

**CATERPILLAR INC.
EMPLOYEE HEALTH, LIFE AND DISABILITY BENEFIT PROGRAM**

**CATERPILLAR INC.
FLEXIBLE SPENDING ACCOUNT PLAN**

SUMMARY OF MATERIAL MODIFICATIONS

This Summary of Material Modifications (“SMM”) summarizes recent changes made to the information presented to you in the Summary Plan Description (“SPD”) with respect to the Caterpillar Inc. Employee Health, Life and Disability Benefit Program (the “Program”) and the Caterpillar Inc. Flexible Spending Account Plan (the “FSA Plan”). **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.

Contact Information - Effective August 23, 2022, the address for the Plan Sponsor is:

Caterpillar Inc.
5205 N. O’Connor Boulevard, Suite 100
Irving, TX 75039
(972) 891-7700

Employer Identification Number: 37-0602744

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.

Changes to Medical Plan References – The medical plan option available through Blue Cross Blue Shield is now known as the Blue Cross Blue Shield plan option. Each reference in the SPD to the “Blue Cross Blue Shield National EPO” or the “Blue Cross Blue Shield EPO” should

now be read as a reference to the “Blue Cross Blue Shield plan option”. Also, each reference to “EPO” should now be read as a reference to “BCBS”.

Plan Deadlines Triggered by End of COVID-19 National Emergency – As previously announced, beginning March 1, 2020, in accordance with joint guidance issued by the Department of Labor and Internal Revenue Service regarding the COVID-19 National Emergency, certain deadlines otherwise applicable under the Program were extended. Since that date, these deadlines have been subject to a disregarded—or “tolling”—period that ends on the earlier of: (i) one year from the date the individual first became eligible for the relief; or (ii) 60 days after the announced end of the COVID 19 National Emergency (the end of the so-called COVID-19 “Outbreak Period”). No otherwise applicable Program deadline is extended by more than one year. When the Outbreak Period ends, the tolling period will end and all usual Program deadlines will resume.

During the Outbreak Period, the extension applies to all of the following Program deadlines:

- The 31-day (or, if applicable the 60-day) period to request a mid-year special enrollment;
- The 60-day period to elect COBRA continuation 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, including submitting claims for reimbursement to a Health Flexible Spending Account;
- The date a claimant is required to file an appeal of an adverse determination of a claim for benefits; and
- The date by which a claimant is required to file a request for an external review.

The Outbreak Period is Set to End July 10, 2023

Unless guidance is issued to the contrary, the Outbreak Period, and any associated tolling periods applicable under the Program, are set to end on July 10, 2023, and the usual Program deadlines will resume.

For example, assume you gained a dependent due to marriage on November 30, 2022, thereby entitling you to a special enrollment right to enroll your dependent spouse in coverage under the Program. Under the usual Program terms, you had 31 days from the date of marriage to enroll your dependent spouse in the Program (i.e., by December 31, 2022). However, under the extension guidance described above, the time period you have to enroll your dependent spouse in the Program is tolled, but only until the July 10, 2023 end of the Outbreak Period; and as such, the 31-day period you have in which to enroll your dependent spouse in the Program now ends on August 10, 2023.

Notice of Changes to Health Coverage Due to the End of the Public Health Emergency – The Public Health Emergency expired on May 11, 2023. Coverage and cost-sharing

requirements for COVID-19 vaccines and testing (including over-the-counter at-home tests) and related Covered Services are subject to the coverage details and schedules included in the SPD. You may contact the Claims Administrator if you have questions regarding the expiration of the Public Health Emergency.

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

COVID-19 Testing and Vaccinations: The Public Health Emergency expired on May 11, 2023. Normal Program rules (including regular cost-sharing requirements, if applicable) for vaccines and preventive care services apply.

Elective Abortions: Effective June 1, 2022, services and expenses for elective abortions will be covered in accordance with current Program rules.

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.

Travel Benefit: Effective January 1, 2023, the Program will reimburse certain lodging and transportation expenses when access to a covered service by an in-network provider requires travel more than 100 miles from your place of residence. You may contact the Claims Administrator for additional information regarding covered expenses and limitations.

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

Participation in a Strike or Lockout – Effective January 1, 2023, participation in a strike or lockout will result in loss of coverage, unless prohibited by an applicable collective bargaining agreement. Upon reinstatement of the participant, the elections in effect immediately prior to loss of coverage will apply.

Definition of Solar Employee - The definition of “Solar Employee” is updated to read as follows:

An Employee of Solar Turbines Incorporated or TurboFab who is employed on a regular, full-time basis and project employees of TurboFab. “Solar Employees” shall not include Employees who are designated as International Service Employees.

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>.

CONTACT INFORMATION

If you have any questions about this SMM, the Program or the FSA Plan, 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 the FSA Plan 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. 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 identity.

• 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.
EMPLOYEE HEALTH, LIFE AND DISABILITY BENEFIT PROGRAM**

**CATERPILLAR INC.
FLEXIBLE SPENDING ACCOUNT PLAN**

SUMMARY OF MATERIAL MODIFICATIONS

This Summary of Material Modifications (“SMM”) summarizes recent changes made to the information presented to you in the Summary Plan Description (“SPD”) with respect to the Caterpillar Inc. Employee Health, Life and Disability Benefit Program (the “Program”) and the Caterpillar Inc. Flexible Spending Account Plan (the “FSA Plan”). **Please keep this document with your copy of the SPD for future reference.**

SUMMARY OF CHANGES

If you are an employee who works at the Denison or Van Alstyne, Texas location and who is covered by the benefits agreement dated May 1, 2021 and effective May 1, 2021 between Caterpillar Global Mining LLC and the United Steelworkers of America Local Lodge No. 8616 (“Denison Steelworkers”), this SMM applies to you. Other employees may disregard this SMM.

Program and FSA Plan benefits for Denison Steelworkers have historically been described in a separate SPD titled “Caterpillar Inc. Employee Benefit Plans Summary Plan Description”. This separate SPD and its associated SMMs also described life, accidental death and dismemberment insurance benefits and disability benefits applicable to these participants under the Caterpillar Global Mining Legacy Welfare Plan for Denison Steelworkers.

Beginning with SPDs and SMMs distributed in February 2023, the benefits for Denison Steelworkers will be described in two SPDs (and their associated SMMs) as follows:

- “Caterpillar Inc. Employee Health, Life and Disability Benefit Program Summary Plan Description” – describes applicable medical, dental, vision, prescription drug, flexible spending account and voluntary benefits. *Denison Steelworkers should disregard the life, accidental death and dismemberment insurance benefits and disability benefits described in this SPD or any associated SMM.*
- “Caterpillar Global Mining Legacy Welfare Plan for Denison Steelworkers Summary Plan Description” – describes the life, accidental death and dismemberment insurance benefits and disability benefits that are specific to Denison Steelworkers

CONTACT INFORMATION

If you have any questions about this SMM, the Program or the FSA Plan, 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 the FSA Plan 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. 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.

CATERPILLAR INC.
EMPLOYEE HEALTH, LIFE AND DISABILITY BENEFIT PROGRAM

CATERPILLAR INC.
FLEXIBLE SPENDING ACCOUNT PLAN

SUMMARY OF MATERIAL MODIFICATIONS

This Summary of Material Modifications (“SMM”) summarizes recent changes made to the Caterpillar Inc. Employee Health, Life and Disability Benefit Program (the “Program”) and the Caterpillar Inc. Flexible Spending Account Plan (the “FSA Plan”). This SMM also supplements or modifies the information presented to you in the Summary Plan Description (“SPD”) with respect to the Program and the FSA Plan. **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.

Long Term Disability (“LTD”) Benefits – Effective January 1, 2021, you may continue to receive LTD benefits during a period of Rehabilitative Employment. If you return to work in Rehabilitative Employment, you will be entitled to receive your regular base pay for the hours worked and up to one-half of the daily equivalent of your LTD benefit for a maximum period of eight weeks. After such eight-week period, if you do not return to your normal, full-time work schedule, and you remain Disabled for purposes of the LTD benefit, you may continue to receive such benefit for the remainder of the applicable coverage period, if any. Any period during which you receive LTD benefits will be counted towards the maximum benefit payable to you. Whether you are eligible for Rehabilitative Employment will be determined by the Company in its sole discretion.

Coverage for Influenza Vaccinations – Effective November 15, 2021, coverage for influenza vaccinations may be submitted under the Prescription Drug Benefit if obtained at a specified Network Pharmacy.

Dependent Care and Health Care FSA Contribution Carryovers – Legislation related to the challenges of the COVID-19 national emergency permitted all unused balances in your Dependent Care FSA and your Health Care FSA remaining after submission and processing of all claims to be carried over into the next year. This expanded carryover relief was limited to the 2020 and 2021 plan years. Effective for the 2022 plan year, unused balances in your Dependent Care FSA will be forfeited and you may carryover unused balances in your Health

Care FSA up to the annual limit set by the IRS (currently \$570, as adjusted for inflation in accordance with IRS guidelines). Each year the Plan Administrator will communicate the carryover limit for unused balances as part of the Annual Enrollment process.

Important Legal Provisions

The following subsection is added to the SPD:

Illinois Consumer Coverage Disclosure Act (Applicable to Illinois Residents Only) – The disclosure required under the Illinois Consumer Coverage Disclosure Act is available at the Caterpillar Benefits Center at CatBenefitsCenter.com. (To access, click “Health & Insurance”, “Plan Information”, “Other Plan Information” and then “Illinois Consumer Coverage Disclosure”.)

The following subsections of the SPD are replaced in their entirety:

No Assignment

- 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 with standing 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.

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 141. They can advise whether your Network Provider is paid by any financial incentive, including those listed above.

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 Administrators 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.

CONTACT INFORMATION

If you have any questions about this SMM, the Program or the FSA Plan, 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 the FSA Plan 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.

Caterpillar Inc.
***Employee Health, Life and
Disability Benefit Program***

Summary Plan Description

* * *

This Summary Plan Description (“SPD”) describes benefits for certain management and non-management employees of Caterpillar Inc. and related companies. If your employment is subject to collective bargaining, your benefits are not described in this Summary Plan Description, unless the collective bargaining agreement applicable to you expressly provides for it. Benefits for retirees are described in another summary.

This SPD issued September 2021.

TABLE OF CONTENTS

INTRODUCTION.....	1
About This Document.....	1
Official Plan Document Overview.....	1
A Special Note About Medicare.....	2
A Special Note About Suspension of Outbreak Period Deadlines.....	2
Contact the Administrator.....	2
ELIGIBILITY.....	3
The Program and FSA plan.....	3
Benefit Eligibility.....	5
Tax Implications and Information.....	6
Qualified Medical Child Support Order (“QMCSO”).....	6
Dual Coverage.....	6
Disabled Children.....	7
HEALTH, LIFE, DISABILITY AND VOLUNTARY.....	8
An Introduction to Your Benefits.....	8
The Benefit Components.....	8
Pre-Tax vs. After-Tax.....	9
Participation.....	9
How to Enroll.....	9
When Coverage Begins.....	11
Changing Your Coverage.....	13
Cost.....	16
Coordination of Benefits.....	16
How Long Coverage Continues.....	21
Continuation of Benefits (COBRA).....	25
Other Events Ending Your Coverage.....	30
MEDICAL BENEFITS.....	31
Overview of Medical Benefits.....	31
Eligibility for Medical Benefits.....	31
What’s Covered – Benefits.....	31
Accessing Benefits.....	31
Identification Card (“ID Card”).....	32
Eligible Expenses.....	32
Advocacy Services.....	33
Personal Health Support.....	33
Notification Requirements.....	33
Premiums.....	34
Wellness Exams.....	34
2nd.MD Services.....	35
Benefits At A Glance.....	35
Benefit Information.....	36
What’s Not Covered – Exclusions.....	54
The Use of Section Headings.....	54
Plan Exclusions.....	55
Description of Network and Non-Network Benefits (Reside in a Caterpillar Network Area).....	61
Network Benefits.....	61
Non-Network Benefits.....	63
Emergency Room Health Services.....	63
Description of Network and Non-Network Benefits (Reside in a UnitedHealthcare Network Area).....	63

Network Benefits	63
Non-Network Benefits	65
Emergency Room Health Services	65
Obtaining Benefits (Reside Outside a Network Area)	65
If You Obtain Services from a Network Provider.....	65
Designated United Resource Network Facilities and Other Providers	66
Emergency Room Health Services	66
PRESCRIPTION DRUG BENEFITS	68
Eligibility for Prescription Drug Benefits	68
Overview of Prescription Drug Benefits	68
Mail Service Program	69
Benefit Limitations	70
Prescription Drug Co-payments/Co-insurance.....	71
DENTAL BENEFITS	72
Eligibility for Dental Benefits.....	72
Overview of Dental Benefits.....	72
Identification (“ID”) Card.....	72
Extended Coverage.....	72
Procedures for Obtaining Dental Benefits	72
Covered Dental Services.....	72
Pre-Determination of Benefits	72
Schedule of Dental Benefits.....	73
Covered Dental Services.....	73
Orthodontic Services.....	77
Overview.....	77
Predetermination of Benefits	77
Orthodontic Maximum.....	77
Level of Reimbursement.....	77
Dental Benefits – General Exclusions.....	78
VISION BENEFITS.....	80
Eligibility for Vision Benefits.....	80
Overview of Vision Benefits.....	80
Identification (“ID”) Card.....	80
Schedule of Vision Benefits.....	80
Schedule of Vision Benefits.....	80
Vision Services From a Network Provider	80
Vision Services From a Non-Network Provider	81
Vision Benefits – General Exclusions.....	81
FLEXIBLE SPENDING ACCOUNT PLAN.....	82
FSA Plan Eligibility	82
FSA Plan Participation.....	82
When You May Enroll.....	82
How to Enroll.....	83
When Participation Ends.....	83
Special 2021 FSA Plan Rules	84
Overview of FSA Plan	84
Contributions.....	84
Health Care FSA	85
Health Care FSA.....	85
Eligible Dependents.....	85
Eligible Health Care Expenses – General Purpose FSA (“GPFSA”).....	86
Ineligible Expenses – GPFSA.....	88

Eligible Health Care Expenses – Limited Purpose FSA (“LPFSA”)	89
FSA Debit Card	90
Direct Deposit	90
Qualified Military Service Distribution	90
Dependent Care FSA	90
Qualified Dependents	90
Eligible Dependent Care Expenses	91
Dependent Care Tax Credit vs. Dependent Care FSA	92
FSA Debit Card	92
Direct Deposit	92
Limits for Higher-Paid Employees	92
HEALTH SAVINGS ACCOUNT	93
How Your HSA Works	93
Who Is Eligible	93
When You Have Coverage Under Your Spouse’s Health Plan	93
Medicare	94
Establishing Your HSA	94
Contributions to Your HSA	94
Amount of Contributions	94
Catch Up Contributions	94
Timing of Contributions	94
Contributions Are Vested	95
Reporting	95
Election Process	95
Changing Your HSA Pre-Tax Contribution Election	95
Withdrawals from Your HSA	95
When Participation Ends	96
Other Information	96
Limits for Higher-Paid Employees	96
DEATH AND AD&D	97
An Introduction to Your Benefits	97
Life and AD&D	97
Eligibility for Life and AD&D	97
Overview of Life and AD&D	97
Life Insurance Benefits	98
AD&D Benefits	100
Discontinuation of AD&D Benefits	100
DISABILITY BENEFITS	102
An Introduction to Your Benefits	102
Short Term and Long Term Disability Benefits	102
Eligibility	102
Short Term Disability (“STD”) Benefits	103
Long Term Disability (“LTD”) Benefits	104
Social Security Disability Insurance Benefits Award	106
VOLUNTARY BENEFITS	108
AN INTRODUCTION TO YOUR BENEFITS	108
Overview of Voluntary Benefits	108
Eligibility for Voluntary Benefits	108
Enrolling in Voluntary Benefits	108
Cost of Coverage	108
No Continuation of Voluntary Benefit Coverage	109

GENERAL ADMINISTRATION.....	110
Claims Procedure	110
Filing a Claim for Benefits	110
Medical Benefit Claims	114
Prescription Drug Benefit Claims	115
Dental Benefit Claims	116
Vision Benefit Claims	116
Flexible Spending Account Claims.....	116
Death and Disability Claims	117
Voluntary Benefits Claims.....	117
Benefit Determination.....	117
Initial Decision.....	117
Claims Administrator’s Decision.....	118
Further Review and Appeals.....	120
Medical, Prescription Drug, Dental and Vision Benefit Claims	121
Flexible Spending Account Claims.....	125
Death, Disability and Voluntary Benefits Claims	126
 GENERAL ADMINISTRATION INFORMATION	 128
Important Legal Provisions	128
Plan Document.....	128
Clerical Error	128
Plan Administration	128
Amendment and Termination	128
Benefits Not Vested	129
Company Audit.....	129
Representations Contrary to the Plan.....	129
No Assignment	129
Qualified Medical Child Support Orders (“QMCSOs”)	129
No Contract of Employment.....	130
Participating Companies	130
Implied Promises	130
Protection From Creditors.....	130
Change of Address	130
Appointment of Authorized Representative.....	130
Severability	130
Recovery of Payments Made by Mistake.....	130
Forfeiture of Unclaimed or Abandoned Benefit Payments	131
Refund of Overpayments	131
Subrogation.....	131
Reimbursement to the Plan	135
Plan Funding.....	135
Applicable Law	136
Legal Action Limitations	136
HIPAA Privacy and Security	136
Relationship With Providers	136
Incentives to Providers.....	137
Incentives to You	137
Rebates and Other Payments.....	138
Information and Records.....	138
Examination of Covered Persons.....	138
Workers’ Compensation Not Affected.....	138
Women’s Health and Cancer Rights Act of 1998.....	139
Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act	139
Statement of ERISA Rights	139

CONTACT INFORMATION	141
General Information.....	141
Plan Information	141
DEFINITIONS.....	144
EXHIBIT A	147

INTRODUCTION

ABOUT THIS DOCUMENT

This document is a summary of many of your welfare benefits provided by Caterpillar Inc. (the “Company”) plans:

- Employee Health, Life and Disability Benefit Program (the “Program”)
- Flexible Spending Account Plan (the “FSA Plan”)

If you are an employee of the Company, your medical, prescription drug, dental, vision, life, accidental death and dismemberment (“AD&D”), short term disability (“STD”) benefits, long term disability (“LTD”) and voluntary benefits are provided by the Program. If you are an employee of Solar Turbines Incorporated, your medical, prescription drug, dental, vision, life, AD&D and voluntary benefits are provided by the Program, but your STD and LTD benefits are provided by the Solar Turbines Incorporated Group Insurance Program. Your Health Care and Dependent Care Flexible Spending Accounts are provided by the FSA Plan. This document also describes the Health Savings Account (“HSA”), though the HSA is not a component of the Program or FSA Plan and is not an employee welfare benefit plan.

The provisions of this SPD are generally effective January 1, 2021. You are encouraged to read this SPD in its entirety.

When the words “you” and “your” are used in this SPD, they refer to people who are Covered Persons as the term is defined in the *Definitions* section beginning on page 144.

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

- *Eligibility* – This section describes the eligibility requirements under each of the employee benefit plans covered by this SPD.
- *Health, Life, Disability and Voluntary* – This section describes the medical, prescription drug, dental, vision, flexible spending account, life insurance, AD&D, STD, LTD, and voluntary benefits under the Program and the FSA Plan available to Eligible Persons. This section also contains general information about the HSA.
- *General Administration* – This section describes (i) how to file a claim and the appeals process under the employee benefit plans covered by this SPD; (ii) the legal provisions applicable to such plans, and (iii) the plans’ 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 and the FSA Plan.

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

In the event of any discrepancy between this SPD and the official plan documents (including the applicable service agreements, administrative documents and insurance policies), 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 govern.

