the Company has administrative services contracts with third-party administrators to decide and to process claims.	An Insurance Carrier is a legal reserve life insurance company selected by the Company that provides administrative services. The Insurance Carrier insures coverages and makes benefit payments. The Company pays premiums to the Insurance Carrier for coverages from its own funds.

APPLICABLE LAW

The plans are governed and construed in accordance with ERISA, and in the event that any reference shall be made to state law, the laws of the state of Illinois shall apply.

LEGAL ACTION LIMITATIONS

As a participant in the Program, you may bring action in court to recover Program benefits after you have exhausted the Program's claims procedures. Except as provided below, any action brought in court must be brought within six months after you receive a final adverse benefit determination under the claims' procedures. Any such court action must be brought in the U.S. District Court for the Central District of Illinois, where the Program is administered.

For claims involving life insurance or AD&D benefits, you may have a longer period of time of up to three years to bring an action in court after exhausting the Program's claims procedures. Contact MetLife at (888) 228-1811 for the specific filing limitations that apply to your claim.

HIPAA PRIVACY AND SECURITY

As a participant in the Program (including the medical, prescription drug, dental and vision benefits) your "protected health information" is subject to safeguards under the privacy and electronic security provisions of the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, these plans have adopted policies and procedures that restrict the use and disclosure of your protected health information and impose security measures for protected health information in electronic form.

Generally, under HIPAA's privacy rules, use and disclosure are limited to payment and healthcare operation functions, and only the "minimum necessary" information may be used or disclosed. Under HIPAA's final regulations, the privacy provisions went into effect on April 14, 2003 and the security provisions are effective April 20, 2005. Under HIPAA's electronic security rules, additional safeguards have been implemented to protect information that is in electronic form.

This is only a brief summary of HIPAA. As a participant in the plans listed in this section, you have received a "privacy notice" that more fully describes the important uses and disclosures of protected health information and your rights under the HIPAA privacy provisions. If you need a free copy of this notice, you should contact the HIPAA Privacy Officer at (309) 675-6199.

RELATIONSHIP WITH PROVIDERS

The relationships between the Company, the Claims Administrator and Network Providers are contractual relationships between independent contractors. Network Providers are not agents or employees of the Company. Nor are they agents or employees of the Claims Administrator. Neither the Company nor any of its employees are agents or employees of Network Providers. Neither the Company nor the Claims Administrator are liable for any act or omission of any Provider.

The Company does not provide health care services or supplies, nor does it practice medicine. Instead, the Company pays benefits. Network Providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the Providers' licenses and other credentials but does not assure the quality of the services provided.

The Claims Administrator is not considered to be an employer or Plan Administrator for any purpose with respect to the administration or provision of benefits under the Program.

The Plan Administrator or its designee is responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of benefits.
- Notifying you of the termination or modifications to the Program.

The relationship between you and any Provider under the Program is that of Provider and patient.

- You are responsible for choosing your own Provider.
- You must decide if any Provider treating you is right for you. This includes Network Providers you choose and Providers to whom you have been referred.
- You must decide with your Provider what care you should receive.
- Your Provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Company is that of employer and retiree, Dependent or other classification as defined in the Program.

INCENTIVES TO PROVIDERS

The Claims Administrator pays some Network Providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and cost effectiveness.
- Capitation - a group of Network Providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

The methods used to pay specific Network Providers may vary. From time to time, the payment method may change. If you have questions about whether your Network Provider's contract includes any financial incentives, the Company encourages you to discuss those questions with your Provider. You may also contact the Claims Administrator at the telephone number on your ID card or in the section entitled *Contact Information* beginning on page 121. They can advise whether your Network Provider is paid by any financial incentive, including those listed above.

INCENTIVES TO YOU

Sometimes the Claims Administrator may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours

alone but the Company recommends that you discuss participating in such programs with your Physician. These incentives are not benefits and do not alter or affect your benefits. Contact the Claims Administrator if you have any questions.

REBATES AND OTHER PAYMENTS

The Company and the Claims Administrators may receive rebates for certain prescription drugs. This includes rebates for those drugs that you receive before you meet your Annual Deductible. The Company and the Claims Administrator do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Co-payments and Co-insurance.

INFORMATION AND RECORDS

At times, the Company or the Claims Administrator may need additional information from you. You agree to furnish the Company and the Claims Administrator with all information and proofs that they may reasonably require regarding any matters pertaining to the Program. If you do not provide this information upon request, the Company or the Claims Administrator may delay or deny payment of your benefits.

By accepting benefits under the Program, you authorize and direct any person or institution that has provided services to you to furnish the Company or the Claims Administrator with all information or copies of records relating to the services provided to you. The Company or the Claims Administrator has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the retiree's enrollment form. The Company and the Claims Administrator agree that such information and records will be considered confidential.

The Company and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Program, for appropriate medical review or quality assessment, or as the Company is required to do by law or regulation. During and after the term of the Program, the Company, the Claims Administrator, and related entities may use and transfer the information gathered under the plan for research and analytic purposes.

For complete listings of your medical records or billing statements, the Company recommends that you contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from the Company, it also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the Company or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

EXAMINATION OF COVERED PERSONS

In the event of a question or dispute regarding your right to benefits, the Company may require that a Network Physician or Dentist of its choice under the Program examine you at its expense.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Company provides benefits under the Program for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Co-payments, Co-insurance and any Annual Deductible) is the same as is required for any other Covered Health Service. Limitations on benefits are the same as for any other Covered Health Service.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans, health insurance issuers, and hospitals 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, insurers and hospitals may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

STATEMENT OF ERISA RIGHTS

As a participant in the employee benefit plans described in this SPD, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plans, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plans, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plans' annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse, your Same-Sex Domestic Partner or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or you are discriminated against for exercising your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CONTACT INFORMATION

General Information

General Contact Information	
Personal Health Support Notification	UnitedHealthcare (866) 228-4215 www.myuhc.com
Caterpillar Benefits Center	(877) 228-4010 [Outside the U.S. 718-354-1345] http://CatBenefitsCenter.com
COBRA Administrator	Caterpillar Benefits Center (877) 228-4010 [Outside the U.S. 718-354-1345] http://CatBenefitsCenter.com For HRA Benefits only: Via Benefits (866) 766-6087
Caterpillar HR Service Center – Americas	(800) 447-6434 HR_Service_Center@cat.com
General Health and Welfare Benefit Information	benefits.cat.com
MetLife National Benefit Center for Caterpillar	(888) 228-1811 metlife.com/mybenefits

Plan Sponsor:	Agent for Legal Service:
Caterpillar Inc. 5205 N. O'Connor Boulevard, Suite 100 Irving, TX 75039 (972) 891-7700 Employer Identification Number: 37-0602744	Corporation Service Company 251 Little Falls Drive Wilmington, DE 19808