A SPECIAL NOTE ABOUT MEDICARE

For additional information relating to Medicare and Disability, please see page 19, *When a Covered Person Qualifies for Medicare*.

A SPECIAL NOTE ABOUT 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 COVID-19 national emergency period, the following deadlines were extended:

- The 31-day (or, if applicable the 60-day) period to request a special enrollment during the plan year;
- 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 benefits;
- The date a claimant is required to file an appeal of an adverse determination of a claim for benefits; and
- The date by which a claimant is required to file a request for an external review.

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 COVID-19 national emergency period.

Reminder: If you will lose health care 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. Go to <https://www.healthcare.gov/> for more information. 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/>.

If you have concerns with respect to your coverage or meeting an applicable deadline under the Program or FSA Plan due to the COVID-19 national emergency, contact the Plan Administrator at the number stated in the section entitled *Contact Information* beginning on page 141.

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 141.

ELIGIBILITY

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

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

THE PROGRAM AND FSA PLAN

This section describes the eligibility requirements under the Program and FSA Plan.

Some provisions of the Program and some benefits under the Program are applicable to only “Management” or “Non-Management” Employees.

- Management Employees are Employees placed by the Company in its sole discretion on the Management payroll of Caterpillar or a Participating Company.
- Non-Management Employees are all other Employees of Caterpillar or a Participating Company, other than those for whom benefits are covered by a collective bargaining agreement with a union (unless such agreement specifically provides for participation in the Program or in certain benefits available under the Program).

Individual	Eligibility Requirements
You	Generally, the Program and FSA Plan cover certain Eligible Persons.
Employees	
Employees	<p>You are eligible to participate in the Program and FSA Plan if you are a:</p> <ul style="list-style-type: none"> • Management Employee of Caterpillar or one of the Participating Companies; • Non-Management (e.g., a Salaried/Support or Non-Bargained Hourly) Employee of Caterpillar or one of the Participating Companies; • Part-Time Employee of Caterpillar or one of the Participating Companies; • International Service Employee of Caterpillar or one of the Participating Companies; • Supplemental Employee of Caterpillar or one of the Participating Companies; or • Temporary Employee of Caterpillar or one of the Participating Companies. <p><i>Note:</i> Not all classifications of employees listed above are eligible for all benefits of the Program or FSA Plan. Please see “Benefit Eligibility” below for additional information regarding eligibility.</p>
Dependents	
Your Eligible Dependents	<p>Certain coverage under the Program 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. Only one parent who is a Covered Person may elect coverage for the Dependent child(ren).</p> <p>Except for Solar Participants, a Spouse or Same-Sex Domestic Partner eligible in his or her own right or who is a Covered Person Under Their Own Right is not covered as a Dependent by the Program (“Covered Person Under Their Own Right” means the Spouse or Same-Sex Domestic Partner is an eligible Employee or retiree of the Company or an Affiliate. See the Definitions section for more information.) Thus, for example, if you have a Spouse or Same-Sex Domestic</p>

Individual	Eligibility Requirements
	<p>Partner who is an active Employee eligible for or covered by the Program, you are each covered separately.</p> <p>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 an Employee or retiree, provided they meet all eligibility criteria. In no event can a Solar Participant be covered as both a dependent and an Employee or retiree.</p> <p>Spouses and Same-Sex Domestic Partners of Supplemental Employees and Temporary Employees are not eligible to participate in the Program.</p> <p>Your children include your natural children, your stepchildren, your adopted children or children placed with you for adoption. To be eligible for coverage, your child must be</p> <ul style="list-style-type: none"> (1) Under 26 years of age; or (2) 26 years of age or older; and <ul style="list-style-type: none"> (i) Is unmarried; (ii) Is 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-Employee 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. <p>For purposes of life insurance coverage, your married child will not be a Dependent if applicable law otherwise prohibits life insurance coverage for married dependents.</p> <p>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.</p> <p>Note: You are required to provide proof of Dependent status. If proof of Dependent status is not provided in accordance with procedures determined by the Plan Administrator, your Dependent’s coverage under the Program will be terminated.</p> <p>Dependents are not eligible to participate in the FSA Plan. However, you can use amounts you set aside in your Health Care FSA (“HCFSA”) or Dependent Care FSA to reimburse you for eligible health care or dependent care expenses. You can use the HCFSA to reimburse your eligible dependents’ eligible health care expenses if they qualify as a dependent under the HCFSA. See the section entitled <i>Health Care FSA</i> beginning on page 85 for more information. You can use the Dependent Care FSA to reimburse your eligible dependents’ eligible dependent care expenses if they are a qualified dependent. See the section entitled <i>Dependent Care FSA</i> beginning on page 90 for more information.</p>

BENEFIT ELIGIBILITY

Except as stated below, all classifications of Employees listed above are eligible for all benefits offered under the Program and FSA Plan.

- Part-Time Employees and their Dependents are eligible only for medical, dental, vision, prescription drug and voluntary benefits under the Program. Part-Time Employees are not eligible for life insurance benefits, accidental death and dismemberment insurance benefits, short term disability benefits and long term disability benefits under the Program.
- Solar Employees and their Dependents, if applicable, are eligible only for medical benefits, dental benefits, vision benefits, prescription drug benefits, life insurance benefits, accidental death and dismemberment insurance and voluntary benefits under the Program. Solar Employees are not eligible for short term disability and long term disability benefits under the Program.
- International Service Employees are eligible for the life insurance benefits, accidental death and dismemberment insurance benefits, short term disability benefits and long term disability benefits under the Program, but are not eligible for medical, dental, vision, prescription drug and voluntary benefits unless they are not eligible to participate in any other plan sponsored by the Company or a Related Company that provides medical, dental, vision, prescription drug and voluntary benefits, in which case they will be eligible for medical, dental, vision, prescription drug and voluntary benefits under the Program.
- Supplemental Employees and their Dependents are eligible only for medical, prescription drug and voluntary benefits under the Program. Supplemental Employees are not eligible for dental, vision, life insurance benefits, accidental death and dismemberment insurance benefits, short term disability benefits and long term disability benefits under the Program.
- Temporary Employees and their Dependents are eligible only for medical, prescription drug and voluntary benefits under the Program. Temporary Employees are not eligible for dental, vision, life insurance benefits, accidental death and dismemberment insurance benefits, short term disability benefits and long term disability benefits under the Program.
- Employees of Solar Turbines Incorporated, or one of its foreign Affiliates, who are classified as International Service Employees are eligible for life insurance and accidental death and dismemberment insurance benefits under the Program, but are not eligible for short term disability benefits, long term disability benefits, and medical, dental, vision, prescription drug and voluntary benefits (unless they are not eligible to participate in any other plan sponsored by the Company or a Related Company that provides medical, dental, vision, prescription drug and voluntary benefits, in which case they will be eligible for medical, dental, vision, prescription drug and voluntary benefits under the Program).
- Employees covered by the benefits agreement dated March 15, 2017 and effective March 27, 2017 between the Company and the International Union, United Automobile Aerospace and Agricultural Implement Workers of America (UAW) and affiliated locals 145, 751, 1872, 974 and 2096, other than those classified as “supplemental employees” as described in the Benefits Agreement, will be eligible for medical, dental, vision, prescription drug and voluntary benefits, but will not be eligible for life, accidental death and dismemberment insurance benefits and disability benefits under the Program.
- Employees covered by the benefits agreement dated September 20, 2018 and effective September 24, 2018 between the Company and the International Association of Machinists and Aerospace Workers, AFL-CIO, and Local Lodge No. 360 will be eligible for medical, dental, vision, prescription drug and voluntary benefits, but will not be eligible for life, accidental death and dismemberment insurance benefits and disability benefits under the Program.
- Canadian Inpatriates will be eligible for long term disability benefits under the Program, but will not be eligible for medical, dental, vision, prescription drug, life, accidental death and dismemberment insurance benefits, short term disability and voluntary benefits under the Program. “Canadian Inpatriates” means those Inpatriates who are employees

of a foreign Related Company with headquarters in Canada. For purposes of long term disability benefits only, Canadian Inpatriates shall be treated as if they are Management and Salaried/Support Employees.

- Any participant who becomes eligible for the Caterpillar Inc. International Service Employee Healthcare Plan shall cease to be eligible for the HCFSA (both General Purpose and Limited Purpose FSA) no later than the end of the plan year in which he or she becomes eligible for the Caterpillar Inc. International Service Employee Healthcare Plan.

TAX IMPLICATIONS AND INFORMATION

For those Dependents (*i.e.*, children and Same-Sex Domestic Partners) who do not qualify under Code Section 152 or Internal Revenue Service Notice 2010-38 as a dependent, you must pay for their coverage under the Program on an after-tax basis. The value of any coverage that the Company provides is includable in your reportable income. The current year value of coverage that the Company provides can be found by contacting the Claims Administrator. See the section entitled *Contact Information* beginning on page 141 for the Claims Administrator's contact information.

Therefore, before enrolling for Program coverage for your Dependents who do not qualify as your dependents under the federal tax code, you should check with your tax advisor for assistance in determining the precise manner in which these additional benefits affect your personal income tax situation. Different rules may apply for state income tax purposes. In addition, you should not contribute to the FSA Plan in anticipation of reimbursing expenses with respect to Dependents who do not qualify as dependents under Code Section 152 or Internal Revenue Service Notice 2010-38, as the Code prohibits reimbursements from the FSA Plan for non-dependents.

QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")

The Program also provides coverage 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 takes 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 on page 3, unless you are a Solar Employee, 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

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 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 Employee, the non-Employee parent or in a licensed special care home or facility; and
- Receives more than one-half of his or her financial support from the Employee.

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 (866) 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 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 Employee's death. Following the Employee's death, coverage for such Enrolled Dependent will end in accordance with the section entitled *Continued Protection for Survivors of Participants in the Program* beginning on page 29.

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 the 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.

HEALTH, LIFE, DISABILITY AND VOLUNTARY

AN INTRODUCTION TO YOUR BENEFITS

This *Health, Life, Disability and Voluntary* section summarizes the medical, prescription drug, dental, vision, flexible spending account, life, accidental death and dismemberment (“AD&D”), short term disability (“STD”), long term disability (“LTD”) and voluntary benefits.

If you are enrolled in the Blue Cross Blue Shield EPO (the “EPO”), the EPO 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 and the FSA Plan 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. The EPO will send you, under separate cover, information about the medical benefits provided by the EPO. If you have questions about your medical benefits, refer to the telephone number on the back of the identification card issued by the EPO. Please note that it is the responsibility of the EPO to provide you with the necessary information about your specific medical benefits. If you do not receive that information from the EPO, contact the Plan Administrator.

Carefully review the section entitled *Eligibility* beginning on page 3. If you have any questions, contact the Claims Administrator at the address listed in the section entitled *Contact Information* beginning on page 141.

THE BENEFIT COMPONENTS

The following chart shows the benefit components available to you as an active employee under the Program and the FSA Plan. In addition, it shows which coverages the Company pays for, which coverages you pay for, which coverages you and the Company pay for together and how you pay your share of the cost.

Active Coverage*	Company Pays	You Pay	You and the Company Pay	You Pay Pre-Tax/After-Tax
Medical			x	Pre-Tax
Prescription Drug			x	Pre-Tax
Dental			x	Pre-Tax
Vision			x	Pre-Tax
Flexible Spending Account		x		Pre-Tax
Life Insurance (Basic)**	x			N/A
Life Insurance (Optional)		x		After-Tax
Life Insurance (Spouse and Dependent)		x		After-Tax
AD&D	x			N/A
Short term Disability (STD)	x			N/A
Long term Disability (LTD)	x			N/A
Voluntary Benefits		x		After-Tax

* Not all individuals eligible for the Program are eligible for all benefits under the Program. See *Eligibility Requirements* beginning on page 3 for specific eligibility information.

** If you are a tobacco user, you will be required to pay a portion of the applicable premium of basic life coverage.

PRE-TAX VS. AFTER-TAX

As an active employee, you participate in the Company's Medical Premium Payment Plan. This means that you will pay for certain coverages with pre-tax dollars deducted from your paycheck each pay period. Generally, you pay for the cost of medical, prescription drug, dental, and vision coverage under the Program (including any coverage for Spousal coverage, if applicable) on a pre-tax basis. Using pre-tax dollars reduces your taxable income for federal, Social Security and (in most cases) state income tax purposes. This means that you pay for the coverages without a tax cost. For many, this advantage may be significant.

You pay for other coverages on an after-tax basis. This means that you pay for the coverages with your already-taxed dollars (your take-home pay). Your after-tax contributions are also deducted from your paycheck each pay period.

If you elect medical coverage for a Same-Sex Domestic Partner or the children of a Same-Sex Domestic Partner, and such individuals do not qualify as your dependents under Section 152 of the Internal Revenue Code, you must pay for this coverage on an after-tax basis. Federal law does not permit you to pay for this coverage on a pre-tax basis. Adjustments will be made to your paycheck to reflect the after-tax basis of the premiums.

Note: Using pre-tax dollars can affect any Social Security benefits you may eventually receive. This is because your Social Security benefit is based on Social Security wages and paying with pre-tax dollars reduces your Social Security wages. The reduction is typically more than offset by the tax savings you experience over the course of your career. If you have any concerns or if you need additional information, contact your local Social Security Administration office.

PARTICIPATION

HOW TO ENROLL

NEW-HIRE ENROLLMENT

You must elect coverage for yourself and your eligible Dependents (if applicable) by enrolling in the Program within 31 days of becoming eligible to participate.

You will receive information from the Caterpillar Benefits Center describing the healthcare benefit options available to you, the applicable costs and the enrollment procedures and deadlines. Elections can be made through the Caterpillar Benefits Center either via internet at CatBenefitsCenter.com or telephone at (877) 228-4010. If you do not receive this information within 10 to 14 business days of your hire date, contact the Caterpillar Benefits Center.

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.

Once elections are made, you will receive confirmation of your enrollment. As part of the enrollment process, you acknowledge that premiums will be withheld from your pay.

If you do not enroll during this period, you will **not** have healthcare coverage for the rest of the plan year. You will not be able to enroll for medical, prescription drug, dental, vision, or flexible spending account coverage until annual enrollment, unless the change in status rules apply (see the section entitled *Changes in Status* beginning on page 14 under the section *Changing Your Coverage*) or the special enrollment rules apply (see the subsection entitled *Special Enrollments During the Year* beginning on page 14 under the section *Changing Your Coverage*).

ANNUAL ENROLLMENT

Each year, you may elect coverage 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 medical, dental, vision, and 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 medical, dental, vision, or prescription drug coverage for the following plan year during the Annual Enrollment Period. Your election under the FSA Plan does not carry over. If you want to participate in the FSA Plan, you must re-enroll during each Annual Enrollment Period.

ENROLLMENT FOR LIFE, AD&D AND DISABILITY COVERAGE

In addition to the enrollment procedures for medical, prescription drug, dental, vision and flexible spending account coverage described above, the following describes the enrollment procedures for life, accidental death and dismemberment (AD&D), and disability coverage.

If you are an Eligible Person, you are automatically enrolled in basic life insurance and AD&D, and such coverage will begin on your first day of Active Employment. You may terminate your basic life insurance and AD&D coverage at any time. In addition, if you are an Eligible Person, you are automatically enrolled in disability benefit coverage. For STD benefit eligibility, you must satisfy the 60-day waiting period starting on your first day of Active Employment prior to coverage beginning.

If you are an Eligible Person, you may enroll in optional, Spousal/Same-Sex Domestic Partner and/or Dependent child life insurance coverage by providing the following information.

- The life insurance coverage elected (*i.e.*, optional, Spousal/Same-Sex Domestic Partner and/or Dependent child life insurance); and
- Your consent to pay the cost of such coverage and to otherwise be bound by the terms of the Program.

This information may be provided in hard copy form, via the internet, or otherwise, as determined by the Plan Administrator. You will be provided with more specific enrollment instructions upon hire. You may also be required to provide Evidence of Insurability. Refer to the subsection entitled *Optional Life Insurance Coverage* beginning on page 12.

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 that any required contribution for your Dependent child's coverage will be withheld from your paycheck unless a state agency pays the required contribution. 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 6 for additional information.

WHEN COVERAGE BEGINS

IF YOU ARE ELIGIBLE TO PARTICIPATE IN THE PROGRAM

If you are already covered under the Program, your coverage continues. If you are not covered under the Program, your coverage will be subject to the rules described in this section.

Your benefits under the Program, other than optional, Spousal/Same-Sex Domestic Partner and Dependent child life insurance and disability benefits coverage, will be effective on the first day you become eligible to participate in the Program (or in the case of Inpatriates, any other day as designated by the Plan Administrator), as long as you enroll by your enrollment deadline.

Your optional life insurance coverage will be effective on the date described in the section entitled *Optional Life Insurance Coverage* beginning on page 12. Your disability benefits will be effective on the date described in the section entitled *Short Term and Long Term Disability Benefits* beginning on page 102.

YOUR ELIGIBLE DEPENDENTS

If you have properly enrolled your eligible Dependents in the Program, 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 an Employee 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.
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>i.e.</i> , 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>i.e.</i> , 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 this purpose, "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:

- An Employee's relationship will be treated as a Same-Sex Domestic Partnership, regardless of whether the Employee 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 Employee, then the Same-Sex Domestic Partner is the person who first met the criteria in this definition.
- Notwithstanding anything herein to the contrary, if an Employee has a spouse recognized for purposes of federal law, no person will qualify as the Employee'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 Employee (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") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), the Program will provide continuation coverage rights to your Same-Sex Domestic Partner that are similar to those provided to Spouses under COBRA and USERRA.
- 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.

Your eligible Same-Sex Domestic Partner and dependent children of your Same-Sex Domestic Partner are also eligible for Spousal life insurance and Dependent child life insurance, as applicable, under the rules of the Program.

OPTIONAL LIFE INSURANCE COVERAGE

Generally, to enroll in or increase optional, Spousal/Same-Sex Domestic Partner life insurance coverage, you must submit Evidence of Insurability for you and/or your Spouse or Same-Sex Domestic Partner, as applicable. Your optional, Spousal/Same-Sex Domestic Partner life insurance coverage will begin on the first of the month you are Actively at Work following the date the Claims Administrator approves your application for such coverage and accepts your or your Spouse's or Same-Sex Domestic Partner's Evidence of Insurability. However, if within 31 days of initially meeting the eligibility requirements, you elect optional life insurance coverage of 100% or 200% of your Annual Base Salary, or in connection with an event that would justify an election change on the applicable insurance policy, you elect optional life insurance coverage of 100% of Annual Base Salary or you elect to increase optional life insurance coverage by 100% of Annual Base Salary, then such optional life insurance coverage will begin on the first of the month you are Actively at Work following the date the Claims Administrator approves your application for optional life insurance coverage, and you will not be required to submit Evidence of Insurability.

Generally, your Dependent child life insurance coverage will begin on the day you acquire a new Dependent if you have such coverage in effect on that date. If you do not have Dependent child life insurance coverage on the day you acquire a new Dependent, your Dependent child life insurance coverage will begin on the first day of the month you are Actively at Work following the date the Claims Administrator approves your application for Dependent child life insurance coverage. You will not be required to submit Evidence of Insurability for Dependent child life insurance coverage.

You may decrease or terminate your optional, Spousal/Same-Sex Domestic Partner and/or Dependent child life insurance coverage at any time. If your life insurance coverage has terminated as a result of a Leave of Absence, special rules may apply. Please contact the Claims Administrator for more information.

CHANGING YOUR COVERAGE

The circumstances under which you may change your coverage 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. Except in the case of life insurance coverage, this limitation applies whether or not you pay for your coverage on a pre- or after-tax basis. With respect to your life insurance coverage (optional, Spousal/Same-Sex Domestic Partner and/or Dependent child life), you may drop, add or increase your coverage during the year, provided you fulfill any eligibility and/or application requirements that may apply, as described above and in the section of the SPD entitled *Death and AD&D* beginning on page 97.