Plan Information

Plan Name/Type	Plan Number	Funding/Claims Administrator	Plan Administrator	Plan Year
Caterpillar Inc. Retiree Benefit Program	501	Medical benefit claims are administered by: UnitedHealthcare Insurance Company P.O. Box 150450 450 Columbus Blvd. Hartford, CT 06115-0450 (866) 228-4215 benefits.cat.com Prescription drug benefit claims are administered by: Magellan Rx Management Attn: Claims Department 11013 W. Broad St. Suite #500 Glen Allen, VA 23060	Caterpillar Inc. Attn: Plan Administrator – Retiree Benefit Program 100 NE Adams Street Peoria, IL 61629 (309) 675-1000	The 12-month period ending December 31

Plan Name/Type	Plan Number	Funding/Claims Administrator	Plan Administrator	Plan Year
		Fax: (800) 424-7644 Phone: (877) 228-7909		
		Dental benefit claims are administered by: CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037 (800) 244-6224 myCigna.com Vision benefit claims are administered by: VSP P.O. Box 385018 Birmingham, AL 35238-5018 (800) 877-7195 VSP.com HRA Benefits are administered by: Your Spending Account P.O. Box 785040 Orlando, FL 32878-5040 (866) 766-6087 Life insurance claims are administered by: MetLife P.O. Box 14406 Lexington, KY 40511 (888) 228-1811 metlife.com/mybenefits		

DEFINITIONS

Affiliate – A company or other trade or business that is connected to the Company by an 80% or more ownership link.

Alternate Facility – A health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services.
- Emergency Room Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an Outpatient or Inpatient basis.

Annual Deductible – If you are enrolled in the traditional PPO or BCBS option, the amount you must pay for Covered Health Services in a calendar year before the Program will begin paying for benefits in that calendar year. If you are enrolled in a CDHP option, the amount you must pay for Covered Health Services and covered prescription expenses in a calendar year before the program will begin paying for benefits that calendar year. There is also an Annual Deductible for Covered Dental Services, which is tracked separately. The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Amounts paid by manufacturer assistance programs, copay cards or other such patient assistance programs for prescription drug costs are also excluded from the Annual Deductible. The Annual Deductible amounts shall be established from time to time by the Plan Administrator in its sole discretion and as such Annual Deductible amounts may be different for different categories of participants or services.

Annual Enrollment Period – A period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Program, opt out of coverage, or change benefit elections previously made. The Plan Administrator will determine the period of time that is the Annual Enrollment Period.

Annual Maximum Benefit – The maximum amount paid for Covered Dental Services during a calendar year for a Covered Person under the Program. The Annual Maximum Benefit is stated in the *Schedule of Dental Benefits* beginning on page 70.

Beneficiary – Includes (a) the legal or natural person(s) or entity(ies) designated by a participant (concurrently, contingently or successively) to receive the benefit resulting from the death of the participant, or (b) the participant, who will receive the benefit resulting from the death of his or her Dependent(s) who is a Covered Person.

BMI – A measure used in obesity risk assessment to determine the degree of obesity by approximating the measure of total body fat as compared with the assessment of body weight alone. Also referred to as Body Mass Index.

Caterpillar Benefits Center – The third-party administrator (currently Alight Solutions) for eligibility, change in status events and COBRA continuation coverage under the Program.

Cause – An individual's (1) commission of an act of fraud, embezzlement, malfeasance, dishonesty or other misconduct in connection with the performance of his employment duties, as determined by the Plan Sponsor in its sole discretion; (2) violation of Plan Sponsor policies regarding employment, including, without limitation, attendance, substance abuse, sexual harassment and discrimination, which violation, in the reasonable judgment of the Plan Sponsor, has interfered with the individual's ability to perform his duties or may cause or has caused significant harm to the Employer; (3) failure to return from an approved leave of absence without providing notification to the Plan Sponsor prior to the scheduled end of such leave of absence; or (4) failure to adequately perform his employment duties, as determined by the Plan Sponsor is its sole discretion. The Plan Sponsor shall

determine whether an individual's employment has been terminated for cause and the Plan Administrator shall be entitled to conclusively rely on such determination.

Claims Administrator – The Company or its designee that provides certain claim administration services for the Program.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985 as amended from time to time, which extends group medical, prescription drug, dental and vision coverage to terminated employees and their qualifying dependents.

COBRA Administrator – The Company or its designee that provides COBRA services for the Program.

Co-insurance – The charge you are required to pay for certain Covered Health Services or Covered Dental Services, after satisfaction of the Annual Deductible. Co-insurance also refers to the charge you are required to pay for certain covered prescription drugs. The Co-insurance amounts shall be established from time to time by the Plan Administrator, in its sole discretion, and such Co-insurance amounts may be different for different categories of participants or services. Co-insurance is typically a percentage of Eligible Expenses.

Company – Caterpillar Inc.

Compounded Drug – Any product designated as such by the Company, and generally may be a product not commercially available that is the result of the combining, mixing, or altering of two or more ingredients (one of which is a prescription drug) in order to create a customized medication.

Consumer-Directed Health Plan or CDHP – The high deductible health plan options offered by the Company that are intended to qualify as a high deductible health plan under Section 223(c)(2) of the Internal Revenue Code.

Co-payment or Co-pay – The charge you are required to pay for certain Covered Health Services and Covered Dental Services. A Co-payment is typically a set dollar amount and must continue to be paid in addition to Co-insurance amounts, even after satisfaction of the Annual Deductible or the Maximum Out-of-Pocket. Co-payment or Co-pay also refers to the charge you are required to pay for certain covered prescription drugs. The Co-payment amounts shall be established from time to time by the Plan Administrator in its sole discretion, and such Co-payment amounts may be different for different categories of participants or services.

Cosmetic Procedures – Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Personal Health Support^{SM} (which is the Claims Administrator).

Covered Dental Service(s) – Dental care or treatment provided by a Dentist to a Covered Person, provided such care or treatment is recognized, in the sole discretion of the Claims Administrator, as a generally accepted form of care or treatment according to prevailing standards of dental practice. A Covered Dental Service is a dental service or supply described in *Covered Dental Services* beginning on page 69 under the *Dental Benefits* section of this SPD as a Covered Dental Service, which is not excluded as set forth herein. Covered Dental Services must be provided:

- When the Program is in effect; and
- Prior to the effective date of any applicable individual termination conditions set forth in this SPD; and
- When the person who receives services is a Covered Person and meets all eligibility requirements specified in the Program.

The Claims Administrator, in its sole discretion, may make decisions about whether to cover new technologies, procedures and treatments, taking into consideration conclusions of prevailing dental research, based on well-conducted, randomized trials or cohort studies.

Covered Health Service(s) – Those health services provided for the purpose of diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse or their symptoms. A Covered Health Service is a health care service or supply described in *What's Covered – Benefits* subsection beginning on page 33 under the *Medical Benefits* section of this

SPD as a Covered Health Service, which is not excluded as set forth herein. Covered Health Services must be provided:

- When the Program is in effect; and
- Prior to the effective date of any of the individual termination conditions set forth in this SPD; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Program.

The Claims Administrator, in its sole discretion, may make decisions about whether to cover new technologies, procedures and treatments, taking into consideration conclusion of prevailing medical research, based on well-conducted, randomized trials or cohort studies, as described.

Covered Person – Either the retiree or an Enrolled Dependent or Beneficiary, but this term applies only while the person is enrolled under the applicable plan. References to "you" and "your" throughout this SPD generally are references to a Covered Person.

Credited Eligibility Service – Generally, the service used for purposes of determining whether an individual is eligible for participation in the Program and is equal to the sum of the following:

- For periods of service prior to January 1, 2011, the years (and fractional years) of service determined under the Caterpillar Inc. Retirement Income Plan for purposes of determining vesting thereunder.
- For periods of service on or after January 1, 2011, the years (and fractional years) of service determined under Caterpillar's 401(k) plans for purposes of determining vesting thereunder.

If you are in a classification of employees eligible for the Program but do not participate in RIP or Caterpillar's 401(k) plans and you are not a UAW Retiree or a Post-2018 Mapleton Patternmakers IAM Retiree, the Plan Administrator will determine your Credited Eligibility Service in a manner to best approximate the service you would have earned had you participated in RIP and the 401(k) plans. If you are a UAW Retiree or a Post-2018 Mapleton Patternmakers IAM Retiree, your Credited Eligibility Service shall be determined by applying the rules and provisions of the Caterpillar Inc. Non-Contributory Pension Plan regarding the determination of credited service for purposes of retirement eligibility.

Except as provided in this paragraph, no individuals hired or rehired on or after January 1, 2013, shall earn any Credited Eligibility Service. Individuals hired by Solar Turbines Incorporated as salaried employees on or after January 1, 2014 are not eligible for the Program and shall not earn any Credited Eligibility Service. Individuals hired by Solar Turbines as hourly employees on or after January 1, 2016, are not eligible for the Program and shall not earn any Credited Eligibility Service. Certain rehired retirees, as defined in Appendix A, shall earn Credited Eligibility Service for their period of reemployment that ends on or before January 1, 2019.

For Solar Retirees who retired on or before December 31, 2016, Credited Eligibility Service includes vesting service under a qualified defined benefit plan sponsored by Solar Turbines Incorporated or the Company or, for Solar Retirees not eligible to participate in such plan, Credited Eligibility Service includes vesting service under a qualified defined contribution plan sponsored by Solar Turbines Incorporated or the Company. For a former employee who was accruing benefits under a defined benefit retirement plan, but who terminated employment with Solar Turbines Incorporated or a related employer and was then ineligible to resume participation in the defined benefit retirement plan because it was frozen to rehired employees, Credited Service Eligibility includes vesting service accrued under the defined benefit retirement plan sponsored by Solar Turbines Incorporated or the Company combined with vesting service accrued under a defined contribution retirement plan sponsored by Solar Turbines Incorporated or the Company. Note, however, that no former employee shall receive credit for vesting under both a defined benefit retirement plan and a defined contribution retirement plan for this purpose for the same period of time.

Custodial Care – Services that:

- Are non-health-related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating);
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing or improving to a predictable level of recovery; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dentist – Any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental services, perform dental surgery or administer anesthetics for dental surgery.

Dependent – Except for Solar Retirees, the retiree's (a) legal Spouse or Same-Sex Domestic Partner who is not eligible in his or her own right or a Covered Person under their own right or (b) Dependent child of the retiree or the retiree's Spouse or Same-Sex Domestic Partner who is not an individual eligible in their own right. For Solar Retirees, the Retiree's (a) legal Spouse or Same-Sex Dependent or (b) Dependent child of the Retiree or the Retiree's Spouse or Same-Sex Domestic Partner. For purposes of this definition of Dependent, Dependent child includes Dependent children identified in the *Eligibility* section of this SPD.

A Dependent does not include anyone who is also enrolled as a retiree. No one can be a Dependent of more than one retiree.

Designated Provider – A Hospital that the Claims Administrator, in its sole discretion, names as a Designated Provider. A Designated Provider has entered into an agreement with the Claims Administrator to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Provider may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Provider.

Durable Medical Equipment – Medical equipment, as determined by the Claims Administrator, that:

- Is ordered or provided by a Physician for Outpatient use;
- Is used for medical purposes;
- Can withstand repeated use;
- Is not disposable;
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms; and
- Is appropriate for use in the home.

Eligible Expenses –

Eligible Expenses (whether for Medical or Dental benefits) must be a Covered Health Service or a Covered Dental Service (as applicable) not exceed the fees that the Provider would charge any similarly situated payor for the same services. In the event that a Provider routinely waives any fee or other amount, the waived fee is not considered to be part of the Eligible Expenses.

Medical Benefits: For purposes of medical benefits under the Program, the amount the Program will pay (and the amount of the Covered Person's Co-insurance or Co-payment), for Covered Health Services, incurred while the Program is in effect, is determined as stated below:

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare; or
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Eligible Expenses are calculated by the Claims Administrator, in its sole discretion.

Dental Benefits: For purposes of dental benefits under the Program, the amount the Company will pay and the amount of the Covered Person's Co-insurance or Co-payment, for Covered Dental Services, incurred while the Program is in effect, is determined as stated below.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines, which have been adopted by the Plan Administrator. The Claims Administrator's reimbursement policy guidelines are developed by the Claims Administrator, in its sole discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Dental Terminology (publication of the American Dental Association);
- As reported by generally recognized professionals or publications;
- As utilized for Medicare;
- As determined by medical or dental staff and outside medical or dental consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Eligible Expenses are calculated by the Claims Administrator, in its sole discretion.

Eligible Person – An individual who satisfies the eligibility requirements explained in the *Eligibility* section beginning on page 9.

Emergency – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

An Emergency is also a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

An Emergency is also a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Emergency Room Health Services – With respect to an Emergency, both of the following:

- A medical screening examination (as required under *section 1867 of the Social Security Act, 42 U.S.C. 1395dd*) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.

- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as required under *section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employee Program – The Caterpillar Inc. Employee Health, Life and Disability Benefit Program or the Caterpillar Inc. International Service Employee Healthcare Plan, as they may be amended from time to time.

For UAW Retirees, references to the "Employee Program" shall include the Caterpillar Inc. Group Insurance Plan A or the Caterpillar Inc. Group Insurance Plan, as applicable, for periods prior to January 1, 2018.