As noted above, under certain circumstances, you may enroll in coverage, add or remove covered Dependents, or change coverage that is paid for on a pre-tax basis 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 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 14;
- 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. (This does not apply to your HCFSA account);
- 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 (this does not apply to your HCFSA account);
- You, your Spouse or your Dependent child experience a significant reduction in coverage or a total loss of coverage (this does not apply to your HCFSA account);
- The Program adds a benefit package option or significantly improves coverage under an existing option (this does not apply to your HCFSA account);
- 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 15; and
- You experience a reduction in hours of service as described in the *Reduction in Hours of Service* section beginning on page 15.

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.

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 Plan benefits on an after-tax basis. Contact the Caterpillar Benefits Center at (877) 228-4010 if you have questions about changing your elections.

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 change the amounts you contribute to the FSA Plan, and you 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, or gets married);
- 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) that leads to a loss of or gain in eligibility for coverage; or
- You change from part-time to full-time or vice versa regardless of loss of or gain in eligibility for coverage;
- 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.

Please note, effective August 1, 2021, if you experience a full-time to part-time change in employment status, you may be permitted to change your health benefit elections, but you may not drop your current coverage or enroll in coverage under the Program. If you experience a part-time to full-time change in employment status, you may be permitted to change your health benefit elections or enroll in coverage under the Program, but you may not drop your current coverage.

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.

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. 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 Plan benefits on an after-tax basis. Contact the Caterpillar Benefits Center at (877) 228-4010 if you have questions about changing your elections.

SPECIAL ENROLLMENTS DURING THE YEAR

Under HIPAA, you have the right to enroll yourself and your Dependents for the Program benefit coverage and coverage under the FSA Plan, 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 terminate; 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.

REDUCTION IN HOURS OF SERVICE

You may revoke your coverage election under the Program if 1) you reasonably expected to average at least 30 hours of service per week but you experience a change in your employment status so that you are now reasonably expected to average less than 30 hours per week; and 2) the revocation of your coverage election corresponds to the intended enrollment of you (and any Dependents who also lost coverage due to your revocation) in another plan that provides “minimum essential coverage,” with the new coverage effective no later than the first day of the second month following the month in which your coverage under the Program was revoked.

CHANGING YOUR CONTRIBUTION AMOUNTS UNDER THE FLEXIBLE SPENDING ACCOUNT

Generally, you may not stop or change the amount you contribute to a flexible spending account during the FSA Plan year, unless you meet one of the conditions described in the *Changing Your Coverage* section beginning on page 13 prior to November 1 of any year. If you meet one of the conditions on or after November 1 of any FSA Plan year, you may not make any changes to your flexible spending account during that FSA Plan year. If you meet one of those conditions prior to November 1 and you elect to change your FSA contribution, any change in the amount you contribute (except for a change resulting from a Family Leave of Absence) will change the maximum reimbursement for the remainder of the FSA Plan year in which the election change is made. This maximum reimbursement for the remainder of the FSA Plan year will be equal to the new contribution amount you elect. For example, if your original election was \$1,200 and your new election is \$1,000, your maximum reimbursement for the remainder of the year is \$1,000. Notably, you cannot reduce your contribution to the FSA Plan below the amount already deducted from your pay, or below the amount already paid to you from the FSA Plan during the FSA Plan year. Similarly, if you change your contribution to the FSA Plan to a greater amount, you will only be reimbursed for amounts that are greater than your original election if the costs were incurred after the date the new election was made. However, please see the section entitled *Permitted 2021 Mid-Year Flexible Spending Account Changes* directly below. For questions regarding these election change rules, contact the Claims Administrator.

Permitted 2021 Mid-Year Flexible Spending Account Changes

As a result of the challenges of the COVID-19 national emergency, during the 2021 FSA Plan year, you may prospectively revoke an election under the FSA Plan, make a new election to enroll in the FSA Plan, or change your election to increase or decrease your contributions to a flexible spending account prior to November 1, 2021, regardless of whether the basis for the election change meets one of the conditions described in the *Changing Your Coverage* section beginning on page 13; provided,

however, that you cannot reduce your contribution to the FSA Plan below the amount already deducted from your pay, or below the amount already paid to you from the FSA Plan during the 2021 FSA Plan year.

COST

You pay the entire cost of the following coverages:

- Your optional life insurance coverage;
- Your Spouse/Same-Sex Domestic Partner and Dependent child life insurance; and
- Your and your eligible Dependents' voluntary benefits.

You also pay the full amount that you elect to contribute to the FSA Plan, if you decide to participate.

For all other coverage, the Company pays either a portion of or all of the cost. The amounts you are required to pay are made with either pre- or after-tax dollars deducted from your pay. See the chart in the section entitled *The Benefit Components* beginning on page 8 for details.

Your coverage cost may change each plan year. The most up-to-date cost of each coverage option will be in your annual enrollment materials or contact the Plan Administrator. Coverage under the Program is subject to payment of any required contribution unless, in the case of a child who is eligible for coverage pursuant to a QMCSO, payment of the required contribution is made by a state agency.

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 healthcare benefits under the Program with those of any other plan that provides benefits to you. For information on coordination of benefits for prescription drug, dental, and vision benefits, contact the applicable Claims Administrator listed on the *Plan Information* chart beginning on page 141.

WHEN COORDINATION OF BENEFITS APPLIES

This coordination of benefits (“COB”) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. Failure to comply with the Primary Coverage Plan provisions to utilize a required network will deem the services not allowable under the Program for secondary coverage. If enrolled for secondary coverage in a Network Benefits plan, use of a Network Provider is required to receive maximum reimbursement from the Program.

DEFINITIONS

For purposes of this *Coordination of Benefits* section, capitalized terms are defined as follows:

- “Coverage Plan” is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
 - “Coverage Plan” includes group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long term care contracts, such as skilled nursing care;

medical benefits under group or individual automobile contracts; and Medicare (see the section entitled *When a Covered Person Qualifies for Medicare* beginning on page 19) or other governmental benefits, as permitted by law.

- “Coverage Plan” does not include individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under the items listed above is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

- The order of benefit determination rules determine whether this Coverage Plan is a “Primary Coverage Plan” or “Secondary Coverage Plan” when compared to another Coverage Plan covering the person. When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan’s benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan’s benefits.
- “Allowable Expense” means a health care service or expense, including deductibles, co-payments, and co-insurance that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services (for example, a health maintenance organization), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:
 - If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room (unless the patient’s stay in a private Hospital room is Necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.
 - If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of reasonable and customary fees, any amount in excess of the highest of the reasonable and customary fees for a specific benefit is not an Allowable Expense.
 - If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of reasonable and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan’s payment arrangements shall be the Allowable Expense for all Coverage Plans.
 - The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions is not an Allowable Expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
- “Closed Panel Plan” is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.
- “Custodial Parent” means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

1. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.
2. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the

Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide Non-Network Benefits.

3. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.
4. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.
 - Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent (for example, as an employee, member, subscriber or retiree) is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent and primary to the Coverage Plan covering the person as other than a dependent (*e.g.*, a retired employee), then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.
 - Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:
 - The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
 - (i) The parents are married;
 - (ii) The parents are not separated (whether or not they ever have been married); or
 - (iii) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

- If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.
 - If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - (i) The Coverage Plan of the custodial parent;
 - (ii) The Coverage Plan of the Spouse or Same-Sex Domestic Partner of the custodial parent;
 - (iii) The Coverage Plan of the noncustodial parent; and then
 - (iv) The Coverage Plan of the Spouse or Same-Sex Domestic Partner of the noncustodial parent.
- Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired employee and as a dependent of an actively working spouse will be determined under the rule labeled "Non-Dependent or Dependent."
 - Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
 - Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

- If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

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 do not elect it. There are, however, Medicare-eligible individuals for whom the Program pays benefits first and Medicare pays benefits second:

- Employees with active Full-time current employment status age 65 or older;
- Covered Spouses of Employees with active current employment status regardless of whether the Employee or his or her Spouse is age 65 or older (however, this provision does not apply to Same-Sex Domestic Partners pursuant to the Medicare rules); and
- Covered Persons with end-stage renal disease, for a limited period of time.

A Special Note About Medicare and Disability

Benefits under the Program are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Program. ***If you are eligible for or enrolled in Medicare, please read the following information carefully.***

You may become eligible for Medicare on a primary basis due to disability. **You should enroll for and maintain coverage under both Medicare Part A and Part B.** If you are disabled and become eligible for Medicare, Medicare becomes the primary payer because you are not actively working. If you don't enroll and maintain that coverage or elect to opt out of that coverage, and if the Program is the secondary payer as described in the *Coordination of Benefits* section beginning on page 16, the Program will pay benefits as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the expenses that Medicare would have paid and you will incur a larger out-of-pocket expense.

If you are enrolled in a Medicare+Choice (Medicare Part C) plan on a primary basis (Medicare pays before benefits under the Program), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Program is the secondary payer, it will pay any benefits available to you under the Program as if you had followed all rules of the Medicare+Choice plan. You will be responsible for any additional costs or reduced benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Please note that you are not required to enroll in Medicare Part D (prescription drug coverage) and if you are not enrolled, that coverage will not be considered in determining your prescription drug coverage under the Program.

Determining the Allowable Expense When the Program is Secondary

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 do not accept Medicare) will be the Allowable Expense. Medicare payments, combined with the Program benefits, will not exceed 100% of the total Allowable Expenses.

If you are eligible for, but not enrolled in, Medicare, and the Program is secondary to Medicare, benefits payable under the Program will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

EFFECT ON THE BENEFITS OF THE PLAN

When this Coverage Plan is secondary, it may reduce its benefits by the total benefits paid or provided by all Coverage Plans primary to this Coverage Plan. As each claim is submitted, this Coverage Plan will:

- Determine its obligation to pay or provide benefits under its plan; and
- Determine the difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan and the benefit payments paid or provided by all Coverage Plans primary to this Coverage Plan.

If there is a difference, this Coverage Plan will pay that amount. Benefits paid or provided by this Coverage Plan plus those of Coverage Plans that are primary to this Coverage Plan may be less than 100 percent of total Allowable Expenses.

If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan. Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is eligible for but not enrolled in Medicare (including, by way of example but not limitation, persons eligible for Medicare only if the person pays an additional cost to enroll). Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

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 this Coverage Plan and other Coverage Plans. The Claims Administrator may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits.

The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give the plan any facts it needs to apply those rules and determine benefits payable. If you do not provide the information needed to apply these rules and determine the benefits payable, your claim for benefits will be denied.

PAYMENTS MADE

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, the Program may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. The Program will not have to pay that amount again. The term "payment made"

includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments the Program made is more than it should have paid under this COB provision, the plan may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for you. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

HOW LONG COVERAGE CONTINUES

Generally, your coverage under the Program continues while you are employed by the Company and provided you are contributing your appropriate share of the cost. Your coverage under the FSA Plan generally continues while you are employed by the Company, are Actively at Work, and are contributing to the HCFSA or DCFSA.

WHEN COVERAGE ENDS

In general, your coverage will end on the day you are no longer Actively at Work, unless you return to work with the Company within the same calendar month. If you take a Leave of Absence from employment to perform Uniformed Services for a period of 31 days or more, your coverage will terminate on the last day of the month in which such Leave of Absence begins.

Your Dependent’s coverage ends on the earlier of (1) the day your coverage ends; (2) the day in which he or she ceases to be a Dependent. In the case of a Dependent who ceases to be a Dependent due to the attainment of age 26, coverage will end on the earlier of: (a) the day your coverage ends; or (b) the last day of the month of the Dependent’s 26th birthday.

If you intend to leave the Company, be sure to check with your local Human Resources representative about your benefit status as soon as possible. You may use the existing balance in your FSA Plan account for any claims you incur before your termination date. In addition, you may be able to elect COBRA coverage or convert certain coverage to individual policies if you no longer qualify for group coverage through the Company.

Under the circumstances described in the following paragraphs of this subsection *How Long Coverage Continues*, you may be entitled to continued coverage under the Program for a specified period of time after you leave Active Employment. However, in all cases you will be required to pay the applicable premium for such continued coverage and you may be required to make such payment on an after tax basis (for example, if you are on an unpaid Leave of Absence).

HOSPITAL CONFINEMENT

If you (or your covered Dependent) are confined to a Hospital for an Inpatient Stay when your 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 25 for more information on continuation coverage under COBRA.

DISABILITY LEAVE OF ABSENCE

If you are on a disability Leave of Absence, your coverage under the Program will be continued as follows:

If You Are A Management Employee And Become Disabled

If you are in this classification, coverage will continue until the end of your disability Leave of Absence. However, if you return to work, coverage under this section will end on the date you return to active employment and you will thereafter be covered as an active employee, provided you meet eligibility criteria. While you are on a disability Leave of Absence, optional life coverage will continue as long as you make the required contributions (Spousal and Dependent child life coverage, if applicable, will only continue until you attain age 65 and only if you make the required contributions). In no event will coverage be continued longer than the period for which you are eligible to receive disability benefits as described in *Disability Benefits* beginning on page 102.

If You Are A Non-Management Employee And Become Disabled prior to Age 60

If you are in this classification, coverage will continue until the end of your disability Leave of Absence. However, if you return to work, coverage under this section will end on the date you return to active employment and you will thereafter be covered as an active employee, provided you meet eligibility criteria. In no event will coverage be continued longer than the period for which you are eligible to receive disability benefits as described in the section entitled *Disability Benefits* beginning on page 102.

Your life and AD&D benefits will not terminate prior to the last day of the month in which you reach age 65 (or your early retirement date as defined under the applicable pension plan, if applicable), provided you are receiving a disability retirement benefit under the Caterpillar Inc. Retirement Income Plan (or another defined benefit plan sponsored by the Company and in which you participate). You must make the required contribution for optional life coverage (and Spousal and Dependent child life coverage, if applicable) for the duration of the leave.

If You Are A Non-Management Employee And Become Disabled at or after Age 60

If you are in this classification, coverage will continue until the end of your disability Leave of Absence. However, if you return to work, coverage under this section will end on the date you return to active employment and you will thereafter be covered as an active employee, provided you meet eligibility criteria. While you are on a disability Leave of Absence, optional life coverage will continue as long as you make the required contributions (Spousal and Dependent child life coverage, if applicable, will only continue until you attain age 65 and only if you make the required contributions). In no event will coverage be continued longer than the period for which you are eligible to receive disability benefits as described in the section entitled *Disability Benefits* beginning on page 102.

FAMILY LEAVE OF ABSENCE

If you are on a Family Leave of Absence, your coverage under the Program will be continued while you are on Family Leave of Absence. You will be required to pay the same portion of the applicable cost for coverage under the Program that you paid prior to your leave. This includes the requirement that you pay the cost applicable to tobacco users for basic life insurance, if applicable, and the cost of optional life insurance coverage, if any.

However, coverage will be terminated earlier than stated above if (i) you do not return to work after your Family Leave of Absence expires, or (ii) before the expiration of the maximum continued coverage period, you notify the Company that you will not be returning to work.

If your coverage under the Program was terminated while you were on a Family Leave of Absence due to nonpayment of any required contributions or you revoked coverage, your coverage will be automatically reinstated under the Program when you return to work, unless you make a new election or decline coverage within 31 days of the date when you return from leave.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you take a Leave of Absence to perform Uniformed Services and you are entitled to protection under the Uniformed Services Employment and Reemployment Rights Act (USERRA), your coverage will be continued as follows.

- If you take a Leave of Absence for 30 days or less, you will be considered Actively at Work for purposes of coverage under the Program.

- If you take a Leave of Absence for 31 days or more, coverage will be terminated on the last day of the month in which the Leave of Absence begins. However, you may elect to continue medical, prescription drug, dental and vision coverage from the effective date of your Leave of Absence to
 - the last day of the 24-month period beginning on the effective date of your Leave of Absence;
 - the date you fail to make a required USERRA premium payment; or
 - the date your reemployment rights under USERRA expire.

During your Leave of Absence, you will be required to contribute to the cost of coverage, plus two percent (2%).

If you take a Leave of Absence to perform Uniformed Services for 31 days or more, coverage for your Spouse and/or Dependents will continue, provided the required contributions for coverage are made, unless your Spouse and/or Dependents elect to terminate coverage. Coverage will continue from the effective date of your Leave of Absence to the earliest of

- the last day of your military Leave of Absence;
- the date your Spouse and/or Dependent fails to make a required premium payment; or
- the date your reemployment rights under USERRA expire.

SPOUSAL LEAVE OF ABSENCE

If you are a Spouse or Same-Sex Domestic Partner who is a “Covered Person under Their Own Right” and you go on a Leave of Absence as a result of your Spouse’s or Same-Sex Domestic Partner’s transfer of employment within the Company, your medical, prescription drug, dental, and vision coverage under the Program and your HCFSA and Dependent Care Flexible Spending Account under the FSA Plan will continue until the last day of the month in which your Leave of Absence begins. You will then be eligible to continue medical, prescription drug, dental, and vision coverage under the Program as a Spouse or Same-Sex Domestic Partner. Your Spouse or Same-Sex Domestic Partner will be required to contact the Caterpillar Benefits Center to enroll you in coverage as a Dependent within 31 days of your loss of coverage. Your life insurance coverage under the Program will continue as long as you pay the cost applicable to tobacco users, if applicable, for basic life insurance and the cost of optional life insurance coverages, if enrolled. If you were making contributions to your HSA through Caterpillar, you will no longer be able to do so when your Leave of Absence begins.

PARENTAL LEAVE

If you are on a parental leave, coverage will be continued for the duration of the parental leave.

OTHER LEAVES OF ABSENCE

In the case of a Non-Management Employee on a Leave of Absence for a reason other than one of the above, medical, prescription drug, dental, vision and life insurance coverage will continue for up to 12 months. In order to continue life insurance coverage beyond the end of the month in which you complete 30 days of your Leave of Absence, you must, during that month, request such continuation. You will be required to pay the cost charged to tobacco users (if applicable) for basic life insurance and, if enrolled, the cost of optional life insurance coverages.

In the case of a Management Employee, medical, prescription drug, dental, vision and life insurance coverage will continue for the duration of the leave. Life insurance (basic and/or optional) coverages will continue beyond the end of the month in which you complete 30 days of your Leave of Absence only if you pay the cost, if one applies (*i.e.*, the cost charged to tobacco users for basic life insurance and, if enrolled, the cost of optional life insurance coverages).

If your coverage under the Program was terminated while you were on an unpaid Leave of Absence due to nonpayment of any required contributions or you revoked coverage, your coverage will be automatically reinstated under the Program when you return, unless you make a new election or decline coverage within 31 days of the date when you return from leave.

INVOLUNTARY TERMINATION AS A RESULT OF JOB ELIMINATION OR LAYOFF

An Employee who is involuntarily terminated as a result of a job elimination or skill-set mismatch (as determined by the Company) or who is placed on Layoff may be eligible to continue his or her coverage under the Program for the period set forth in the chart below (provided he or she continues to pay any applicable premiums):

Reason	Medical, Prescription Drug, Dental and Vision Drug Benefits	Basic Life Insurance Coverage	Optional, Spousal/Same-Sex Domestic Partner and Dependent Child Life Insurance Benefits	Accidental Death and Dismemberment Benefits	Disability Benefits
Job Elimination or Skill-Set Mismatch	Up to six (6) months following the date of termination.*	Up to six (6) months following the date of termination.	Up to six (6) months following the date of termination.	Up to six (6) months following the date of termination.	No continuation
Layoff	The shorter of (i) the duration of your layoff, or (ii) the remainder of the calendar month you ceased to be Actively at Work and then for the following twelve (12) calendar months.**	The shorter of (i) the duration of your layoff, or (ii) the remainder of the calendar month you ceased to be Actively at Work and then for the following twelve (12) calendar months	The shorter of (i) the duration of your layoff, or (ii) the remainder of the calendar month you ceased to be Actively at Work and then for the following twelve (12) months.	The shorter of (i) the duration of your layoff, or (ii) the remainder of the calendar month you ceased to be Actively at Work and then for the following twelve (12) months.	The shorter of (i) the duration of your layoff, or (ii) the remainder of the calendar month you ceased to be Actively at Work and then for the following twelve (12) months.
Temporary Layoff	The duration of the Temporary Layoff.***	The duration of the Temporary Layoff.	The duration of the Temporary Layoff.	The duration of the Temporary Layoff.	The duration of the Temporary Layoff.

* This extension period is at the discretion of the Company and runs concurrently with any continuation period under COBRA. The former employee will be required to pay the applicable premium charged to active employees during this extension period.

** This extension period runs concurrently with any continuation period under COBRA and the employee will be required to pay the premium applicable to active employees during the extension period. Coverage may be continued beyond the extension period only if you file a request for such continued coverage in accordance with procedures established by the Claims Administrator and pay the required contribution, where applicable. Contact the Claims Administrator for more information.

***This extension period does not run concurrently with COBRA. The employee will be required to pay the applicable premium charged to active employees during this extension period.

If an Employee who is involuntarily terminated as a result of a job elimination or skill-set mismatch or who is placed on Layoff voluntarily opts out of any Company-provided severance or placement program offered in connection with such job elimination or skill-set mismatch, such individual is not eligible for the continued coverage described above.

LIFE INSURANCE CONVERSION RIGHT

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.

CONTINUATION OF BENEFITS (COBRA)

If you and your Dependents have health care coverage (*e.g.*, medical, prescription drug, dental and vision) 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.” In addition, you and your Dependents may continue to participate in the HCFSAs (on an after-tax basis) after a qualifying event for a specific period of time. 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 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. While the Company will notify the COBRA Administrator of your death, termination of employment, or loss of eligibility due to a reduction in hours, it is your responsibility to notify the COBRA Administrator of any other 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 141. In addition, you may add a newborn or an adopted child during the COBRA continuation period in accordance with the “special enrollment” rules outlined earlier in the *When Coverage Begins* section beginning on page 11.

To continue coverage, you or your affected Dependents (each, a “qualified beneficiary”) are required to pay the full group rate, plus an administrative fee, as allowed by law.

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 141.

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. Special rules apply to FSA Plan coverage as described in the section entitled *Special Rules for Health Care Flexible Spending Accounts* beginning on page 28.

If:	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
You	Have a reduction in hours	You and your covered Dependents	18 months
	Terminate employment (for reasons other than gross misconduct)	You and your covered Dependents	18 months
	Do not return from an FMLA Leave of Absence	You and your covered Dependents	18 months
	Become disabled within the first 60 days of COBRA continuation coverage	You and your covered Dependents	Up to 29 months*

If:	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
	Die	Your covered Dependents	36 months
	Become divorced	Your covered Dependents	36 months
	Become entitled to Medicare while on COBRA	Your covered Dependents	Up to 36 months*
Your covered Dependent	Is no longer an eligible Dependent (due to age limit or divorce)	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 you (or another qualified beneficiary) are totally disabled when you (or the other qualified beneficiary) become eligible for COBRA coverage or become 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. (Any covered Dependents can also continue their COBRA coverage during this extension period.)

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.

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:

- Reduction in hours that makes you ineligible for coverage;
- You do not return from a FMLA Leave of Absence;
- Your termination of employment (or service, as applicable) for any reason other than gross misconduct;
- 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 occurs.

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.

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 health care coverage ends on the day on which the qualifying event occurred.

Please note that the American Rescue Plan Act (“ARPA”) may provide you with a temporary 100% COBRA premium subsidy if (i) you lost health care coverage, or will lose health care coverage, due to an involuntary termination of employment or a reduction in hours; and (ii) your COBRA continuation coverage period falls within the period beginning April 1, 2021 and ending September 31, 2021. You will receive a separate notice from the COBRA Administrator if you are eligible for this temporary COBRA premium subsidy, which will also describe your COBRA continuation coverage election rights. The suspension of the deadlines discussed in the section entitled *A Special Note About Suspension of Outbreak Period Deadlines* on page 2 does not apply to the newly created, 60-day election window under the ARPA. Therefore, subsidy-eligible individuals who fail to elect COBRA continuation coverage within 60 days of the date they receive the notice from the COBRA Administrator will not be eligible for a COBRA premium subsidy. If you have questions about the COBRA premium subsidy under APRA or believe you may be eligible for the COBRA premium subsidy, contact the Plan Administrator.

WHEN 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 are 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.

SPECIAL RULES FOR HEALTH CARE FLEXIBLE SPENDING ACCOUNTS

You are also permitted to elect COBRA continuation coverage due to a qualifying event for your HCFSA by continuing contributions on an after-tax basis. Generally, the COBRA rules described above are the same, except that the maximum period for which you may continue after-tax contributions to your HCFSA is the remainder of the plan year in which your qualifying event occurred, unless you are eligible to carry over a balance in your HCFSA, as determined by the Plan Administrator.

Electing COBRA for your HCFSA gives you the benefit of extending the time period for which claims for reimbursement may be incurred. Normally, to be eligible for reimbursement a claim must be incurred while you are covered under and contributing to the HCFSA. If you have not incurred enough expenses at the time of your qualifying event to recover your contributions to the account, then you should consider electing COBRA in order to extend the coverage period long enough to incur claims that would allow for full reimbursement, but not past the end of the year. For this reason, COBRA is only available to you or your Dependents if the amount you could be reimbursed exceeds the amount you would have to pay into the account on an after-tax basis. Additionally, the 100% COBRA premium subsidy under ARPA discussed in the section entitled *Deciding Whether to Continue Coverage* on page 27 does not apply to the HCFSA.

Election Period for COBRA Continuation Coverage under the Health Care FSA

If an Employee is continuing coverage under federal law, continuation must be elected by the later of 60 days after the qualifying event occurs, or 60 days after the Employee is sent notice of the continuation right from the Plan Administrator. A qualified beneficiary may elect to continue coverage under a HCFSA subject to the provisions below.

Coverage will continue if the qualified beneficiary's account has a balance remaining at the time employment stops or work hours are reduced until the earliest of the following dates:

- The end of the plan year;
- The date the FSA Plan stops being in force;
- The date the qualified beneficiary fails to make the required payment for the coverage; or
- The date the qualified beneficiary, after electing this continuation, becomes covered under any other group health plan (including Medicare). (This does not apply if the other group health plan excludes or limits coverage for a qualified beneficiary's pre-existing condition.)

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). However, please see the section entitled *Deciding Whether to Continue Coverage* on page 27 regarding the 100% COBRA premium subsidy under ARPA. 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.

If the Company elects, in its sole discretion, to continue health coverage at active Employee rates for a period following your involuntary termination as a result of a job elimination or skill-set mismatch, and you properly elect COBRA coverage, you will be required to pay the applicable premium for active Employees for the first six months of COBRA coverage. In order to continue COBRA coverage after such six-month period, you will be required to pay the full applicable COBRA premium.

The COBRA premium under the HCFSA is 100% of the election remaining on the date coverage ends. A qualified beneficiary has 45 days from the date of COBRA 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.

CONTINUED PROTECTION FOR SURVIVORS OF PARTICIPANTS IN THE PROGRAM

If you are a participant in the Program and you die, your survivors who were covered under the Program at the time of your death may be eligible to elect to continue their Dependent coverage, as described below.

Survivors of Employees that are Not Retirement Eligible: If you were not eligible to retire under the Retiree Program at the time of your death, coverage for your surviving Spouse or Same-Sex Domestic Partner and Dependent children that were covered under the Program at the time of your death will continue, as follows:

- The coverage for your covered surviving Spouse or Same-Sex Domestic Partner and the coverage for any surviving Dependent children may continue (i) for twelve (12) months at the applicable active employee rate(s), and then (ii) for an additional period not to exceed the maximum period of continuation coverage under COBRA and at the applicable COBRA rate(s).
- If an Employee died prior to December 31, 2008 and his or her covered surviving Spouse is age 45 or older as of the Employee's death, his or her coverage, and the coverage for any surviving Dependent children may continue (i) for twelve (12) months at the applicable active employee rate(s); and then (ii) for the life of the surviving Spouse at the applicable full group rate(s) (unsubsidized by the Company), subject to the Plan Administrator's sole discretionary right to change or discontinue the Program at any time.
- Any period of continued coverage for survivors will run concurrently with any period of continuation coverage that may be available under COBRA. If there is no surviving Spouse or Same-Sex Domestic Partner at the time of your death, all other covered Dependents, if any, may be eligible to elect and pay for continuation coverage pursuant to COBRA. Refer to the subsection *Continuation of Benefits (COBRA)* beginning on page 25 for more information regarding COBRA continuation coverage.

Survivors of Retirement Eligible Employees: If you were eligible to retire under the Retiree Program at the time of your death, your surviving Spouse or Same-Sex Domestic Partner and Dependent children may be eligible for coverage under the Retiree Program, in accordance with its terms.

Survivor's coverage will end if your 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 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.
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 or FSA Plan.

MEDICAL BENEFITS

OVERVIEW OF MEDICAL BENEFITS

This *Medical Benefits* section presents an overview of your medical benefits. You are encouraged to review the benefit limitations of this *Medical Benefits* section by reading the *What's Covered – Benefits* beginning on page 31 and *What's Not Covered – Exclusions* section beginning on page 54 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.

ELIGIBILITY FOR MEDICAL BENEFITS

You are eligible for medical benefits under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled *Eligibility* beginning on page 3 and any additional requirements described in this section. International Service Employees who are eligible for medical benefits under another plan sponsored by the Company or a Related Company are not eligible for medical benefits under the Program.

WHAT'S COVERED – BENEFITS

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 Program generally pays benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. 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 58. 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. An internet 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 Hospital or Skilled Nursing Facility to obtain Network Benefits. If you use a Network Physician, 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 141. 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 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. An internet 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 141.

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

Caterpillar Inc. 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

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 SupportSM designed to encourage personalized, efficient care for you and your covered Dependents. Personal Health SupportSM 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 SupportSM 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 SupportSM 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 SupportSM 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 SupportSM 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 SupportSM 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 SupportSM* row in the *Benefits Information Grid* beginning on page 37.

To notify Personal Health SupportSM, call the telephone number shown on your ID card or in the section entitled *Contact Information* beginning on page 141. 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 SupportSM* row 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 SupportSM before

receiving Covered Health Services when Medicare is the primary payer. However, you should notify Personal Health SupportSM 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.

PREMIUMS

OVERVIEW

The premium is the portion you pay for your benefits under the Program. In most instances, premiums are required for coverage under the Program. Several factors are taken into consideration in determining the premium applicable to you and your Dependents, including your coverage choice (e.g., Employee only, Employee and Spouse, Employee and children, or Employee, Spouse and children).

Your premium amount is reported to you each pay period on your check stub.

SPOUSAL SURCHARGE

If an Employee's covered Spouse or Same-Sex Domestic Partner is not employed by the Company or an Affiliate that has adopted the Program, and has other group health coverage available and has not elected such other coverage, the coverage for the Employee's Spouse or Same-Sex Domestic Partner will be subject to a surcharge. The amount of the surcharge will be determined each year by the Plan Administrator in its sole discretion and will be applied in a uniform manner. The spousal surcharge does not apply to Employees covered by a collective bargaining agreement that does not provide for the assessment of the spousal surcharge. You will be informed regarding the amount of the surcharge each year at or before the time of enrollment.

If applicable, the spousal surcharge will be deducted from your pay on a pre-tax basis. If you experience a change in status or any other event described in this SPD which permits a mid-year election change related to your spousal surcharge, you must call the Caterpillar Benefits Center at (877) 228-4010 within 31 days after the event to change your spousal surcharge. If you do not, you cannot change your spousal surcharge until the next Annual Enrollment Period, unless you once again experience a permitted event.

WELLNESS EXAMS

The Company encourages employees to get periodic general medical wellness exams. For this reason, the Company provides you the opportunity to have a general medical wellness exam at no additional cost to you. Note that not all facilities offer this benefit and it is only offered to employees. Dependents are not eligible for this benefit, even if they are otherwise eligible under the Program. To determine if this benefit is offered to employees at your facility, contact the Wellness Exam Coordinator at (877) 838-0596 or Corporate Medical at (309) 675-5314.

If you are employed at a facility that offers this benefit but does not have an on-site medical clinic, you may receive, at no cost to you, a general medical wellness exam from a medical professional in your area that has been identified by the Company for purposes of providing this benefit. The Company has contracted with specific medical professionals in certain areas in order to obtain preferred pricing for this benefit. However, the Company does not endorse the medical professionals identified.

Wellness exams will typically include diagnostic testing of the blood, baseline EKG testing at age 50, and similar general tests. The exam is not intended to treat any illness or disease. Prescriptions cannot be written or dispensed as part of the exam. You will be responsible for the cost of any services beyond the scope of the wellness exam, follow-up care, or medical care following a referral (to the extent such services are not otherwise covered under the Program). Other limitations may apply.

This benefit is provided according to the following schedule:*

Employee's Age as of January 1 of the Plan Year	Frequency of Exam
Under age 25	Not Available
Ages 25, 28, 31, 34, 37, 40, 43, 46, and 49	One exam at each age**
Ages 50 and up	One exam each year, until termination of employment for any reason

*Employees interested in participating in a voluntary wellness program may obtain an exam outside of this schedule to determine eligibility for the voluntary wellness program.

** If you fail to have an exam at a specified age, you may be able to obtain an exam prior to reaching the next designated age.

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 Program 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 tables below outline 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 tables 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		Network	Non-Network	Network	Non-Network	Network	Non-Network
		Individual	Family	Individual	Family	Individual	Family						
		Individual	Family	Individual	Family	Individual	Family	Network	Non-Network	Network	Non-Network	Network	Non-Network
Reside in a Network Area	BCBS National EPO	\$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 enrolled in family coverage under the PPO or EPO 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.

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 EPO 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 must 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.

BENEFIT INFORMATION

IMPORTANT POINTS TO REMEMBER

Benefits that are not Covered Health Services are sometimes listed in two places:

- The *Benefits Information* grid beginning on page 37

- The *What's Not Covered – Exclusions* section beginning on page 54

BENEFITS INFORMATION GRID

Note: See the *Description of Network and Non-Network Benefits* section beginning on page 63 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 ^{SM?}	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
<p>1. Acupuncture Services</p> <p>Acupuncture services for pain therapy when both of the following are true:</p> <ul style="list-style-type: none"> • Another method of pain management has failed. • The service is performed by a Provider in the Provider’s office. <p>Acupuncture is also a Covered Health Service for the treatment of:</p> <ul style="list-style-type: none"> • Nausea of Chemotherapy, or • Post-operative nausea, or • Nausea of early Pregnancy. 	No	20% after deductible	50% after deductible
<p>2. Allergy Services</p> <p>Testing</p> <p>Covered Health Services include testing for allergy care in a Physician’s office.</p> <p>Drug Treatment for Allergy Care</p> <p>Covered Health Services include <u>drug treatment</u> for allergy care in a Physician’s office.</p> <p>Coverage for an office visit associated with the allergy treatment described herein shall be determined in accordance with the provisions below regarding Physician’s Services.</p>	No	20% after deductible	50% after deductible
<p>3. Ambulance Services</p> <p>Ground Ambulance:</p> <p>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).</p>	No*	20% after deductible	50% after deductible
<p>4. Air Ambulance:</p> <p>Air ambulance transport is covered in the following circumstances:</p> <ul style="list-style-type: none"> • Either: <ul style="list-style-type: none"> 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 	No	20% after deductible	50% after deductible

<p>2. Ground transportation is not appropriate due to distance or need of rapid transit; and</p> <ul style="list-style-type: none"> Such method of transportation is deemed medically required by the attending Physician (<i>e.g.</i>, because of the individual’s medical condition, land transportation cannot be used); and Such method of transportation is in fact an ambulance service and not a charter flight service. <p>*Note: You are not required to notify Personal Health SupportSM. However, for air ambulance, you should call to verify coverage is available.</p>			
<p>5. Chiropractic Services/Spinal Manipulations</p> <p>Covered Health Services include chiropractic therapy and/or adjustments (for Sickness or Injury). X-rays and labs performed in the chiropractor’s office are addressed in the Professional Fees for Surgical and Medical Services section of this Benefits Information Grid.</p> <p>Massage therapy is not a Covered Health Service.</p> <p>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.</p>	No	20% after deductible	50% after deductible
<p>6. COVID-19 Testing and Vaccinations</p> <p>Effective March 18, 2020, Covered Health Services includes COVID-19 testing, related respiratory illness testing and related office (including virtual visits), Urgent Care Center and emergency room visits where the test is ordered or administered. This temporary suspension of cost-sharing will continue during the applicable period of emergency.</p> <p>Effective March 27, 2020, Covered Health Services includes FDA-authorized COVID-19 vaccines that have been either (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, regardless of the administering Provider’s or pharmacy’s network status. This temporary suspension of cost-sharing as related to non-Network Providers will continue through the end of the national emergency period (unless otherwise provided by applicable law). Following expiration of this temporary provision, normal Program rules (including regular cost-sharing requirements, if applicable) for vaccines and preventive care services apply.</p>	No	0% no deductible applies	0% no deductible applies
<p>7. Durable Medical Equipment</p> <p>Durable Medical Equipment must meet all of the following criteria:</p> <ul style="list-style-type: none"> 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 a disease or disability. <p>The Claims Administrator is responsible for determining the coverage criteria for Durable Medical Equipment and has the final determination.</p> <p>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.</p>	Yes, for items over \$1,000*	20% after deductible	50% after deductible
<p>Examples of Durable Medical Equipment include, but are not limited to:</p>			

<ul style="list-style-type: none"> • 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 speech impediment or lack of speech directly attributed to sickness or injury. <p>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.</p> <p>In some cases, benefits may be provided for the replacement of a type of Durable Medical Equipment.</p> <p>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.</p> <p>* Note: It is strongly recommended that you contact Personal Health SupportSM if you have any questions on whether an item will be covered. You are required to contact Personal Health SupportSM for items over \$1,000.</p>			
<p>8. Emergency Room Health Services</p> <p>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.</p> <p>Network benefits are paid for Emergency Room Health Services, even if the services are provided by a non-Network Provider.</p> <p>If you are enrolled in a traditional PPO 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. There is no Emergency room Co-payment for Inpatients and their eligible Dependents. The Emergency room Co-payment is waived if you are admitted to the Hospital from the emergency room. Observation is not considered an admission.</p> <p>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 between 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.</p> <p>*Note: Please remember that if you are admitted to a Hospital as a result of an Emergency, you should notify Personal Health SupportSM within two business days or the same day of admission, or as soon as reasonably possible.</p>	No*	20% after deductible for all Covered Persons, plus a \$100 Co-pay for those enrolled in a traditional PPO plan option	20% after deductible for all Covered Persons, plus a \$100 Co-pay for those enrolled in a traditional PPO plan option
<p>9. Gender Dysphoria</p>	Yes	20% after deductible	50% after deductible