For Post-2018 Mapleton Patternmakers IAM Retirees, references to the "Employee Program" shall include the Caterpillar Inc. Group Insurance Plan A or the Caterpillar Inc. Group Insurance Plan, as applicable, for periods prior to January 1, 2019.

Enrolled Dependent – A Dependent who is properly enrolled under the applicable plan. Except for Solar Retirees, a Dependent Spouse or Same-Sex Domestic Partner who is an Eligible Person must enroll as a retiree.

ERISA – The Employee Retirement Income Security Act of 1974, as amended, which establishes certain rights and protection for participants.

Experimental or Investigational Services – Medical, surgical, diagnostic, psychiatric, substance abuse or other health care or dental services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time a determination by the Claims Administrator, in its sole discretion, is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment), the Claims Administrator may, in its sole discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service or Covered Dental Service for that Sickness or condition. For this to take place, the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Health Reimbursement Arrangement or **HRA** – A health reimbursement arrangement as described in IRS Notice 2002-45.

Health Savings Account or HSA – A tax-advantaged medical savings account that you may be eligible for if you are enrolled in a CDHP option. The HSA is not a component of the Program and is not an employee welfare benefit plan.

Healthcare Benefit Service – The service used for purposes of determining the amount allocated to a retiree's (and the retiree's spouse, if applicable) HRA Account.

For a participant who is not a UAW Retiree or a Post-2018 Mapleton Patternmakers IAM Retiree, Healthcare Benefit Service is equal to the sum, rounded down to the nearest whole year, of the following:

- For periods of service prior to January 1, 2011, the years of "credited benefit service" (rounded down to the nearest whole year) determined under the Caterpillar Inc. Retirement Income Plan.
- For periods of service on or after January 1, 2011, the years (rounded down to the nearest whole year) of service determined under Caterpillar's 401(k) plans for purposes of determining "points" thereunder (not for purposes of vesting).

If you are in a classification of employees eligible for the Program but do not participate in RIP or Caterpillar's 401(k) plans, the Plan Administrator will determine your Healthcare Benefit Service in a manner to best approximate the service you would have earned had you participated in RIP and the 401(k) plans.

For a UAW Retiree or a Post-2018 Mapleton Patternmakers IAM Retiree, Healthcare Benefit Service is equal to credited service as calculated for determining retirement eligibility under the Caterpillar Inc. Non-Contributory Pension Plan.

Hearing Aid – 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.

Home Health Care Agency – A program or organization authorized by law to provide health care services in the home, and which (a) is licensed, certified, or approved by the jurisdiction in which it does business to provide the full array of covered services; is certified under Medicare; and may be a Hospital or Skilled Nursing Facility affiliated with or a freestanding not-for-profit or for-profit; and (b) has policies which are established and reviewed by health care professionals including at least one physician who is a Doctor of Medicine, Doctor of Osteopathy (see definition of Physician), or graduate registered nurse; and (c) keeps clinical records on each patient, and (d) is approved by the Plan Administrator, in its sole discretion.

Hospice Agency – A Hospital, Home Health Care Agency or other agency or organization approved by the Plan Administrator, in its sole discretion, which meets each of the following requirements:

- Has Hospice Care available twenty-four (24) hours a day;
- Meets licensing or certification standards set forth by the jurisdiction in which it performs services;
- Provides or arranges for the following services as appropriate: (1) services of a Physician; (2) physical or occupational therapy; (3) part-time home health aide services which mainly consist of caring for terminally ill persons; and (4) Inpatient care in a facility when needed for pain control and acute and chronic symptom management;
- Establishes policies governing the provision of Hospice Care; and
- Keeps clinical records on each patient.

Hospice Care – Care given to a terminally ill person by or under arrangements with a Hospice Agency. A person is terminally ill if the medical prognosis is that the patient's life expectancy is six months or less if the illness runs its normal course. Generally, Hospice Care is continuous care designed to give supportive care to people in the final phase of a terminal illness focusing on comfort, pain control, and quality of life. Services provided may include drugs to control pain and manage other symptoms, medical supplies and equipment, medical social services, dietary and other counseling, and home care. Hospice Care may also apply to a professional facility that provides care to dying patients who can no longer be cared for at home and as an alternative to hospitalization.

Hospital – An institution, operated as required by law, which:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals, with care provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and

- Has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

HRA Account – The notional accounts established by the Company in your name and the name of your Spouse or Same-Sex Domestic Partner to track health reimbursement amounts. The HRA Account is not a funded account and does not hold segregated assets.

HRA Benefits – The Health Reimbursement Arrangement under the Program established to reimburse eligible retirees and their Spouses or Same-Sex Domestic Partners for eligible healthcare expenses.

Initial Enrollment Period – The initial period of time, as determined by the Plan Administrator, during which Eligible Persons may enroll themselves and their Dependents under the Program.

Injury – Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient – A patient stay that is an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Inpatient Rehabilitation Facility – A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Insurance Carrier – An insurance company, as selected by the Company in its sole discretion.

Intensive Behavioral Therapies – 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 *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment – A structured outpatient mental health or substance use disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Level of Reimbursement – The percentage of Eligible Expenses paid for Covered Dental Services under the Program. You are responsible for the payment of any percentage that is not covered by the Program directly to the Provider of the Covered Dental Services at the time of service or when billed by the Provider.

Maximum Out-of-Pocket – The maximum amount of Annual Deductibles and Co-insurance you pay out-of-pocket every calendar year.

For a Covered Person enrolled in BCBS or the traditional PPO plan option, only medical Covered Health Services will apply to your Maximum Out-of-Pocket. Once you reach the Maximum Out-of-Pocket, benefits for Covered Health Services are payable at 100% of Eligible Expenses during the remainder of the calendar year.

If you are enrolled in BCBS or the traditional PPO plan option, the following costs will never apply to the Maximum Out-of-Pocket:

- Any charges for non-Covered Health Services;
- Any Co-payments for Covered Health Services;
- Charges that exceed Eligible Expenses including any amounts over Eligible Expenses; and

- Any part of the Annual Deductible, Co-payments and Co-insurance for health services received from a non-Network Provider when you are required to use a Network Provider to obtain the highest level of reimbursement; and
- Co-payments and Co-insurance under the prescription drug benefit.

You are responsible for these amounts even after the Maximum Out-of-Pocket has been satisfied.

For a Covered Person enrolled in a CDHP option, both Covered Health Services and covered prescription drug expenses will apply to your Maximum Out-of-Pocket. Once you reach the Maximum Out-of-Pocket, benefits for Covered Health Services and covered prescription drug expenses are payable at 100% of Eligible Expenses during the remainder of the calendar year.