<p>Benefits for the treatment of gender dysphoria limited to the following services:</p> <ul style="list-style-type: none"> • Psychotherapy for gender dysphoria and associated co-morbid psychiatric diagnoses are provided as described under Item 17 (Mental Health Services). • Cross-sex hormone therapy: <ul style="list-style-type: none"> ▪ Cross-sex hormone therapy administered by a Physician (for example during an office visit). ▪ Cross-sex hormone therapy dispensed from a Pharmacy. • Puberty suppressing medication injected or implanted by a Physician in a clinical setting. • Laboratory testing to monitor the safety of continuous cross-sex hormone therapy. <p>Surgery for the treatment for gender dysphoria, including the surgeries listed below:</p> <p>Male to Female:</p> <ul style="list-style-type: none"> • Clitoroplasty (creation of clitoris) • Labiaplasty (creation of labia) • Orchiectomy (removal of testicles) • Penectomy (removal of penis) • Urethroplasty (reconstruction of female urethra) • Vaginoplasty (creation of vagina) <p>Female to Male:</p> <ul style="list-style-type: none"> • Bilateral mastectomy or breast reduction • Hysterectomy (removal of uterus) • Metoidioplasty (creation of penis, using clitoris) • Penile prosthesis • Phalloplasty (creation of penis) • Salpingo-oophorectomy (removal of fallopian tubes and ovaries) • Scrotoplasty (creation of scrotum) • Testicular prosthesis • Urethroplasty (reconstruction of male urethra) • Vaginectomy (removal of vagina) • Vulvectomy (removal of vulva) <p>Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements</p> <p>The Covered Person must provide documentation of the following for breast surgery:</p> <ul style="list-style-type: none"> • A written psychological assessment from at least one qualified behavioral health provider experienced in treating gender dysphoria. The assessment must document that the Covered Person meets all of the following criteria: <ul style="list-style-type: none"> ▪ Persistent, well-documented gender dysphoria; 			
--	--	--	--

<ul style="list-style-type: none"> ▪ Capacity to make a fully informed decision and to consent for treatment; ▪ Must be 18 years or older; and ▪ If significant medical or mental health concerns are present, they must be reasonably well controlled. <p>The Covered Person must provide documentation of the following for genital surgery:</p> <ul style="list-style-type: none"> • A written psychological assessment from at least two qualified behavioral health providers experienced in treating gender dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria. <ul style="list-style-type: none"> ▪ Persistent, well-documented gender dysphoria; ▪ Capacity to make a fully informed decision and to consent for treatment; ▪ Must be 18 years or older; ▪ If significant medical or mental health concerns are present, they must be reasonably well controlled; ▪ Complete at least 12 months of successful continuous full-time real-life experience in the desired gender; and ▪ Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated). <p>The treatment plan is based on identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance.</p> <p>Prior Authorization Requirement for Surgical Treatment:</p> <ul style="list-style-type: none"> • You must obtain prior authorization as soon as the possibility of surgery arises. • If you fail to obtain prior authorization as required, Covered Health Services will be reduced to 50% of Eligible Expenses. <p>Prior Authorization Requirement for Non-Surgical Treatment:</p> <ul style="list-style-type: none"> • Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category. <p>Exclusions:</p> <ul style="list-style-type: none"> • Abdominoplasty • Blepharoplasty • Breast enlargement, including augmentation mammoplasty and breast implant • Body contouring, such as lipoplasty • Brow lift • Calf implants • Cheek, chin, and nose implants • Injection of fillers or neurotoxins • Face lift, forehead lift, or neck tightening • Facial bone remodeling for facial feminizations 			
---	--	--	--

<ul style="list-style-type: none"> • Hair removal • Hair transplantation • Lip augmentation • Lip reduction • Liposuction • Mastopexy • Pectoral implants for chest masculinization • Rhinoplasty • Skin resurfacing • Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the adam’s apple) • Voice modification surgery • Voice lessons and voice therapy 			
<p>10. Habilitative Services</p> <p>Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>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.</p> <p>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.</p> <p>Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under <i>Durable Medical Equipment</i> and <i>Prosthetic Devices</i>.</p>	No	20% after deductible	50% after deductible
<p>11. Hearing Care</p> <p>Audiologist</p> <p>Coverage limited to charges by a licensed or certified audiologist for Physician-prescribed hearing evaluations to determine location of a disease within the auditory</p>	No	20% after deductible	50% after deductible

<p>system. The Program covers tests and treatment due to illness and Injury only. An audiometric exam is covered in conjunction with medical illness.</p> <p>Hearing Aid</p> <p>Coverage limited to one hearing aid per ear every sixty (60) months. The Program will not cover duplicates or replacements for lost or stolen hearing aids.</p> <p>Hearing Evaluation</p> <p>Coverage limited to one hearing evaluation every sixty (60) months for one or both ears.</p>			
<p>12. Home Health Care</p> <p>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 SupportSM 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.</p> <p>Services must be both of the following:</p> <ul style="list-style-type: none"> • Ordered by a Physician. • Provided by an agency that is licensed by the state as a Home Health Care Agency and is Medicare certified. <p>If a patient qualifies for coverage under the home health benefit, the following services may be covered:</p> <ul style="list-style-type: none"> • Registered Nurse • Licensed Practical Nurse • Home Health Aide or Certified Nursing Assistant • Physical Therapist/Occupational Therapist/Speech Therapist • Medical Social Worker • Intravenous medications and TPN • Intravenous supplies • Wound care supplies • Enteral feeding formula and supplies when the enteral feeds are needed due to an inborn error in metabolism • Dietician • Line maintenance supplies <p>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.</p> <p>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.</p> <p>*Note: Please remember to notify Personal Health SupportSM five business days before receiving services.</p>	<p>Yes*</p>	<p>20% after deductible</p>	<p>50% after deductible</p>
<p>13. Hospice Care</p>	<p>Yes*</p>	<p>20% after deductible</p>	<p>50% after deductible</p>

<p>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.</p> <p>Services must be provided by an agency that is licensed by the state as a home health or Hospice Agency and is Medicare certified.</p> <p>If a patient qualifies for coverage under the hospice benefit, the following services may be covered in the home:</p> <ul style="list-style-type: none"> • Registered Nurse • Licensed Practical Nurse • Home Health Aide or Certified Nursing Assistant • Medical Social Worker • IV medications and supplies related to the terminal condition • Wound care supplies <p>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.</p> <p>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.</p> <p>Coverage for room and board is subject to a lifetime limit of 30 days.</p> <p>Durable Medical Equipment is covered under the regular Durable Medical Equipment benefit.</p> <p>For prescription drugs (other than IV), see the <i>Prescription Drug Benefits</i> section beginning on page 68 of this SPD.</p> <p>There is no coverage for bereavement counseling or chaplain services.</p> <p>*Note: Please remember to notify Personal Health SupportSM five business days before receiving services.</p>			
<p>14. Hospital – Inpatient Stay</p> <p>Benefits are available for:</p> <ul style="list-style-type: none"> • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). <p>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 (<i>e.g.</i>, infectious hepatitis, spinal meningitis, severe burns).</p> <p>*Note: Please remember that if you are admitted to a Hospital, you should notify Personal Health SupportSM within two business days or the same day of admission, or as soon as reasonably possible.</p>	Yes*	20% after deductible	50% after deductible
<p>15. Infertility Services</p> <p>Therapeutic services for the treatment of infertility when provided by or under the direction of a Physician. Infertility benefits are limited to the following procedures:</p> <ul style="list-style-type: none"> • Assisted Reproductive Technologies (ART); • Frozen embryo transfer cycle including the associated cryopreservation and storage of embryos; • Intracytoplasmic Sperm Injection (ICSI); 	No	20% after deductible	100% after deductible

<ul style="list-style-type: none"> • Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)); • Embryo transportation related network disruption; • Ovulation induction (or controlled ovarian stimulation); • Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA), a male factor associated surgical procedures for retrieval of sperm; • Surgical procedures: laparoscopy, lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, ovarian cystectomy; • Electroejaculation; • Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo; and • Treatment for the diagnosis and treatment of the underlying cause of infertility is covered as described in this SPD. Benefits for diagnostic tests are described in Item 21 (Outpatient Surgery, Diagnostic and Therapeutic Facility Services). <p>To be eligible for the infertility services, the Covered Person must have a diagnosis of infertility. To meet the definition of infertility, the Covered Person must meet one of the following:</p> <ul style="list-style-type: none"> • Not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination: <ul style="list-style-type: none"> ▪ one year, if you are a female under age 35, or ▪ six months, if you are a female age 35 or older; • A female and have failed to achieve or maintain a pregnancy due to impotence/sexual dysfunction; • A male and have a diagnosis of a male factor causing infertility (e.g., treatment of sperm abnormalities including the surgical recovery of sperm); • A female: <ul style="list-style-type: none"> ▪ under age 44 and using own oocytes (eggs), or ▪ under age 55 and using donor oocytes (eggs); or • Have infertility that is not related to voluntary sterilization or failed reversal of a voluntary sterilization. <p>For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.</p> <p>The Fertility Solutions is a program administered by UnitedHealthcare or its affiliates. The Fertility Solutions program provides:</p> <ul style="list-style-type: none"> • Specialized clinical consulting services to Covered Persons to educate on infertility treatment options; and • Access to specialized Network facilities and Physicians for infertility services. <p>The Program pays benefits for the infertility services described above when provided by Designated Providers participating in the Fertility Solutions program. The Fertility Solutions program provides education, counseling, infertility management and access to a national network of premier infertility treatment clinics.</p>			
--	--	--	--

<p>Covered Persons who do not live within a 60 mile radius of a Fertility Solutions Designated Provider will need to contact an Fertility Solutions case manager to determine a Network Provider prior to starting treatment. For infertility services and supplies to be considered Covered Health Services through the Fertility Solutions program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.</p> <p>Covered Persons may:</p> <ul style="list-style-type: none"> • Be referred to Fertility Solutions by UnitedHealthcare; • Call the telephone number on your ID card; or • Call Fertility Solutions directly at (866) 774-4626. <p>To take part in the Fertility Solutions program, call a nurse at (866) 774-4626. The Fertility Solutions program will only pay benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).</p> <p>The following infertility treatment-related services are NOT covered under the Program:</p> <ul style="list-style-type: none"> • Cryo-preservation and other forms of preservation of reproductive materials except as described in this section; • Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue; • Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees; • Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes; • Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor; • Ovulation predictor kits; or • The following services related to gestational carrier or surrogate: <ul style="list-style-type: none"> ▪ Fees for the use of a gestational carrier or surrogate, ▪ Insemination costs of surrogate or transfer embryo to gestational carrier, ▪ IVF for a traditional surrogate, ▪ Pregnancy services for a gestational carrier or surrogate who is not a Covered Person, and ▪ Costs of donor eggs and donor sperm. 			
<p>16. Maternity Services</p> <p>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.</p> <p>The Program will pay benefits for an Inpatient Stay of at least:</p> <ul style="list-style-type: none"> • 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. <p>If the mother agrees, the attending Provider may discharge the mother and/or the newborn child earlier than these minimum time frames.</p>	No*	20% after deductible	50% after deductible

<p>*Note: Please remember that if you are admitted to a Hospital, you should notify Personal Health SupportSM within two business days or the same day of admission, or as soon as reasonably possible.</p>			
<p>17. Mental Health Services</p> <p>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.</p> <p>Benefits include the following levels of care:</p> <ul style="list-style-type: none"> • Inpatient treatment. • Residential Treatment. • Partial Hospitalization/Day Treatment. • Intensive Outpatient Treatment • Outpatient treatment. <p>Services include the following:</p> <ul style="list-style-type: none"> • 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
<p>18. Nutritional Counseling</p> <p>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.</p> <p>Some examples of such medical conditions include:</p> <ul style="list-style-type: none"> • 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
<p>19. Obesity Surgery</p> <p>Benefits under this section include surgical treatment of morbid obesity. Currently, the Program follows guidelines set by the Claims Administrator.</p> <p>Limitations:</p> <ul style="list-style-type: none"> • Benefits are limited to one surgery per lifetime per Covered Person. 	Yes	20% after deductible	100% after deductible

<ul style="list-style-type: none"> • Repeat bariatric or lap band repair are covered only if the following guidelines are adhered to: <ul style="list-style-type: none"> ▪ 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>i.e.</i>, breakdown 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 reinstatement of an acceptable bariatric surgical modality. <p>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-Area Plan.</p> <p>Note: It is important to contact the Claims Administrator to determine allowable coverage prior to services being rendered.</p>			
<p>20. Oral Surgery</p> <p>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 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 <i>Dental Benefits</i> section beginning on page 72 of this SPD for additional oral surgery coverage.</p> <p>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 a Dental Benefit.</p> <p>*Note: You are not required to notify Personal Health SupportSM; however, it is strongly recommended that you contact Personal Health SupportSM to verify that the services you require are covered under this benefit.</p>	No*	20% after deductible	50% after deductible
<p>21. Outpatient Surgery, Diagnostic and Therapeutic Facility Services</p> <p>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 24 (Professional Fees for Surgical and Medical Services).</p> <p>Covered Health Services received on an Outpatient basis at a Hospital or Alternate Facility, including:</p> <ul style="list-style-type: none"> • 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). 	No	20% after deductible	50% after deductible
<p>22. Physician's Services</p> <p>Benefits for Physician's services include:</p>	No	20% after deductible; 0% no	50% after deductible (video

<ul style="list-style-type: none"> • 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. • Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices for Disease Control and Prevention if such recommendation went into effect at least one year prior to the beginning of the plan year (e.g., if an immunization received a recommendation on March 15, 2018, the Program will cover such immunization effective January 1, 2020). • 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. • Effective March 27, 2020 through December 31, 2022 (unless otherwise provided by applicable law), non-COVID-19 telehealth and virtual visits with specific telehealth Network Providers (as determined by the Claims Administrator) will be payable for a Covered Person. <p>Not Covered:</p> <ul style="list-style-type: none"> • Routine/preventive health checkups (except as described below). • Immunizations associated with employer-required travel (except as described above). • Video consultations, including virtual visits, from a non-Network Provider. 		deductible applies for non-COVID-19 telehealth and virtual visits (through December 31, 2022, unless otherwise provided by applicable law)	consultations including virtual visits from a non-Network Providers are not covered)
<p>23. Preventive Care Services</p> <p>The Program covers preventive care services in accordance with the PPACA, as modified by the Healthcare and Education Reconciliation Act of 2010. Preventive care services are covered at 100% by the Program if you use a Network Provider and the primary purpose of your visit is the delivery of such preventive care service. If you use a non-Network Provider, you will be subject to the applicable Co-insurance. For additional information on preventive care services covered by the Program, please visit: www.healthcare.gov/center/regulations/prevention.html, www.uspreventiveservicestaskforce.org, or www.cdc.gov/vaccines.</p> <p>Immunizations – Benefits are payable in any plan year for immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practice for Disease Control and Prevention if such recommendation went into effect at least one year prior to the beginning of such plan year.*</p> <p>Well Child Preventive Care – Benefits are payable in any plan year for infants, children and adolescents for preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration if such guideline is issued at least on year prior to the beginning of such plan year.*</p>	No	0% no deductible applies	50% no deductible applies

<p>Well Woman Preventive Care – Covered health services are payable for one annual routine gynecological exam which includes a physician pelvic and breast exam. Covered health services for a PAP smear will be payable according to United States Preventive Services Task Force (USPSTF) recommendations. The USPSTF currently recommends screening for cervical cancer in women ages 21 to 65 years with cytology (PAP smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.* The Claims Administrator, in its sole discretion, may define well women preventive care services to include services beyond those required by the PPACA.</p> <p>Grade A and Grade B Recommended Services – Benefits are payable in any plan year for items or services that have in effect a rating of A or B in the current recommendation of the USPSTF if such recommendation went into effect at least one year prior to the beginning of such plan year.*</p> <p>NOTE: This section only describes preventive care services. Diagnostic services are covered at the appropriate Co-insurance level without age limits.</p> <p>* For example, if an immunization or service received a recommendation on March 12, 2018, the Program will cover such immunization or service effective January 1, 2020.</p>			
<p>24. Professional Fees for Surgical and Medical Services</p> <p>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:</p> <ul style="list-style-type: none"> • Pathology. • X-ray/diagnostic interpretation. • Anesthesiology. • Radiation therapy. 	No	20% after deductible	50% after deductible
<p>25. Prosthetic Devices</p> <p>Prosthetic devices that replace a limb or body part including:</p> <ul style="list-style-type: none"> • 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. • Orthotic appliance and devices when prescribed by a Physician and custom manufactured or custom fitted to you by a Physician. 	No	20% after deductible	50% after deductible
<p>The following orthotic appliance and devices are NOT covered:</p> <ul style="list-style-type: none"> • 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 subluxation of the foot; • Any braces or orthotic appliances that can be obtained without a Physician’s order; and 			

<ul style="list-style-type: none"> Any other orthotic appliance or device determined unnecessary by the Claims Administrator. <p>It is recommended that you contact Personal Health SupportSM if you have any questions on whether an item will be covered.</p> <p>If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.</p> <p>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.</p> <p>Duplicates and replacement of stolen prosthetic devices are not covered.</p>			
<p>26. Reconstructive Procedures</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 <i>Contact Information</i> beginning on page 141.</p> <p>Cosmetic Procedures are always excluded from coverage.</p> <p>*Note: You should notify Personal Health SupportSM before receiving services. When you provide notification, Personal Health SupportSM can verify that the services are a reconstructive procedure rather than a Cosmetic Procedure.</p>	Yes*	20% after deductible	50% after deductible
<p>27. Rehabilitation Services – Outpatient Therapy</p> <p>Rehabilitation services must be performed by a licensed therapy Provider, under the direction of a Physician.</p> <p>Outpatient rehabilitation services for:</p>	No	20% after deductible	50% after deductible

<ul style="list-style-type: none"> Physical therapy. Occupational therapy. Cardiac rehabilitation therapy. Pulmonary rehabilitation therapy. <p>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.</p>			
<p>28. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p> <p>Covered Health Services include services for an Inpatient Stay in a Skilled Nursing Facility or non-acute Inpatient Rehabilitation Facility. Benefits are available for:</p> <ul style="list-style-type: none"> Services and supplies received during the Inpatient Stay. Room and board in a Semi-private Room (a room with two or more beds). <p>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.</p> <p>The Covered Person is expected to improve to a predictable level of recovery.</p> <p>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).</p> <p>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.</p> <p>*Note: Please remember to notify Personal Health SupportSM five business days prior to your admission.</p>	Yes*	20% after deductible	50% after deductible
<p>29. Speech Therapy</p> <p>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 from the American Speech and Hearing Association, and (iii) where applicable, is licensed by the state.</p> <p>Speech therapy is limited to sixty (60) visits per Covered Person, per calendar year.</p>	No	20% after deductible	50% after deductible
<p>30. Substance Abuse Services</p> <p>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.</p> <p>Benefits include the following levels of care:</p>	No	20% after deductible	50% after deductible

<ul style="list-style-type: none"> • Inpatient treatment. • Residential Treatment. • Partial Hospitalization/Day Treatment. • Intensive Outpatient Treatment • Outpatient treatment. <p>Services include the following:</p> <ul style="list-style-type: none"> • 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. 			
<p>31. Temporomandibular Joint Dysfunction (TMJ)</p> <p>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, congenital defect, developmental defect, or oropathology. Please note that benefits are not available for charges for services that are dental in nature.</p>	No	20% after deductible	50% after deductible
<p>32. Transplantation Services</p> <p>Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a Designated Provider(s) or a Caterpillar designated facility to receive full benefits.</p> <p>URN Facilities may change from time to time. For information on current URN facilities, contact the Claims Administrator at the number on your ID card or in the section entitled <i>Contact Information</i> beginning on page 141. It is your responsibility to determine what facilities qualify as URN Facilities before you receive services or treatment.</p> <p>Generally, services by radiologists, anesthesiologists and pathologists are included in covered expenses and subject to limitations.</p> <p>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:</p> <ul style="list-style-type: none"> • Bone marrow/peripheral stem cell transplants (not all bone marrow transplants meet the definition of a Covered Health Service). • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Pancreas transplants. • Kidney/pancreas transplants. • Liver transplants. 	Yes*	20% after deductible	50% after deductible

<ul style="list-style-type: none"> • Cornea transplants (it is not required that a cornea transplant be performed at a designated facility). <p>The Claims Administrator will determine if the transplant is a Covered Health Service.</p> <p>Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Personal Health SupportSM 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 SupportSM at the telephone number on your ID card or in the section entitled <i>Contact Information</i> beginning on page 141.</p> <p>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.</p> <p>If the transplant is a Covered Health Service and it is:</p> <ul style="list-style-type: none"> • Received at a Designated Provider(s) or a Caterpillar designated facility, benefits will be payable at the appropriate Network Co-insurance level (after you meet your deductible). • Received at a non-Designated Provider(s), benefits will be payable at 50% of Eligible Expenses (after you meet your deductible). <p>*Note: Personal Health SupportSM notification is required for all transplant services. You must notify Personal Health SupportSM within seven (7) business days before the scheduled date of any of the following:</p> <ul style="list-style-type: none"> • The evaluation. • The donor search. • The organ procurement/tissue harvest. • The transplant. <p>You should notify Personal Health SupportSM as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).</p>			
<p>33. Urgent Care Center Services</p> <p>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 22 (Physician’s Services) earlier in this section.</p>	No	20% after deductible	50% after deductible

¹ See the *Description of Network and Non-Network Benefits* section beginning on page 63 to understand which Providers are considered Network Providers in the Caterpillar Network and which are considered Network Providers in the UnitedHealthcare Network.

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 31 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 72 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 20, Oral Surgery, of the *Benefits Information Grid* beginning on page 37 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 68 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.

Please note, however, approved clinical trials are covered to the extent required by the PPACA. Please refer to the definition of Experimental or Investigational Services on page 162 of this SPD for more information.

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 as described under Item 25 (Prosthetic Devices) of the *Benefits Information Grid* beginning on page 37; and
- Special shoes unless they are an integral part of a leg brace or scoliosis appliance as described under Item 25 (Prosthetic Devices) of the *Benefits Information Grid* beginning on page 37.

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 7 (Durable Medical Equipment) of the *Benefits Information Grid* beginning on page 37.

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*;
- 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 the Nutritional Counseling section of the *Benefits Information Grid* beginning on page 37, 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 144 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 26 (Reconstructive Procedures) of the *Benefits Information Grid* beginning on page 37;
- 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, unless otherwise required by law;
- 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, except those described under Item 15 (Infertility Services) of the *Benefits Information Grid* beginning on page 37;

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 32 (Transplantation Services) of the *Benefits Information Grid* beginning on page 37;
- 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 32 (Transplantation Services) of the *Benefits Information Grid* beginning on page 37.

TRAVEL

- Travel or transportation expenses, even though prescribed by a Physician.
- Immunizations required for travel except for those covered under Item 23 (Preventive Care Services) of the *Benefits Information Grid* beginning on page 37.

VISION

Refer to the *Vision Benefits* section beginning on page 80 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 144 of this SPD.);
- Vaccinations and immunizations that are associated with employer-required travel, except those covered under Item 22 (Physician's Services) of the *Benefits Information Grid* beginning on page 37;
- 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 31 of this SPD.

COMPARISON OF NETWORK AND NON-NETWORK BENEFITS

	Network	Non-Network
Benefits	Discounted charges means less cost to you. See the <i>What's Covered – Benefits</i> section beginning on page 31.	Charges based upon accepted market reimbursement which may mean a lower level of benefits and more cost to you. See the <i>What's Covered – Benefits</i> section beginning on page 31.
Who Should File Claims?	You are responsible for ensuring that a claim has been filed; however, a Provider may file claims on	You are responsible for ensuring that a claim has been filed; however, a Provider may file claims on

	Network	Non-Network
	your behalf. See the <i>Filing a Claim for Benefits</i> section beginning on page 110.	your behalf. See the <i>Filing a Claim for Benefits</i> section beginning on page 110.
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, 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 section entitled *Contact Information* beginning on page 141, 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 Network or other discounts for services, treatments, items or supplies that are not covered under the Program.

DESIGNATED UNITED RESOURCE NETWORK FACILITIES AND OTHER PROVIDERS

If you have a medical condition that Personal Health SupportSM believes needs special services, they may direct you to a Designated Provider(s) or other Provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Personal Health SupportSM 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(s) or other Provider chosen by Personal Health SupportSM.

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 the 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. 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 141. 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 a non-Network Provider provides the services. If you are confined in a non-Network Hospital after receiving Emergency Room Health Services, Personal Health SupportSM must be notified within two business days or on the same day of admission if reasonably possible. Personal Health SupportSM 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 SupportSM 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-pay 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-pay will apply. The Emergency room Co-pay information can be found in the tables located in the *Benefits at a Glance* section beginning on page 35.

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 31 of this SPD.

COMPARISON OF NETWORK AND NON-NETWORK BENEFITS

	Network	Non-Network
Benefits	Discounted charges means less cost to you. See the <i>What's Covered – Benefits</i> section beginning on page 31.	Charges based upon accepted market reimbursement which may mean a lower level of benefits and more cost to you. See the <i>What's Covered – Benefits</i> section beginning on page 31.
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 <i>Filing a Claim for Benefits</i> section beginning on page 110.	You are responsible for ensuring that a claim has been filed; however, a Provider may file claims on your behalf. See the <i>Filing a Claim for Benefits</i> section beginning on page 110.
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 Provider in order to receive Network Benefits. A Provider 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 non-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 Claims Administrator at the number on your ID card or in the section entitled *Contact Information* beginning on page 141, 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 Network or other discounts for services, treatments, items or supplies that are not covered under the Program.

DESIGNATED UNITED RESOURCE NETWORK FACILITIES AND OTHER PROVIDERS

If you have a medical condition that Personal Health SupportSM believes needs special services, they may direct you to a Designated Provider(s) or other Provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Personal Health SupportSM 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(s) or other Provider chosen by Personal Health SupportSM.

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 the 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. 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 141. 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 SupportSM must be notified within two business days or on the same day of admission if reasonably possible. Personal Health SupportSM 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 SupportSM 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-pay 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-pay will apply. The Emergency room Co-pay information can be found in the tables located in the *Benefits at a Glance* section beginning on page 35.

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 section entitled *Contact Information* beginning on page 141, 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.

DESIGNATED UNITED RESOURCE NETWORK FACILITIES AND OTHER PROVIDERS

If you have a medical condition that Personal Health SupportSM believes needs special services, they may direct you to a Designated Provider(s) or other Provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Personal Health SupportSM 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(s) or other Provider chosen by Personal Health SupportSM.

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 SupportSM 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-pay 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-pay will apply. The Emergency room Co-pay information can be found in the Plan Option tables located in the *Benefits at a Glance* section beginning on page 35.

PRESCRIPTION DRUG BENEFITS

ELIGIBILITY FOR PRESCRIPTION DRUG BENEFITS

You are eligible for prescription drug benefits under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled *Eligibility* beginning on page 3 and any additional requirements described in this section. International Service Employees who are eligible for prescription drug benefits under another plan sponsored by the Company or a Related Company are not eligible for prescription drug benefits under the Program.

OVERVIEW OF PRESCRIPTION DRUG BENEFITS

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 Health Services 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 Health Services 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 Health Services for reimbursement.

BCBS NATIONAL EPO AND UHC CHOICE PLUS PPO PLAN OPTIONS

If you are enrolled in a PPO or EPO 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. In no event, though, will the combined prescription drug coverage Maximum Out-of-pocket and medical benefits coverage Maximum Out-of-Pocket exceed the annual federal limit provided under the PPACA.

The following examples help illustrate how this works.

Suppose that you are enrolled in individual coverage under the UHC Choice Plus PPO plan option with a medical benefits coverage Maximum Out-of-Pocket of \$3,000 for the 2021 calendar year. In 2021, the annual federal maximum out-of-pocket limit provided under the PPACA is \$8,550 for individual coverage.

Example 1. As of May 1, 2021, you have accumulated \$3,000 in medical expenses that apply to your medical benefits coverage Maximum Out-of-Pocket. You have met your medical benefits coverage Maximum Out-of-Pocket and benefits for Covered Health Services under your medical benefits coverage are payable at 100% during the remainder of the calendar year. Your prescription drug coverage maximum out-of-pocket, however, is not met until you accumulate \$5,550 in prescription drug expenses. Once you have accumulated \$5,550 in prescription drug expenses, your medical benefits coverage Maximum Out-of-Pocket of \$3,000 and prescription drug coverage out-of-pocket maximum of \$5,550 add up to the federal limit of \$8,550 and your prescription drug benefits will also then be payable at 100% of Eligible Expenses.

Example 2. As of May 1, 2021, you have accumulated \$6,400 in prescription drug expenses that apply to your prescription drug coverage maximum out-of-pocket and \$2,150 in medical expenses that apply to the medical benefits coverage Maximum Out-of-Pocket. You have met both your prescription drug coverage out-of-pocket maximum and your medical benefits coverage Maximum Out-of-Pocket because you have reached the combined federal limit of \$8,550. Benefits for Covered Health Services under your medical benefits coverage and prescription drug benefits are payable at 100% of Eligible Expenses during the remainder of the calendar year.

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 Health Services 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 Health Services 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.

MAIL SERVICE PROGRAM

- Prescription drugs can be purchased through the mail from AllianceRx Walgreens Prime 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 Prime Home Delivery at (866) 840-1222 (TTY for deaf: (800) 573-1833) 24 hours a day, seven days a week. Order forms and instructions are available at benefits.cat.com under the “U.S. RX” tab, or you can call AllianceRx Walgreens Prime Home Delivery.

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 Health Services 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.
- If a manufacturer assistance program, copay card or other such patient assistance program is used when filling a prescription medication, the dollar amount paid by such program shall not count towards the Annual Deductible or Maximum Out-of-Pocket limit (if applicable).

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

- 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.

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.*, 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 Health Services at (877) 228-7909.

The Co-payment or Co-insurance amounts for drugs purchased at an Out-of-Network or Non-Network Pharmacy 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 0” or “Tier 1,” or less than the Co-insurance minimum amount for “Tier 2,” “Tier 3,” a Compounded Drug or “Tier 4.”

Medicare Part D. You are not required to enroll in Medicare Part D.

If you qualify for Medicare and you are enrolled in PPO coverage under the Program, prescription drug coverage under the Program is, on average, as good as or better than standard Medicare Part D prescription drug coverage. This means you can keep the coverage under the Program 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 notice you received regarding your prescription drug coverage under the Program and Medicare.

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

DENTAL BENEFITS

ELIGIBILITY FOR DENTAL BENEFITS

You are eligible for dental benefits under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled *Eligibility* beginning on page 3 and any additional requirements described in this section. International Service Employees who are eligible for dental benefits under another plan sponsored by the Company or a Related Company, Supplemental Employees and Temporary Employees are not eligible for dental benefits under the Program.

OVERVIEW OF DENTAL BENEFITS

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 (800) 244-6224.

Cigna Dental ID cards are available by contacting Cigna Dental at (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, it is recommended that you 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 73.

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 orthodontic life maximum 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. Subject to orthodontic lifetime maximum.

Deductible/Annual Maximum	Amount
Annual Individual Deductible	\$50
Annual Family Deductible	\$100
Annual Maximum Benefit	\$1,500 per Covered Person age 18 and older. No annual maximum amount (other than expenses for Orthodontic Treatment) for Covered Persons under age 18.
Lifetime Orthodontic Maximum Benefit	\$1,500 per Covered Person age 21 and under

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 144 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 78.

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 73.

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 conjunction with regular prophylaxis. Annual Deductible does not apply.
Sealants	Limited to one treatment per Covered Person under the age of 14 every three calendar years on unrestored primary 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.

Benefit Description	Special Limitations
Cosmetic Bonding	For Covered Persons ages 8 to 19 years of age 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 flurosis, 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	
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 <i>Medical Benefits</i> section beginning on page 31 of this SPD for additional coverage for Oral Surgery (e.g., treatment of fractures and reduction of dislocation). Refer to <i>Major Dental Services</i> beginning on page 76 for implants.

Benefit Description	Special Limitations
Adjunctive Services	
<p>Analgesia</p> <p>Desensitizing Medicament</p> <p>General Anesthesia</p> <p>Intravenous Sedation and Analgesia</p> <p>Injection of antibiotics</p> <p>Occlusal Adjustment</p>	<p>Coverage for Analgesia limited to Dependent children who are 0 to 6 years of age, or patients with behavioral problems or physical disabilities.</p> <p>Coverage for General Anesthesia only when administered in connection with oral surgery or other Covered Dental Services.</p> <p>Pretreatment estimate is suggested to deem medical necessity.</p>
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
<p>Crowns</p> <p>Gold Inlay or Onlay</p> <p>Porcelain Onlays</p> <p>Post & Cores for Single Tooth Crown (only for teeth that have had root canal therapy)</p>	<p>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.</p>
Fixed Bridges	<p>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 procedure cannot restore the teeth.</p> <p>Preauthorization recommended prior to treatment.</p>
Dentures – Full	<p>Limited to one time per 60 consecutive months.</p> <p>Includes precision attachments for dentures.</p> <p>Includes adjustments during the six-month period following installation.</p> <p>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.</p>
Dentures – Partial	<p>Limited to one time per 60 consecutive months.</p> <p>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.</p>
Implants	<p>Limited to one time per 60 consecutive months. Covered only when a less expensive procedure cannot restore the tooth.</p> <p>Preauthorization recommended prior to treatment.</p>

Benefit Description	Special Limitations
Orthodontic Treatment	Limited to Covered Persons under age 21, 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 and under (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. Orthodontic services are subject to the orthodontic lifetime maximum.

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 Dental Benefits* section beginning on page 72 does not apply to orthodontic services.

DENTAL BENEFITS – GENERAL EXCLUSIONS

Except as may be specifically provided in the *Covered Dental Services* section beginning on page 72 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 *Medical Benefits* section beginning on page 31 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 68 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 20 (Oral Surgery) of the *Benefits Information Grid* beginning on page 37 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 20 (Oral Surgery) of the *Benefits Information Grid* beginning on page 37 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 20 (Oral Surgery) of the *Benefits Information Grid* beginning on page 37 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 72. 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 Covered Persons 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.

VISION BENEFITS

ELIGIBILITY FOR VISION BENEFITS

You are eligible for vision benefits under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled *Eligibility* beginning on page 3 and any additional requirements described in this section. International Service Employees who are eligible for vision benefits under another plan sponsored by the Company or a Related Company, Supplemental Employees and Temporary Employees are not eligible for vision benefits under the Program.

OVERVIEW OF VISION BENEFITS

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 BENEFITS – 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.

FLEXIBLE SPENDING ACCOUNT PLAN

FSA PLAN ELIGIBILITY

You are eligible to participate in the Flexible Spending Account Plan (“FSA Plan”) if you satisfy the eligibility criteria applicable to Employees (described in the section entitled *Eligibility* beginning on page 3 of this SPD) and any additional requirements described in this section. Under the FSA Plan, you can elect to establish two Flexible Spending Accounts. These accounts let you make pre-tax contributions from your salary, which can then be used to reimburse yourself for eligible expenses.

The Health Care Flexible Spending Account (“HCFSA”) is a type of FSA used for reimbursement of eligible healthcare expenses (defined in the Health Care Flexible Spending Account section), including certain medical, dental and vision expenses for you, your Spouse, your dependent children, and any other dependents as determined by Caterpillar Inc. and in compliance with the Internal Revenue Code.

- If you are enrolled in a CDHP plan option, the HCFSA you are eligible for is considered a Limited Purpose FSA (“LPFSA”). Under a LPFSA, eligible expenses include *only* certain dental and vision expenses. Eligible expenses from your LPFSA *do not include* general medical expenses.
- If you are enrolled in the PPO or EPO plan option, the HCFSA you are eligible for is considered a General Purpose FSA (“GPFSA”). Under a GPFSA, eligible expenses include certain medical, dental, and vision expenses.

If you are an Expatriate, you will no longer be eligible for the GPFSA or the LPFSA at the end of the year in which you become eligible to participate in the Caterpillar Inc. International Service Employee Healthcare Plan (the “International Plan”), provided you remain eligible for the International Plan at the end of such year.

The Dependent Care Flexible Spending Account (“DCFSA”) is a type of FSA used for reimbursement of eligible dependent care expenses (as defined in the Dependent Care FSA section), such as daycare.

FSA PLAN PARTICIPATION

WHEN YOU MAY ENROLL

You may elect to participate in the FSA Plan during your first 30 days of employment or during any subsequent Annual Enrollment Period. There will be one Annual Enrollment Period each year, at which time you indicate how much, if any, pre-tax earnings you want to contribute to the respective accounts for the next calendar year. You must re-enroll each year if you want to continue to participate.

You should carefully consider the decision to enroll for the following reasons:

- You generally cannot change the amount you set aside during the year, unless you have a qualified change in family status.
- Your contributions for the plan year can be used to reimburse expenses that you incur during the period beginning January 1 (or your participation date, if later) through December 31. Please note that the FSA Plan does not permit any extension beyond this date in which to incur eligible expenses.
- Expenses for the plan year must be filed within 90 days of the end of that plan year (*i.e.*, March 31 of the next plan year). Any unused balance left in your Dependent Care FSA will be lost. This “use it or lose it” rule is mandated by federal income tax laws. Any balances “lost” may be used by the Company to offset the administrative costs or as otherwise permitted by law. However, if you have any unused balance in your HCFSA after all claims filed for the plan year have been submitted and processed, you may carryover unused balances up to the limit set by the Internal Revenue Service (currently \$550), or otherwise described below, into the following plan year for expenses incurred in that plan

year. You must reenroll in the HCFSA for the following plan year to have access to funds carried over for that year. The Plan Administrator will communicate the annual carryover limit for unused balances as part of the Annual Enrollment Period process.

- Authorizing pre-tax deductions reduces your salary base for Social Security calculation purposes. In most cases, the impact to your future Social Security benefits will be minimal.

If you do not elect to participate during your first 30 days of employment or choose not to enroll during the Annual Enrollment Period, you must wait until the next Annual Enrollment Period to elect to participate in the FSA Plan, unless you have experienced a qualified change in family status prior to November 1 of any FSA Plan year. See the section entitled *Changing Your Coverage* beginning on page 13 for a description of the changes in status that permit you to change your coverage under the FSA Plan. You will need to enroll each year, even if you enrolled in the FSA Plan the year before. However, see the section entitled *Permitted 2021 Mid-Year Flexible Spending Account Changes* on page 15 regarding special 2021 mid-year enrollments in the FSA Plan.

HOW TO ENROLL

You may elect to participate in the FSA Plan by calling the Caterpillar Benefits Center at (877) 228-4010 or by visiting CatBenefitsCenter.com. You must specify whether you want to elect to participate in the HCFSA and/or the Dependent Care FSA. You must specify the amount of pre-tax dollars you wish to contribute to the FSA Plan.

WHEN PARTICIPATION ENDS

You will cease to participate in the FSA Plan as of the earlier of:

- The date you cease to be an Eligible Person;
- The date you revoke your election, including reducing your election to \$0.00;
- The date on which the FSA Plan terminates; and
- The date you fail to make a required contribution under the terms of the FSA Plan.
- If you are an Expatriate, your participation in the HCFSA will end on the last day of the year in which you become and remain eligible for the International Plan.

You may submit a claim for reimbursement of eligible health care expenses that were incurred during the plan year of termination, as long as those expenses were incurred prior to the date of your termination in the HCFSA. You may submit a claim for reimbursement of eligible dependent care expense that were incurred during the plan year of termination, as long as those expenses were incurred prior to the date of your termination in the Dependent Care FSA.

Any such claims must be submitted on or before March 31 of the next plan year.

All contributions stop when your pay stops.

If during the plan year in which you enrolled you terminate employment due to an unpaid Leave of Absence your participation in the FSA Plan will depend on whether the Leave of Absence is a Family Leave of Absence. Your participation in the FSA Plan during a Family Leave of Absence will continue, provided you pay the required contributions. Your participation in the FSA Plan during a non-Family Leave of Absence will terminate, and you may elect to continue your coverage under the HCFSA pursuant to your COBRA rights, as described in the *Continuation of Benefits (COBRA)* section.

See the section entitled *Continuation of Benefits (COBRA)* beginning on page 25 for a description of your COBRA rights under the HCFSA.