If you are enrolled in a CDHP option, the following costs will never apply to the Maximum Out-of-Pocket:

- Any charges for non-Covered Health Services;
- Any Co-payments for Covered Health Services;
- Charges that exceed Eligible Expenses;
- Any part of the Annual Deductible, Co-payment, and Co-insurance for medical services received from a non-Network Provider when you are required to use a Network Provider to obtain the highest level of reimbursement;
- Any charges for non-covered prescription drug expenses;
- Any part of the Annual Deductible, Co-payment, and Co-insurance for prescription drugs filled using an Out-of-Network or Network Pharmacy;
- Amounts paid by manufacturer assistance programs, copay cards or other such patient assistance programs for prescription drug costs.

You are responsible for these amounts even after the CDHP Maximum Out-of-Pocket has been satisfied.

Maximum Plan Benefit – The maximum amount the Company will pay for any benefits during the entire period of time that you are enrolled under the Program, or any other plan of the Plan Sponsor.

Medical Care – Services or products furnished by a Provider acting within the scope of his or her professional license and training for the prevention, diagnosis, examination, care or treatment of a Covered Person's Injury or Sickness, that are (a) prescribed, administered, or recommended by a Physician acting within the scope of his or her professional license; and (b) within the definition of "medical care" under Section 213(d) of the Internal Revenue Code.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, *et seq.* and as later amended.

Mental Health Provider – A state-licensed mental health professional who meets the required education of master's level, psychologist, or doctorate level degree.

Mental Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Illness – Those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Program.

Necessary – Covered Health Services and Covered Dental Services which are determined by the Claims Administrator, in its sole discretion, to be necessary. The Claims Administrator maintains policies, processes and/or protocols supporting its determinations regarding the necessity of specific services and supplies that are based on various factors, which may include but are not limited to, professional standards of care, credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, and guidelines of national clinical, research, or health care coverage organizations or governmental agencies. These clinical policies, processes and/or protocols are developed by the Claims Administrator in its sole discretion and are revised from time to time.

The fact that a Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular condition, illness, disease, or injury does not mean that it is a Necessary Covered Health Service or a Necessary Covered Dental Service for purposes of the Program. This definition of necessary relates only to Covered Health Services and Covered Dental Services under the Program and differs from the way in which a provider who is engaged in the appropriate practice may define necessary.

The clinical policies relating to necessary Covered Health Services are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on www.UnitedHealthcareOnline.com.

Network – When used to describe a Provider of health care services, this means a Provider that has a participation agreement in effect with the Plan Sponsor or a designee (directly or through one or more other organizations) of the Plan Sponsor to provide Covered Health Services to Covered Persons.

A Provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services. In this case, the Provider will be a Network Provider for the Covered Health Services included in the participation agreement, and a non-Network Provider for other Covered Health Services. The participation status of Providers may change from time to time.

Network Benefits – Benefits for Covered Health Services that are provided by a Network Physician or other Network Provider.

Network Pharmacy – Any Physician, pharmacy or other organization licensed to dispense drugs which has entered into an agreement with the Company to provide prescription drugs under the Program, and/or is designated by the Company as Network Pharmacy.

Non-Covered Provider – A Network or Non-Network provider of services, treatments, items or supplies that the Claims Administrator, in its sole discretion, deems ineligible to provide Covered Health Services or Covered Dental Services.

Non-Network Benefits – Benefits for Covered Health Services that are provided by a non-Network Physician or other non-Network Provider.

Non-Network Pharmacy – Any Physician, pharmacy or other organization licensed to dispense drugs which has not been authorized to provide prescription drugs under the Program through the Company or its prescription benefits vendor, and/or is designated by the Company as a Non-Network Pharmacy. Coverage under the Program will be reduced for claims filled using a Non-Network Pharmacy.

Orthodontic Treatment – The preventive and corrective treatment of all those dental irregularities which result from the anomalous growth the development of dentition and its related anatomic structures or as a result of accidental Injury and which require repositioning of teeth to establish normal occlusion.

Out-of-Area Plan – A plan pursuant to which a Covered Person who resides outside of the Network area may elect to receive Covered Health Services from a Network or non-Network Provider. If a Covered Person enrolled in an Out-of-Area Plan receives Covered Health Services from a Network Provider, then the Co-insurance amount shall be applied to the negotiated network fee, less the applicable Co-payment and Annual Deductible amounts. If a Covered Person enrolled in an Out-of-Area Plan receives Covered Health Services from a non-Network provider, the Co-

insurance amount shall be applied to the Eligible Expenses, less the applicable Co-payment and Annual Deductible amounts.

Out-of-Network Pharmacy – Any Physician, pharmacy, or other organization licensed to dispense drugs which has contracted with the Company's prescription benefits vendor, but has not entered into an agreement with the Company and/or is designated by the Company as an Out-of-Network Pharmacy. Coverage under the Program will be reduced for claims filled using an Out-of-Network Pharmacy.

Outpatient – A patient stay at a Hospital or other health care facility that is not Inpatient.

Partial Hospitalization/Day Treatment – A structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participating Company – A subsidiary or Affiliate of Caterpillar Inc. that adopts the Program for the benefit of its eligible retirees with the approval of Caterpillar Inc.

Part-Time Employee - An individual who: (a) is employed by Caterpillar Inc. or a Participating Company on a part-time basis who otherwise meets the definition of an exempt management employee or non-management employee (including salaried and non-bargained employees); (b) was a management or non-management employee immediately prior to transitioning to part-time employment; (c) transitioned to part-time employment on or after January 1, 2017; and (d) is otherwise eligible to participate in the Program at the time of transition to part-time employment.

Personal Health Support℠ – A program provided by the Program Claims Administrator designed to encourage an efficient system of care of Covered Persons by identifying and addressing possible unmet covered health care needs.

Physician – Any Doctor of Medicine ("M.D.") or Doctor of Osteopathy ("D.O.") who is properly licensed and qualified by law. Please note that any podiatrist, Dentist, psychologist, chiropractor, optometrist, or other Provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a Provider is described as a Physician does not mean that benefits for services from that Provider are available to you. The Program will not consider an individual to be a Physician with respect to services performed on someone who shares the same legal residence as the individual or who is related by birth or marriage to the individual.

Plan Administrator – Caterpillar Inc. or its designee as that term is defined under ERISA. The Plan Administrator for each of the plans included in this SPD is listed in the *Plan Information* chart beginning on page 121.

Plan Sponsor – Caterpillar Inc. and any of its subsidiaries that adopt the plans described in this SPD.

Pregnancy – Includes all of the following:

- Prenatal care;
- Postnatal care;
- Childbirth; and
- Any complications associated with Pregnancy.

Preventive Drug – Any medical substance or product that is designated as a preventive drug under the Program and is listed on the Caterpillar Inc. Consumer-Directed Health Plan (CDHP) Preventive Drug List (the "Preventive Drug List"). You may obtain the Preventive Drug List on benefits.cat.com or by calling Magellan Rx Management at (877) 228-7909.