SPECIAL 2021 FSA PLAN RULES

As described in more detailed in the section entitled *Permitted 2021 Mid-Year Flexible Spending Account Changes* on page 15 regarding special 2021 mid-year enrollments in the FSA Plan, as a result of the challenges of the COVID-19 national emergency, during the 2021 FSA Plan year, you may prospectively revoke an election under the FSA Plan, make a new election to enroll in the FSA Plan, or change your election to increase or decrease your contributions to a flexible spending account prior to November 1, 2021.

Additionally, after all claims for reimbursement have been submitted and processed, any unused amounts remaining in your HCFSA or Dependent Care FSA for the 2020 plan year may be carried over into the 2021 plan year. You must re-enroll in the HCFSA or Dependent Care FSA for the 2021 plan year with a minimum contribution of \$75 to access 2020 funds carried over.

OVERVIEW OF FSA PLAN

Under current federal tax laws, the FSA Plan can provide you with an opportunity to pay health care and dependent (child or elder) care expenses with pre-tax earnings. This method of paying for health care and dependent care expenses allows you to realize tax savings on the dollars spent for those types of expenses. An amount equal to your elected payroll deduction will be credited to your FSA Plan account each pay period before taxes are calculated. Because your taxable salary is less, your federal, state and local taxes (note: not all state and local taxes allow the tax advantage to FSA Plan participants) as well as your FICA taxes are lower. The W-2 issued to you at year-end will reflect your earnings minus the FSA Plan deductions. You are reimbursed for health care and dependent care expenses from your individualized accounts. Under the FSA Plan, you can elect to establish two flexible spending accounts. You can elect to participate in the HCFSA, and you can also elect to participate in the Dependent Care FSA.

You can elect to make payroll deductions each plan year (January 1 through December 31) to your HCFSA and/or Dependent Care FSA. Then, during the plan year, you can receive reimbursement from the appropriate account for your eligible expenses that are not otherwise reimbursed. The applicable contribution limit will be communicated to you by the Plan Administrator during the Annual Enrollment Period.

Note: The HCFSA is for healthcare expenses that you, your Spouse, or your eligible dependents incur. The Dependent Care FSA is for babysitting or daycare expenses incurred for your child or physically impaired adult that allow you to work or look for work. The Dependent Care FSA is NOT used for dependent healthcare expenses.

The Company has entered into an arrangement with an outside third party to administer the FSA Plan (see the section entitled *Contact Information* beginning on page 141). However, this FSA Plan Administrator does not insure the benefits described in this SPD.

CONTRIBUTIONS

Each year, you must decide the amount of pre-tax dollars you want to contribute to the accounts. You may contribute to the HCFSA, as well as the Dependent Care FSA. However, amounts contributed to the HCFSA cannot be used to reimburse expenses under the Dependent Care FSA, and amounts contributed to your Dependent Care FSA cannot be used to reimburse expenses under the HCFSA. You should carefully estimate your health expenses (see below for a list of typical expenses eligible for reimbursement under the GPFSA or LPFSA) and *separately* estimate your dependent care expenses (see *Eligible Dependent Care Expenses* on page 91) for the upcoming plan year because the federal tax law requires that you forfeit any unused funds remaining in either account at the end of the plan year.

The Plan Administrator will communicate the annual contribution limits for the HCFSA and the Dependent Care FSA as part of the annual enrollment process.

Errors in estimating your health or dependent care expenses or a lack of understanding as to what GPFSA, LPFSA, or Dependent Care FSA amounts may be used for will not justify a mid-year change in your contribution election. You may only change your contribution amounts under the FSA as described in the subsection entitled *Changing Your Coverage* beginning on page 13.

If you change your healthcare plan option mid-year because you experience a change in status or other event that allows you to change your elections mid-year, your eligibility for the HCFSAs may be affected. If you move from the traditional PPO or EPO plan option to an HDHP option, you will no longer be eligible to contribute to the GPFSA but can contribute to the LPFSA. You may submit claims for reimbursement for general medical expenses that were incurred prior to the effective date of your HDHP coverage. However, you may not be reimbursed for general medical expenses that were incurred after the effective date of your HDHP coverage. Instead, you may be reimbursed from the LPFSA for dental and vision expenses incurred after the effective date of your HDHP coverage, if you choose to contribute to the LPFSA. More details are provided later in this section regarding expenses that are eligible to be reimbursed from a GPFSA or LPFSA.

If you have questions about your contribution, contact the Plan Administrator before submitting your election.

HEALTH CARE FSA

HEALTH CARE FSA

The HCFSAs can be used to reimburse medical expenses for you and your dependents. The GPFSA can be used to reimburse you for medical, dental, and vision expenses for you and your dependents, and the LPFSA can be used to reimburse you for ONLY dental and vision expenses for you and your dependents. Carefully review the information below regarding the eligible expenses for each type of account.

ELIGIBLE DEPENDENTS

The definition of dependent for purposes of the HCFSAs is different from the definition of Dependent under the Program and has generally included tax dependents under Internal Revenue Code Section 152. The definition of dependent for purposes of the HCFSAs was expanded effective January 1, 2011 to include children described in Internal Revenue Service Notice 2010-38 (“Notice 2010-38”).

Code Section 152 Dependents

To be a Code Section 152 dependent, an individual must meet the requirements under Code Section 152 as either a “qualifying child” or a “qualifying relative.” To satisfy the definition of “qualifying child,” a child must meet several requirements, including that the child:

- Bear one of the following relationships to you:
 - Your child or a descendant of your child, or
 - Your brother, sister, stepbrother, or stepsister or a descendant of any such relative;
- Has the same principal residence as you for more than one-half of the taxable year;
- Unless disabled, is under age 19 if not a student or, if a student, under age 24; and
- Not provide more than one-half of his or her own support.

* The term “child” also includes stepchildren, legally adopted children, and children for whom you are the legal guardian.

To be a “qualifying relative,” the individual must:

- Be your child (or descendant of your child), brother, sister, stepbrother, stepsister, father, mother (or an ancestor of your father or mother), stepfather, stepmother, a son or daughter of your brother or sister, a brother or sister of your mother

or father, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, or an individual who has the same principal residence as you and is a member of your household;

- Receive more than one-half of his or her support from you; and
- Not be a qualifying child of you or of any other taxpayer for the year.

A qualifying child or qualifying relative must also be a U.S. citizen or national, or a resident of the U.S. or a country contiguous to the U.S. (there is an exception for certain adopted children).

Eligible Children under Notice 2010-38

Pursuant to Notice 2010-38, the definition of dependent for purposes of the HCFSAs was expanded January 1, 2011 to include the following children defined in Internal Revenue Code Section 152(f)(1) who as of the end of the plan year have not attained the age of 27:

- Your son or daughter;
- Your stepson or stepdaughter;
- Your legally adopted son or daughter; and
- Your eligible foster child. An “eligible foster child” is an individual who is placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

ELIGIBLE HEALTH CARE EXPENSES – GENERAL PURPOSE FSA (“GPFSA”)

You can elect payroll deductions annually to pay medical, dental, vision, and hearing expenses not paid by plans covering you and your eligible dependents. The minimum and maximum payroll deduction amounts will be communicated to you as part of annual enrollment. For purposes of the GPFSA, your eligible dependents are described in the *Eligible Dependents* section beginning on page 85.

To determine the amount you may want to contribute to your GPFSA, you should first estimate the amount of nonreimbursed health care expenses you will most likely incur in the next plan year for you and your family.

To be eligible for reimbursement from your GPFSA, the health care expenses must be:

- Considered a deductible medical expense for federal income tax purposes (Section 213 of the Internal Revenue Code);
- Incurred while you are participating in the FSA Plan;
- Incurred during the plan year; and
- Not reimbursed under any employer-sponsored health/dental plan that you or your Spouse are covered by.

An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

Please note that the plan terms do not provide for any extension of time beyond the end of the plan year in which to incur eligible expenses. In order to be eligible for reimbursement from your GPFSA, you must incur the qualifying expense on or before the last day of the plan year.

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

Health Care Expenses

- Deductible, Co-payment and Co-insurance amounts;

- Drug Co-payments;
- Excess over Eligible Expenses;
- Routine physical exams;
- Routine lab and x-rays performed for medical reasons;
- Birth control items prescribed by your doctor;
- Childbirth classes;
- Cardiac rehabilitation classes;
- Drug abuse treatment centers;
- Sterilization, unless prohibited by law;
- 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;
- Frames; 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.

You may request reimbursement for eligible expenses that are incurred while you are a participant in the Program and making contributions to your FSA. “Incurred” means the date on which a service is rendered – not the date the service is invoiced or paid. An exception applies to orthodontia-related claims. Certain advance payments for orthodontia services may be reimbursed before services are provided.

A complete description of and a definitive list of what constitutes eligible medical expenses is available in IRS Publication 502 which is available from any regional IRS office or at www.irs.gov. **However, there are certain expenses that are listed as deductible in IRS Publication 502 but which cannot be reimbursed by the GPFSA because of IRS rules applicable to FSA plans.** If you have questions regarding eligible health care expenses under the GPFSA, contact the Claims Administrator at the telephone number listed in the section entitled *Contact Information* beginning on page 141, or at www.myuhc.com.

INELIGIBLE EXPENSES – GPFSA

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

Expenses incurred for cosmetic surgery or other similar procedures cannot be reimbursed under your GPFSA unless the procedure improves the function of the body or eliminates deformities directly related to a congenital condition, a personal injury or a disfiguring disease.

Other examples of ineligible expenses are:

- Expenses reimbursed by any insurance policy or another plan;
- Cosmetics, and other personal care items, vitamins for general health, facial creams, deodorants, toothpaste, bug repellent, sunscreens, hair loss treatments;
- Lessons (*i.e.*, dancing, swimming and other types), even if recommended by your Physician for the general improvement of your health;
- Funeral expenses;
- Health club membership;
- Marriage or family counseling;
- Custodial Care in a nursing home;
- Insurance premiums, including Medicare Part B premiums, Long Term Care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or other health plan); and
- Advance payments for lifetime care paid to a retirement home.

In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, health expenses reimbursed through your GPFSA cannot be used as deductions on your income tax return.

ELIGIBLE HEALTH CARE EXPENSES – LIMITED PURPOSE FSA (“LPFSA”)

Under the LPFSA, you can elect payroll deductions annually to pay dental and vision expenses not paid by plans covering you and your eligible dependents. The minimum and maximum payroll deduction amounts will be communicated to you as part of annual enrollment. For purposes of the LPFSA, your eligible dependents are described in the *Eligible Dependents* section beginning on page 85.

To determine the amount you may want to contribute to your LPFSA, you should first estimate the amount of nonreimbursed dental and vision expenses you will most likely incur in the next plan year for you and your family.

To be eligible for reimbursement from your LPFSA, the dental and vision expenses must be:

- Considered a deductible medical expense for federal income tax purposes (Section 213 of the Internal Revenue Code);
- Incurred while you are participating in the FSA Plan;
- Incurred during the plan year; and
- Not reimbursed under any employer-sponsored health/dental/vision plan that you or your Spouse are covered by.

An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

Please note that the plan terms do not provide for any extension of time beyond the end of the plan year in which to incur eligible expenses. In order to be eligible for reimbursement from your LPFSA, you must incur the qualifying expense on or before the last day of the plan year.

Below is a partial list of typical dental and vision expenses eligible for reimbursement from your LPFSA.

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.

Vision Expenses

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

You may request reimbursement for eligible expenses that are incurred while you are a participant in the Program and making contributions to your FSA. “Incurred” means the date on which a service is rendered – not the date the service is invoiced or paid. An exception applies to orthodontia-related claims. Certain advance payments for orthodontia services may be reimbursed before services are provided.

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

health care expenses under the LPFSA, contact the Claims Administrator at the telephone number listed in the section entitled *Contact Information* beginning on page 141, or at www.myuhc.com.

FSA DEBIT CARD

Eligible expenses under your HCFSA may be purchased directly from the merchant or provider of services through the use of a FSA debit card. You must agree to acquire, submit to the Claims Administrator and retain sufficient documentation for any expense paid with the debit card, including invoices and receipts where appropriate. All charges to the debit card that are not deemed to be fully substantiated at the point-of-sale are treated as conditional pending substantiation of the eligibility of the charge through your documentation.

You should verify that the Claims Administrator considers expenses substantiated. If the Claims Administrator determines that a claim has been paid that was not for an eligible expense or a claim has not been fully substantiated, you are required to refund any amount so identified. If you fail to promptly refund such amount to the FSA Plan, by virtue of agreeing to participate in the FSA Plan, you authorize the plan sponsor to withhold such amount from your wages or other compensation to the extent permitted by law. In addition, the Claims Administrator reserves the right to suspend your use of the debit card and/or credit such amount against other eligible expenses that you may submit until the refund is satisfied.

Your debit card will be cancelled automatically if your employment terminates or if your participation in the FSA Plan otherwise terminates.

DIRECT DEPOSIT

Direct deposit allows the Claims Administrator to deposit your reimbursement checks under the HCFSA directly into the bank of your choice. If you choose direct deposit, the Claims Administrator ensures the complete confidentiality of your account at all times. You may confirm that the Claims Administrator has your correct contact information and/or update, change or cancel your direct deposit bank account information by contacting the Claims Administrator at the telephone number listed in the section entitled *Contact Information* beginning on page 141, or at www.myuhc.com.

QUALIFIED MILITARY SERVICE DISTRIBUTION

If you are called into Uniformed Service for at least 180 days (or for an indefinite period of time) you may elect to withdraw all or a portion of the balance credited in your HCFSA as of the date you make the request. This distribution will be reported as gross income to you on your Form W-2 as a taxable distribution. You do not need to provide proof of eligible medical expenses. The distribution will be made to you no sooner than the date you are called into Uniformed Service, and no later than the last day in which you could submit claims for reimbursements for that plan year (*i.e.*, March 31st of the next plan year).

DEPENDENT CARE FSA

QUALIFIED DEPENDENTS

Since a Dependent Care FSA is for expenses related to the care of your dependents, a few guidelines exist. A qualified dependent must meet one of the following definitions:

- *A child under the age of 13* who qualifies as your dependent as a “qualifying child” under Internal Revenue Code Section 152(a)(1). A “qualifying child” is a child who:
 - Bears one of the following relationships to you:
 - (i) Your child or a descendant of your child, or
 - (ii) Your brother, sister, stepbrother, or stepsister or a descendant of any such relative;
 - Has the same principal residence as you for more than one-half of the taxable year; and

- Does not provide more than one-half of his or her own support.
- *A dependent of any age who is physically or mentally incapable of self-care* (e.g., your child, parent, domestic partner, domestic partner's child) who qualifies as your dependent under Internal Revenue Code Section 152 and has the same principal residence as you for more than one-half of the taxable year. To qualify under Section 152, such individual must be either a "qualifying child" (see above) or a "qualifying relative." A "qualifying relative" is an individual who:
 - Bears a specified relation to you (*i.e.*, your child or descendant of your child; your brother, sister, stepbrother or stepsister; your father or mother, or an ancestor of either; your stepfather or stepmother; a son or daughter of your brother or sister; a brother or sister of your mother or father; your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; or any other individual who has the same principal residence as you and is a member of your household);
 - Receives more than one-half of his or her support from you; and
 - Is not a qualifying child of you or of any other taxpayer for the year.
- *Your Spouse if he or she is physically or mentally incapable of self-care* and has the same principal residence as you for more than one-half of the taxable year.

If you are divorced or legally separated, your child may qualify if you satisfy custody requirements specified by the IRS.

For a disabled dependent to qualify, he or she must regularly spend at least eight hours each day in your home. You are not reimbursed for the care of a dependent in an institution.

ELIGIBLE DEPENDENT CARE EXPENSES

You can elect payroll deductions of \$75 to \$5,000 annually to pay for dependent care. Eligible child and dependent care expenses that can be reimbursed from your Dependent Care FSA are expenses incurred during the plan year for household and dependent care services which enable you and (if married) your Spouse to be gainfully employed.

If your Spouse has no earned income, you cannot use a Dependent Care FSA unless your Spouse is physically or mentally incapable of caring for himself or herself or is a full-time student for at least five months during the plan year.

To qualify for reimbursement, child and dependent care expenses cannot exceed your earned income or, if married, the earned income of the lesser earning Spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If married and your Spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your Spouse to have a monthly income of \$200 if you have one dependent or \$400 if you have two or more dependents for each month that your Spouse is incapable of caring for himself or herself or is a full-time student.

Eligible child and dependent care expenses include, but are not limited to, the following:

- Care at a day care center that complies with all appropriate state and local regulations;
- Care by a housekeeper whose duties include dependent care;
- Care by a relative who cares for your dependents, so long as that relative is over the age of 19 and is not another one of your dependents;
- Care for an elderly or incapacitated dependent, either in your home or outside your home. The dependent must spend at least 8 hours each day in your home if you are claiming reimbursement for care outside your home; and
- Care at a day camp to which you send your school-aged children during school vacations so that you and (if married) your Spouse can go to work or attend school full-time.

Note that dependent care centers that service seven or more individuals must comply with state and local laws.

To determine the amount you may want to contribute to your Dependent Care Account, you should first estimate the total amount of dependent care expenses you will most likely incur in the next plan year. If your Spouse participates in a dependent care account through his or her employer, your total combined deferrals cannot exceed the maximum amount shown (\$5,000).

DEPENDENT CARE TAX CREDIT VS. DEPENDENT CARE FSA

Some Employees may be eligible to receive a dependent care tax credit on their federal income tax. The credit ranges from 20% to 30% of qualifying employment related expenses, depending on the adjusted gross income of the Employee. The amount of the credit is capped each year at \$3,000 for one qualifying dependent and \$6,000 for two or more qualifying dependents. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a Dependent Care FSA.

In general, if you earn more than \$25,000 a year and have only one qualified dependent, you will receive greater tax savings by using the Dependent Care FSA. However, because each Employee's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the spending account.

FSA DEBIT CARD

Eligible expenses under your Dependent Care FSA may be purchased directly from the merchant or provider of services through the use of a FSA debit card. You must agree to acquire, submit to the Claims Administrator and retain sufficient documentation for any expense paid with the debit card, including invoices and receipts where appropriate. All charges to the debit card that are not deemed to be fully substantiated at the point-of-sale are treated as conditional pending substantiation of the eligibility of the charge through your documentation.

You should verify that the Claims Administrator considers expenses substantiated. If the Claims Administrator determines that a claim has been paid that was not for an eligible expense or a claim has not been fully substantiated, you are required to refund any amount so identified. If you fail to promptly refund such amount to the FSA Plan, by virtue of agreeing to participate in the FSA Plan, you authorize the plan sponsor to withhold such amount from your wages or other compensation to the extent permitted by law. In addition, the Claims Administrator reserves the right to suspend your use of the debit card and/or credit such amount against other eligible expenses that you may submit until the refund is satisfied.

Your debit card will be cancelled automatically if your employment terminates or if your participation in the FSA Plan otherwise terminates.

DIRECT DEPOSIT

Direct deposit allows the Claims Administrator to deposit your reimbursement checks under the Dependent Care FSA directly into the bank of your choice. If you choose direct deposit, the Claims Administrator ensures the complete confidentiality of your account at all times. You may confirm that the Claims Administrator has your correct contact information and/or update, change or cancel your direct deposit bank account information by contacting the Claims Administrator at the telephone number listed in the section entitled *Contact Information* beginning on page 141, or at www.myuhc.com.

LIMITS FOR HIGHER-PAID EMPLOYEES

Your coverage and benefits provided under your Dependent Care FSA will comply with any relevant nondiscrimination provisions in Internal Revenue Code Section 125. The Company will restrict enrollment or reduce benefits, or both, if necessary, in a manner determined by the Company, to comply with these requirements.

HEALTH SAVINGS ACCOUNT

If you are a participant in one of the CDHP options and otherwise are an eligible employee, 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 the 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.