Primary Residence – The location in which the participant primarily resides and which is reported to the Plan Administrator.

Provider – A Hospital, Physician, or Mental Health Provider or other individual designated by the Company, in its sole discretion, as an eligible Provider, providing health care services or supplies within the scope of their license that may be subject to reimbursement under the Program.

Reach Age 65 – For purposes of medical benefits under the Program, an individual reaches age 65 on: (1) the last day of the second month immediately preceding the month during which such individual's 65th birthday occurs, if the birthday occurs on the first day of the month; or (2) the last day of the month immediately preceding the month during which such individual's 65th birthday occurs, if the birthday occurs on any day other than the first day of the month.

Residential Treatment – Treatment in a facility which provides Mental Health Services or Substance Abuse Services. The facility must meet all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health Services/Substance Abuse Services administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation so specialized community resources.

A Residential Treatment facility that qualified as a Hospital is considered a Hospital.

Same-Sex Domestic Partner – A Same-Sex Domestic Partner, for purposes of the Program, is the sole, same-sex person who is in a civil union, domestic partnership, or similar legal relationship with the retiree, as recognized under the laws of the federal government or a state government of the U.S., including its territories and possessions and the District of Columbia (or a legally recognized equivalent government of another country), subject to the following rules:

- A retiree's relationship will be treated as a Same-Sex Domestic Partnership, regardless of whether the retiree and his or her Same-Sex Domestic Partner remain in the jurisdiction where the relationship was legally entered to. In the event more than one person meets this definition for a given retiree, then the Same-Sex Domestic Partner is the person who first met the criteria in this definition.
- In any case in which a retiree has a Spouse, no person will qualify as the retiree's Same-Sex Domestic Partner unless the retiree's marriage to his or her Spouse is first lawfully dissolved. If a retiree has a Same-Sex Domestic Partner, such Same-Sex Domestic Partnership must be lawfully dissolved before any other individual can qualify as such retiree's Same-Sex Domestic Partner.
- A Same-Sex Domestic Partner will include a civil union partner under state law, a domestic partner, or other similar partner relationship with the retiree (including an opposite-sex partner), but solely to the extent mandated by applicable state insurance law or required by a contract between the Company and a state or local government entity.

Semi-private Room – A room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area – A geographic area, as determined by the Plan Administrator, in its sole discretion, in which a specific Network is designated to provide services or supplies in connection with a specific benefit or program of benefits under the Program.

Sickness – Illness, disease or maternity services.

Skilled Nursing Facility – A Hospital or nursing facility that is licensed and operated as required by law.

Solar Retiree – A retiree of Solar Turbines Incorporated who is a Covered Person eligible to participate in the Program and, if required for the benefits coverage under the Program, has enrolled in such coverag**e.**

Spouse – The person of the opposite sex or same sex who is considered married to you for federal tax purposes pursuant to Internal Revenue Service guidance.

Substance Abuse Services – Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Program. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Suspension of Outbreak Period Deadlines – Beginning March 1, 2020, in accordance with joint guidance issued by the Department of Labor and Internal Revenue Service regarding the National Emergency Period, the following deadlines were extended:

- The 31-day (or, if applicable the 60-day) period to request a mid-year special enrollment
- The 60-day period to elect COBRA coverage
- The due date for COBRA premium payments
- The date a COBRA qualified beneficiary must provide notice of a qualifying event or a disability determination
- The date a claimant is required to file a claim for Program benefits
- The date a claimant is required to file an appeal of an adverse determination of a claim for benefits

The deadlines are extended until the earlier of:

- One year from the date the deadline would otherwise have occurred; or
- 60 days after the announced end of the National Emergency Period (which as of the date of drafting this SPD has not been announced).

Reminder: If you will lose health coverage due to the end of this relief period, you may have other coverage options available, including the opportunity to enroll in a Health Insurance Marketplace. For a list of states that do not use HealthCare.gov and links to their Marketplaces, go to: https://www.healthcare.gov/marketplace-in-your-state/.

Traditional Healthcare Benefits – The healthcare coverage described in the *Traditional Medical Coverage*, *Traditional Prescription Drug Coverage*, *Traditional Dental Coverage* and *Traditional Vision Coverage* sections of this SPD. HRA Benefits are not Traditional Healthcare Benefits and individuals who are eligible for HRA Benefits are not eligible for Traditional Healthcare Benefits.

Unproven Services – Services that, in the sole discretion of the Claims Administrator, are not consistent with conclusions of prevailing medical or dental research which demonstrate that the health or dental service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted, randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical or dental research, based on well-conducted, randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), the Claims Administrator may, in its sole discretion, determine that an Unproven Service meets the definition of a Covered Health Service or Covered Dental Service for that Sickness or condition. For this to take place, the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care – Care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent Care is usually delivered in a walk-in setting and without an appointment at a facility, distinct from a hospital emergency department, an office, or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – A facility other than a Hospital that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

APPENDIX A

Eligible Retirees

You are eligible to participate in the Program if you meet the applicable eligibility criteria below:

Caterpillar Employees (salaried, management, non-bargained hourly) Hired prior to 1/1/2003	You retire from the Company or a Participating Company[1] on or after January 1, 2011: • After attaining age 55 and accruing at least 15 years of Credited Eligibility Service; or • After attaining age 60 and accruing at least 10 years of Credited Eligibility Service; or • After attaining age 65 and accruing at least 5 years of Credited Eligibility Service; or • After accruing at least 30 years of Credited Eligibility Service. You must have been a participant in the Employee Program on the day before your retirement (with certain exceptions) to be eligible for the Program.
Caterpillar Employees (salaried, management, non-bargained hourly) Hired on or after 1/1/2003 but prior to 1/1/2013[2]	You retire from the Company or a Participating Company[1] on or after January 1, 2011: • After attaining age 55 and accruing at least 15 years of Credited Eligibility Service; or • After accruing at least 30 years of Credited Eligibility Service. You must have been a participant in the Employee Program on the day before your retirement (with certain exceptions) to be eligible for the Program.
Caterpillar Global Mining Hourly Employees Hired prior to 1/1/2005[2]	You meet the criteria specified in (1) or (2) below: (1) You were hired before January 1, 2003 and you retire from the Company or a Participating Company on or after January 1, 2013: • After attaining age 55 and accruing at least 15 years of Credited Eligibility Service; • After attaining age 60 and accruing at least 10 years of Credited Eligibility Service; • After attaining age 65 and accruing at least 5 years of Credited Eligibility Service; or • After accruing at least 30 years of Credited Eligibility Service.

	(2) You were hired on or after January 1, 2003 and before January 1, 2005, and you retire from the Company or a Participating Company on or after January 1, 2013: • After attaining age 55 and accruing at least 15 years of Credited Eligibility Service; or • After accruing at least 30 years of Credited Eligibility Service. You must have been eligible to participate in the CGM Legacy Plan on December 31, 2012 to be eligible for the Program. You are eligible for medical expense benefit coverage up to age 65 only and are not eligible for the HRA feature of the Program.
Caterpillar Global Mining Management and Salaried Employees Hired prior to 1/1/2005[2]	You meet the criteria specified in (1) or (2) below: (1) You were hired before January 1, 2003 and you retire from the Company or a Participating Company on or after January 1, 2012: • After attaining age 55 and accruing at least 15 years of Credited Eligibility Service; • After attaining age 60 and accruing at least 10 years of Credited Eligibility Service; • After attaining age 65 and accruing at least 5 years of Credited Eligibility Service; or • After accruing at least 30 years of Credited Eligibility Service. (2) You were hired on or after January 1, 2003 and before January 1, 2005, and you retire from the Company or a Participating Company on or after January 1, 2012: • After attaining age 55 and accruing at least 15 years of Credited Eligibility Service; or • After accruing at least 30 years of Credited Eligibility Service. You must have been eligible to participate in the CGM Legacy Plan on December 31, 2011 to be eligible for the Program. You are eligible for medical expense benefit coverage up to age 65 only and are not eligible for the HRA feature of the Program.
Denver Logistics Employees[3] Hired prior to 1/10/2005	You retire from the Company on or after May 25, 2016: • After attaining age 55 and accruing at least 15 years of Credited Eligibility Service; or • After attaining age 60 and accruing at least 10 years of Credited Eligibility Service; or • After attaining age 65 and accruing at least 5 years of Credited Eligibility Service; or

	• After accruing at least 30 years of Credited Eligibility Service. You must have been a participant in the Employee Program on the day before your retirement (with certain exceptions) to be eligible for the Program.
Denver Logistics Employees[3] Hired on or after 1/10/2005 but prior to 1/1/2013[2]	You retire from the Company on or after May 25, 2016: • After attaining age 55 and accruing at least 15 years of Credited Eligibility Service; or • After accruing at least 30 years of Credited Eligibility Service. You must have been a participant in the Employee Program on the day before your retirement (with certain exceptions) to be eligible for the Program.
St. Paul Logistics Employees Hired prior to 1/18/1993[2]	You retire from the Company or a Participating Company[1] on or after January 6, 2017: • After attaining age 55 with at least 15 years of Credited Eligibility Service; or • After attaining age 60 with at least 10 years of Credited Eligibility Service; or • After attaining age 65 with at least 5 years of Credited Eligibility Service; or • Any age with at least 30 years of Credited Eligibility Service. You must have been represented by the International Association of Machinists and Aerospace Workers, AFL-CIP and District Lodge 77 immediately prior to January 6, 2017, to be eligible for the Program.
Solar Turbines Incorporated Non-Bargained Hourly Employee Hired prior to 1/1/2016[2]	You retire from Solar Turbines Incorporated on or after January 1, 2017: • After attaining age 55 and accruing at least 15 years of Credited Eligibility Service; or • After attaining age 60 and accruing at least 10 years of Credited Eligibility Service; or • After accruing at least 30 years of Credited Eligibility Service. You must have been a participant in the Employee Program on the day before your retirement (with certain exceptions) to be eligible for the Program. You are eligible for medical expense benefit coverage up to age 65 only and are not eligible for the HRA feature of the Program.
Solar Turbines Incorporated Salaried Employees Hired prior to 1/1/2014[2]	You retire from Solar Turbines Incorporated on or after January 1, 2017: • After attaining age 55 and accruing at least 15 years of Credited Eligibility Service; or • After attaining age 60 and accruing at least 10 years of Credited Eligibility Service; or • After attaining age 65 and accruing at least 5 years of Credited Eligibility Service; or • After accruing at least 30 years of Credited Eligibility Service.

	You must have been a participant in the Employee Program on the day before your retirement (with certain exceptions) to be eligible for the Program.
UAW Retiree[4]	You meet the criteria specified in (1) or (2) below: (1) You retire from Caterpillar Inc., Caterpillar Logistics Inc. or one of their participating subsidiaries on or after March 27, 2017: • After attaining age 55 with the sum of age and Credited Eligibility Service of at least 85; or • After attaining age 60 with at least 10 years of Credited Eligibility Service; or • After attaining age 65 with at least 5 years of participation in the Caterpillar Inc. Non-Contributory Pension Plan; or • Any age with at least 30 years of Credited Eligibility Service. You must have been: (1) covered by the Benefits Agreement dated March 15, 2017 and effective March 27, 2017 between the Company and UAW and affiliated locals 145, 751, 1872, 974 and 2096 (other than employees classified as "supplemental employees" as described in the Benefits Agreement), (2) have a most recent hire, rehire or transfer to the applicable bargaining unit prior to January 10, 2005, and (3) had coverage in effect, or was eligible to have coverage in effect, under the Caterpillar Inc. Group Insurance Plan A on March 26, 2017. (2) You are a former employee who retired prior to March 27, 2017 who was: • Covered under the Central Labor Agreement and retired on or after January 10, 2005; or • Covered under the collective bargaining agreement between the Company and UAW and its affiliated Local No. 119 and retired on or after March 21, 2005; or • Covered under the collective bargaining agreement between the Company and UAW and its affiliated Local No. 710 and retired on or after April 4, 2005. You must have been: (1) eligible for retiree healthcare benefits under the Caterpillar Inc. Group Insurance Plan, Caterpillar Inc. Retiree Group Insurance Plan or the Caterpillar Inc. Group Insurance Plan A immediately following retirement, (2) participating in or eligible to participant in the Caterpillar Inc. Retiree Group Insurance Plan or Caterpillar Inc. Group Insurance Plan A on December 31, 2017, (3) have not opted out of coverage in accordance with procedures established by the Plan Administrator, and (4) are not part of a designated group of retirees who will remain eligible for the Caterpillar Inc. Retiree Group Insurance Plan.
Post-2018 Mapleton Patternmakers IAM Retirees	You retire on or after September 24, 2018: • After attaining age 55 with the sum of age and Credited Eligibility Service of at least 85; or • After attaining age 60 with at least 10 years of Credited Eligibility Service; or

	• After attaining age 65 with at least 5 years of participation in the Caterpillar Inc. Non-Contributory Pension Plan; or • Any age with at least 30 years of Credited Eligibility Service. You must have been: (1) covered by the Benefits Agreement dated September 20, 2018 and effective September 24, 2018 between the Company and International Association of Machinists and Aerospace Workers, AFL-CIO, and Local Lodge No. 360, (2) have a most recent hire, rehire or transfer to the applicable bargaining unit prior to October 1, 2005, and (3) had coverage in effect, or was eligible to have coverage in effect, under the Caterpillar Inc. Group Insurance Plan A on September 23, 2018.
Rehired Retirees	You retire on or before January 1, 2019: • After being rehired in a supervisory position on or after April 15, 2017 and before December 31, 2018 to work at Building HH in East Peoria, Illinois, the Company's Aurora, Illinois facility, or the Company's Joliet, Illinois facility; and • You otherwise meet the applicable eligibility requirements above for Caterpillar retirees.

Notes:

1 Other than Solar Turbines Incorporated

2 You are not eligible for the Program if you were hired after this date.

3 Non-management employees represented by the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America and its affiliated local 1415 immediately prior to May 25, 2016.

4 A UAW Retiree who is disabled and receiving disability benefits under the Caterpillar Inc. Non-Contributory Pension Plan will not be considered a retiree until the first of the month following such individual's attainment of age 65.

APPENDIX B

Facilities That Do Not Provide Retiree Coverage

The following facilities of the Company do not provide retiree coverage (medical, prescription drug, dental and life insurance coverage) under the Program:

1. Cat Logistics Services, Houston, TX – Fac. Code DI (Hourly);
2. Cat Logistics Services, Tulsa, OK – Fac. Code XN (Salaried) This facility has not opted out of retiree life insurance coverage under the Program;
3. Williams Technologies, Summerville, SC – Fac. Code FF (All Payrolls) Closed 07/01/2014;
4. Cat Logistics FT Services, Gouldsboro, PA (Mazda) – Fac. Code K9 (except that hourly employees hired prior to 4/1/04 are eligible to participate in the Program; those hourly employees hired on or after 4/1/04 are not eligible to participate in the Program) Closed 08/01/2012;
5. Cat Logistics Services, Norton, MA (Mazda) – Fac. Code WW (Hourly);
6. Cat Logistics Services, Ontario, CA (Mazda) – Fac. Code YG (except that hourly employees hired prior to 8/1/2003 are eligible for medical, dental, vision and prescription drug coverage under the Program; hourly employees hired on or after 8/1/2003 are not eligible for medical, dental, vision and prescription drug coverage) Closed 08/01/2012;
7. Cat Logistics Services, Sandston, VA (Mazda) – Fac. Code YV (Hourly);
8. Cat Logistics Services, Woodland, CA (Mazda) – Fac. Code ZN (Hourly);
9. Cat Logistics Services, Olive Branch, MS (Mazda) – Fac. Code ZS (Hourly) (except that hourly employees hired prior to 5/1/04 are eligible for medical, dental, vision and prescription drug coverage under the Program; hourly employees hired on or after 5/1/04 are not eligible for medical, dental, vision and prescription drug coverage) Closed 08/01/2012;
10. Cat Reman Powertrain Indiana, Franklin, IN – Fac. Code YP (All Payrolls);
11. Cat Logistics Services, Champaign, IL – Fac. Code 92 (Hourly);
12. Caterpillar Elkader LLC, Elkader, IA – Fac. Code AE (except that hourly employees hired prior to January 1, 2013 who retire on or after April 1, 2015 are eligible to participate in the Program; hourly employees who retire prior to April 1, 2015 are not eligible to participate in the Program);
13. Caterpillar Remanufacturing Drivetrain LLC, Fargo, ND – Fac. Code PE (All Payrolls);
14. North America Motor Grader Facility, North Little Rock, AR – Fac. Code UJ (Hourly);
15. North American Hydraulic Excavators, Victoria, TX – Fac. Code SE (Hourly);
16. CleanAIR Systems, Inc., Santa Fe, NM – Fac. Code VH (Hourly) Closed 12/31/2016;
17. Black Hills Engineering Design Center, Black Hills, SD – Fac. Code CG (Salaried);
18. Caterpillar Axle Manufacturing Plant, Winston-Salem, NC – Fac. Code VF (Hourly);
19. Caterpillar Inc. (f/k/a Anchor Coupling), Menominee, MI – Fac. Code FJ (All Payrolls);
20. Caterpillar Inc. (f/k/a Anchor Coupling), Dixon, IL – Fac. Code FK (All Payrolls);
21. Caterpillar Inc. (f/k/a Anchor Coupling), Goldsboro, NC – Fac. Code XO (All Payrolls) Closed 08/01/2012;
22. Caterpillar Inc. (f/k/a Anchor Coupling), Sterling, IL – Fac. Code VQ (All Payrolls);
23. Van Alstyne, TX Integrated Logistics Services, Van Alstyne, TX – Fac. Code OX (Hourly) Closed 12/25/2016;
24. BCP Athens Georgia Plan, Bogart, GA – Fac. Code JQ (Salaried and Hourly – salaried and hourly employees who retire on or before January 1, 2019 are eligible to participant in the Program; salaried and hourly employees who retire after January 1, 2019 are not eligible to participate in the Program.)
25. Customer Service Support, Arvin, CA -- Fac. Code TT (Hourly)
26. Customer Service Support, Atlanta, GA -- Fac. Code XA (Hourly);
27. Customer Service Support, Clayton, OH -- Fac. Code R6 (Hourly);
28. Customer Service Support, Spokane, WA -- Fac. Code W1 (Hourly);
29. Customer Service Support, Waco, TX -- Fac. Code 1E (Hourly);
30. Customer Service Support, Waco, TX -- Fac. Code R2 (Hourly);
31. Integrated Logistics Services, Athens, GA -- Fac. Code OE (Hourly);
32. Integrated Logistics Services, Corinth, MS -- Fac. Code V7 (Hourly);
33. Integrated Logistics Services, Lafayette, IN -- Fac. Code MQ (Hourly);
34. Integrated Logistics Services, LaGrange, GA -- Fac. Code AS (Hourly);
35. Integrated Logistics Services, Newberry, SC and Ridgeway, SC -- Fac. Code OZ (Hourly) Closing 08/31/2017;

36. Integrated Logistics Services, Sanford, NC and Smithfield, NC -- Fac. Code NY (Hourly);
37. Integrated Logistics Services, Victoria, TX -- Fac. Code V5 (Hourly);
38. Integrated Logistics Services, Waco, TX -- Fac. Code 1E (Hourly);
39. Integrated Logistics Services, Winston-Salem, NC -- Fac. Code OA (Hourly);
40. TurboFab, Channelview, TX -- (All Payrolls);
41. Caterpillar Energy Solutions Inc., Alpharetta, GA – Fac. Code LE (All Payrolls – Those employees who transferred into the Program on 01/01/2020); and
42. Caterpillar Energy Solutions Inc., Alpharetta, GA – Fac. Code N4 (All Payrolls – Those employees who transferred into the Program on 01/01/2020).

In addition to the facilities listed above, no individual who became an employee of Bucyrus International, Inc. or its subsidiaries as a result of the acquisition of Terex Corporation or DBT Group is eligible for participation in any part of the Program, regardless of his facility after the acquisition date.