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

If you do not want to make HSA contributions through pre-tax payroll deductions, you can make tax-deductible lump sum contributions to your HSA at any time up to the IRS maximum allowable amount.

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;
- 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 (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 and make pre-tax contributions to your HSA directly from your paycheck 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 via payroll deductions, up to the IRS maximum allowable amount. If you open your HSA at another bank or financial institution without going through HealthEquity, you may still make contributions to your HSA on a tax-deductible basis.

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. 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.

Currently, for 2021, the IRS maximum allowable amount is \$3,600 if you are enrolled in employee-only coverage, and \$7,200 if you are enrolled in any other coverage tier. The Plan Administrator will communicate the IRS maximum allowable amount as part of the Annual Enrollment Period process. Additionally, you may 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 (800) 829 3676. Or, you can download a copy of the publication from the IRS Web site at www.irs.gov. Or, you can get additional information at www.healthequity.com/caterpillar or contact the Claims Administrator, HealthEquity, at (844) 311-9732.

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 (currently, \$1,000 each year). The Plan Administrator will communicate the IRS maximum annual catch-up contribution as part of the Annual Enrollment Period process.

TIMING OF CONTRIBUTIONS

Employee contributions made through pre-tax payroll deduction are made per pay period. 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, even if your employment with the Company ends.

REPORTING

The Company will report its contributions to your HSA and your pre-tax HSA contributions on your W-2 Form.

ELECTION PROCESS

At the time you elect to enroll in a CDHP option, you may also elect to establish an HSA through HealthEquity and make pre-tax contributions to your HSA. The Company will forward such pre-tax contributions to your HSA within a reasonable time after being withheld from your paycheck if you elect to establish your HSA with HealthEquity.

Remember, you are also permitted to establish an HSA outside of HealthEquity, but you will not be able to make direct payroll contributions or receive the Company contribution. You are free at any time to move any or all of your HSA funds from one financial institution to another financial institution. You should verify that any contributions you make will be in compliance with the rules regulating HSAs.

Note: You cannot elect to participate in both an HSA and the GPFSA. If you establish an HSA, you may still participate in the LPFSA, to help pay for qualified dental and vision expenses.

CHANGING YOUR HSA PRE-TAX CONTRIBUTION ELECTION

You may elect at any time during the calendar year to start making (as long as you satisfy all of the eligibility requirements), stop making or change the amount of pre-tax contributions to your HSA on a prospective basis for the remainder of the year, in accordance with the administrative procedures for processing election changes and subject to the statutory limits described in "Contributions to Your HSA".

No changes can be made to other benefit options in the Program or the FSA Plan as a result of a change in your pre-tax contribution election to your HSA, unless permitted as a result of a Change in Status event as described in this SPD. For example, you may stop your HSA contributions at any time during the plan year; however, you cannot change your pre-tax coverage election midyear under a CDHP option unless you experience a Change in Status event.

Eligible employees can elect at any time during the calendar year to start making, stop making, or change the amount of their HSA pre-tax contributions by contacting the Caterpillar Benefits Center at (877) 228-4010 or accessing the UPoint website at CatBenefitsCenter.com.

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 (whether before or after termination of employment). 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 HCFSA is broader than the definition for your HSA. The IRS permits you to seek reimbursement only 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

Any Company contributions not already contributed to your HSA and your pre-tax payroll contributions to your HSA will be automatically canceled when:

- Your employment with the Company ends for any reason; or
- 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 and pre-tax payroll contribution election 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.

For certain losses of coverage, you or your covered eligible Dependent will have a right to continue coverage under COBRA for a CDHP option. However, the Company will not make contributions to your HSA after you lose coverage under the CDHP option, even if you elect to continue CDHP coverage under COBRA.

OTHER INFORMATION

LIMITS FOR HIGHER-PAID EMPLOYEES

The Company’s contributions to your HSA are made through an Internal Revenue Code Section 125 cafeteria plan that permits participants in the CDHP option to make pre-tax HSA contributions. Your coverage and benefits provided under your HSA, and the Company’s HSA contributions, will comply with any relevant nondiscrimination provisions in Internal Revenue Code Section 125. The Company will restrict enrollment or reduce benefits, or both, if necessary, in a manner determined by the Company, to comply with these requirements.

DEATH AND AD&D

AN INTRODUCTION TO YOUR BENEFITS

This *Death and AD&D* section of the SPD summarizes the life and accidental death and dismemberment (“AD&D”) benefits. The following paragraphs describe the various life insurance and accidental death and dismemberment benefits available under the Program.

LIFE AND AD&D

ELIGIBILITY FOR LIFE AND AD&D

You are eligible for life and AD&D benefits under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled *Eligibility* beginning on page 3 and any additional requirements described in this section. Part-Time Employees, Supplemental Employees and Temporary Employees are not eligible for life and AD&D benefits under the Program.

OVERVIEW OF LIFE AND AD&D

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 the MetLife National Benefit Center for Caterpillar at the telephone number listed in the section entitled *Contact Information* beginning on page 141. You may complete and submit your Beneficiary designation form to the MetLife National Benefit Center for Caterpillar at the address listed in the section entitled *Contact Information* beginning on page 141. 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 the MetLife National Benefit Center for Caterpillar, 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 the MetLife National Benefit Center for Caterpillar at the telephone number listed in the section entitled *Contact Information* beginning on page 141 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.

Changing Life Insurance Benefits

If you have a pay change that affects the amount of your Basic Life or Optional Life Insurance Benefits, the change will become effective upon the first of the month of the later of: (a) the date of your pay change; or (b) the date you return to active employment.

Accelerated Life Benefits

If you have employee life insurance coverage under the Program and you currently have a qualifying serious illness, you may be eligible for an accelerated benefit payment in an amount up to 25% of your basic or, if applicable, your optional coverage in effect (up to a maximum of \$250,000) at the time your application is approved. Any payment of accelerated benefits will reduce your coverage in effect following the date of payment. Accelerated benefits are payable only once. To find out if you qualify for accelerated benefits and to apply for such benefits, contact the Life Administrator identified in the *General Administration* section beginning on page 110.

EVIDENCE OF INSURABILITY

You are required to provide Evidence of Insurability if you are requesting optional life and/or Spousal life insurance coverage or if you are seeking an increase in such coverage, if applicable.

IMPUTED INCOME

Under current tax laws, you are required to pay income taxes on the “value” of your Company-provided basic life insurance benefits coverage over \$50,000. The “value” is determined by your age and according to a schedule established by the IRS. This tax liability is called “imputed income.” These rules regarding imputed income will not apply to your optional life insurance coverage.

LIFE INSURANCE BENEFITS

The Company provides you with basic life insurance benefits at no cost to you (unless you are a tobacco user, in which case you pay a portion of the applicable premium of basic life coverage.) In addition, you may request to enroll for optional life insurance, Spousal/Same-Sex Domestic Partner life insurance and/or Dependent child life coverage and pay the full cost of the coverage in effect, as determined by the Insurance Carrier and as provided on a schedule determined by the Company. Life insurance benefit payments may be paid by check, the establishment of an account that earns interest (the total control account), or by any other means that ensures immediate access of the proceeds to the beneficiaries.

As a participant in the Program, you automatically have basic life insurance coverage. To enroll in optional, Spousal/Same-Sex Domestic Partner and/or Dependent child life insurance coverage, you must file a request for such coverage via the internet at metlife.com/mybenefits or with the MetLife National Benefit Center for Caterpillar at (888) 228-1811 and submit the necessary Evidence of Insurability. Generally, your coverage will remain in effect while you are Actively at Work and provided you make any required contribution.

Certain aspects of the life insurance provisions described in this SPD do not apply to you if you are on a disability leave that began on or before July 1, 1996. Contact the Caterpillar HR Service Center - Americas for details (see the *Contact Information* section beginning on page 141).

Your Life Insurance Coverage	
Benefit	Coverage Available
Basic Life*	200% of Annual Base Salary (up to \$500,000 maximum)
Optional Employee Life (“optional life”)	100%, 200%, 300%, 400%, 500%, 600%, 700%, or 800% of Annual Base Salary (up to \$2,000,000 maximum)
Spousal/Same Sex Domestic Partner Life	\$20,000 or \$40,000
Dependent Child Life	\$10,000

* Your basic and optional life insurance coverage will be reduced when you reach age 70, and thereafter, as described in the *Reduction in Basic Life Insurance Benefits* and *Changes in Optional Life Insurance Coverage* sections below.

Reduction in Basic Life Insurance Benefits

If you are an active Employee and are still in Active Employment with the Company when you reach age 70, your basic life insurance benefits will be continued but will be reduced by 2% at the beginning of the next month. If you continue to be Actively at Work after age 70, your basic life insurance benefits will continue to be reduced each month by 2% of the amount in effect on the day before your 70th birthday, until you retire (but not less than 50% of the amount in force on the day before your 70th birthday).

Remember, in all cases, if you are a tobacco user, contributions are required from you in order to maintain basic life insurance coverage.

Changes in Optional Life Insurance Coverage

You may elect to increase or decrease your percentage of optional life insurance coverage in accordance with the procedures described in the *How to Enroll* section beginning on page 9. Note any changes you request will be effective on the first of the month following the later of your pay change or the first day you are actively at work. If you are an active Employee on the date you reach age 70, your optional life insurance coverage will continue.

In all cases, to continue (or reinstate) coverage, you are required to pay the applicable cost.

Spousal/Same-Sex Domestic Partner and Dependent Child Life

If you elect Spousal/Same-Sex Domestic Partner life insurance coverage, you will be required to provide evidence of your Spouse’s or Same-Sex Domestic Partner’s insurability. Spousal/Same-Sex Domestic Partner life benefits will end on the earlier of your Spouse’s or Same-Sex Domestic Partner’s 70th birthday or the date you are no longer Actively at Work (or on a qualifying leave, as described in the section *How Long Coverage Continues* beginning on page 21).

Dependent child life coverage is available for your or your Same-Sex Domestic Partner’s eligible Dependent child, as determined under the *Eligibility* section beginning on page 3. Dependent life benefits will end on the earlier of the date your or your Same-Sex Domestic Partner’s child is no longer is a Dependent under the Program or the date you are no longer Actively at Work (or on a qualifying leave, as described in the section *How Long Coverage Continues* beginning on page 21).

If both Spouses or Same-Sex Domestic Partners are employed by the Company, the dependent life benefit will only be paid out once per dependent.

Group Variable Universal Life

If you are eligible for group variable universal life insurance, you will not be able to enroll in optional, Spousal/Same-Sex Domestic Partner and/or Dependent child term life insurance under the Program. You will be provided additional information upon your request.

Will Preparation and Estate Resolution Services

Will preparation and estate resolution services are available to you if you have enrolled in optional term life insurance. These services are provided through Hyatt Legal Plans, a MetLife company, which covers the legal fees associated with these services, provided a Hyatt participating attorney is used. For additional information, call the MetLife National Benefit Center for Caterpillar at the telephone number listed in the section entitled *Contact Information* beginning on page 141.

AD&D BENEFITS

The Program will pay AD&D benefits for Accidental death or Accidental dismemberment if you:

- Sustain a Covered Loss through violent, external and Accidental means;
- The Injury is the sole cause of the Covered Loss; and
- The Covered Loss occurs within 365 days after the date of the Accident.

The Program will not pay AD&D benefits for losses caused, in whole or in part, by:

- Physical or mental illness, or the diagnosis or treatment for the illness;
- An infection unless it is caused by (i) a visible external wound which was sustained in an accident; or (ii) accidental food poisoning;
- Suicide;
- Attempted suicide;
- Injuring yourself on purpose;
- The use of any drug, medication or sedative, unless it is taken or used as prescribed by a Physician, or it is an “over the counter” drug, medication or sedative taken as directed;
- War or warlike action in times of peace;
- Committing or trying to commit a felony or other serious crime; or
- Driving a vehicle while intoxicated (as defined by the jurisdiction in which you are driving).

The Company provides you with AD&D benefits at no cost to you. Your AD&D benefits may be paid in installments and will be calculated in accordance with the following chart until they are discontinued as described below:

Your AD&D Coverage	
Benefit	Coverage Available
Accidental Death & Dismemberment	
• One Covered Loss* (except Death)	50% of Annual Base Salary (up to \$125,000 maximum)
• Two Covered Losses* or Death	100% of Annual Base Salary (up to \$250,000 maximum)

* A Covered Loss is the loss of life, a hand, a foot, or all sight from one eye. Loss of sight from an eye means the eye is totally blind and sight cannot be restored. Loss of a hand means loss by severance at or above the wrist. Loss of a foot means loss by severance at or above the ankle.

DISCONTINUATION OF AD&D BENEFITS

Your AD&D benefits will be discontinued on the earliest of the following events:

- The date your basic life insurance coverage under the Program terminates;
- Your termination of employment with the Company or a Participating Company;
- Your retirement date;
- The date you attain age 70; or
- If you are Disabled prior to the date you attain age 60, then the date you attain age 65.

DISABILITY BENEFITS

AN INTRODUCTION TO YOUR BENEFITS

This *Disability* section of the SPD summarizes the short term disability and long term disability benefits available under the Program. Your Disability coverage is designed to help ensure that you continue to receive income if you are unable to work because of a Sickness or Injury.

SHORT TERM AND LONG TERM DISABILITY BENEFITS

The Program offers two Disability coverages: (i) short term disability (“STD”) benefits, and (ii) long term disability (“LTD”) benefits. This section provides the eligibility requirements for those disability benefits.

ELIGIBILITY

You are eligible for STD and LTD benefits under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled *Eligibility* beginning on page 3 and any additional requirements described in this section. Part-Time Employees, Solar Employees, Supplemental Employees and Temporary Employees are not eligible for STD and LTD disability benefits under the Program.

The Program will not pay disability benefits for any Disability directly or indirectly caused by:

- Insurrection, rebellion, terrorist act, war (whether declared or undeclared) or an act of war;
- Active participation in a riot;
- Intentionally self-inflicted Injury (excluding attempted suicide);
- Commission of or attempt to commit a felony; or
- Engaging in activity that results in incarceration from the conviction of a felony.

The Program will not pay STD benefits or LTD benefits (or benefits from any other ERISA-governed plan) for any period of Disability during which you are retired and receiving a pension payment from a pension plan sponsored by the Company, except where the pension payment is a disability retirement benefit under a Company sponsored pension plan.

In addition, the Program will not pay STD or LTD benefits for any period of Disability during which you are receiving workers’ compensation benefits due to an Injury or Sickness you incurred while working for the Company or a Participating Company.

SHORT TERM DISABILITY (“STD”) BENEFITS

Eligibility for STD benefits will begin after sixty (60) calendar days from your first day of Active Employment. After satisfying this waiting period, you will be eligible for STD benefits if you become wholly and continuously Disabled as a result of an Injury or Sickness so that you are prevented from performing any and every duty of your occupation from the time the Injury or Sickness occurs, as determined by the Claims Administrator, in its sole discretion. In addition, you must be under the treatment of a Physician and you must file a claim and supporting evidence of your Disability with the Claims Administrator within 30 days of the first day of your Disability.

LONG TERM DISABILITY (“LTD”) BENEFITS

You will be eligible for LTD benefits provided:

- you become and remain totally Disabled (as defined below); and
- within 30 days of becoming eligible for LTD benefits you file a claim for benefits (with supporting medical evidence) with the Claims Administrator.

Your claim for LTD benefits must be supported by medical evidence of your Disability. In addition, you may be required, from time to time, to furnish additional evidence of your Disability to the Company or Insurance Carrier. You will be considered totally Disabled if you are:

- Not engaged in regular employment or occupation for remuneration or profit (excluding employment or occupation which is determined to be for purposes of rehabilitation); and
- Totally Disabled by bodily Injury or disease so as to be prevented from engaging in any regular occupation or employment, as determined by the Claims Administrator, in its sole discretion and on the basis of medical evidence satisfactory to the claims Administrator.

SHORT TERM DISABILITY (“STD”) BENEFITS

AMOUNT OF STD BENEFITS

The amount of your STD benefits varies according to your employment classification.

- If you are a Management or Salaried/Support Employee, your weekly STD benefit will be 70% of your Annual Base Salary divided by 52.
- If you are a Non-Bargained Hourly Employee, your weekly STD benefit will be 66.67% of your Annual Base Salary divided by 52.

For all employees, STD benefits will be reduced by:

- Benefits paid or payable to you under a salary continuation pay practice of the Company.
- Benefits paid or payable to you for the same period of disability under any workers’ compensation, occupational disease or similar law (except payments under such a law for (i) the loss of, or permanent and complete loss of use of, any bodily member or permanent partial disability payments for a work-related disability, (ii) hospitalization or medical expense, or (iii) disfigurements);
- Disability benefits under any state or governmental program (other than benefits designed to compensate veterans for disabilities);
- The amount of any benefits under any workers’ compensation, occupational disease, or similar law if benefits are attributable to an Injury or Sickness incurred while working for another employer; and
- If you are on Layoff, the amount of any disability benefit which you are entitled to receive (or could become entitled to by making a proper request) for the same week of disability or any portion thereof under a plan financed, in whole or in part, by any other employer.

DURATION OF STD BENEFITS

STD benefits will be paid for up to 26 weeks. Any period of STD benefits includes any period of salary continuation that may be paid under any salary practice of the Company that may apply. STD benefits will not be paid if you are receiving paid time off. If you quit or are involuntarily terminated while you are receiving STD benefits, your STD benefits will stop immediately. In addition, your STD benefits will stop the date you cease to receive appropriate care and treatment. Further, your STD benefits are not be payable for any period during which you are incarcerated as a result of being convicted of a felony. Your benefits will resume once you are no longer incarcerated, provided you remain disabled and eligible for STD benefits under the Program.

Regardless of the duration of your STD benefits, such benefits will begin on the earliest occurrence of the following events (as determined by the Plan Administrator, in its sole discretion):

- The first day you are confined as a patient in a Hospital upon a Physician's order;
- The first day of your Disability that you are under the treatment of a Physician if the Disability is the result of a non-occupational Injury; provided that you are absent from work for the period beginning on the day of your Injury and ending on the day STD benefits begin;
- The first day you undergo a surgical operation covered by the Program and approved by the Claims Administrator, in its sole discretion, for first-day benefits;
- The first day you are confined as a patient in an approved residential facility (*i.e.*, a facility providing detoxification and rehabilitation services, approved by the Claims Administrator, in its sole discretion) upon the order of a Physician;
- The first day you undergo a clinical treatment procedure or organ donation procedure approved by the Claims Administrator, in its sole discretion, for first-day benefits;
- The first day of your date of delivery for childbirth; or
- The eighth calendar day of a Disability caused by any other Sickness or Injury if you have received treatment from a Physician during that time, or the next work day on which you receive treatment from a Physician.

For purposes of determining when your Disability period begins, any day during which you work four (4) hours or more will not be considered as a day of Disability.

SUSPENSION OF BENEFITS

Benefits under the Program may be suspended upon the sole discretion of the Plan Administrator during the 30-day grace period in which you are required to provide proof of continued Disability.

RETURN TO WORK

If you return to work in Rehabilitative Employment you will be entitled to receive your regular base pay for the hours worked and up to one-half of the daily equivalent of your STD benefit for a maximum period of eight weeks. After such eight-week period, if you do not return to your normal, full-time work schedule, and you remain Disabled for purposes of the STD benefit, you may continue to receive such benefit for the remainder of the applicable coverage period, if any. Any period during which you receive STD benefits will be counted towards the maximum benefit payable to you. Whether you are eligible for Rehabilitative Employment will be determined by the Company in its sole discretion.

Your STD benefits are payable for up to 26 weeks. Any succeeding periods of Disability that result from the same or a different cause, or multiple causes, will be considered a continuation of your previous period of Disability, unless you have returned to active, full-time employment for not less than 45 calendar days.

In no event will benefits be paid after the expiration of the 26-week period.

LONG TERM DISABILITY ("LTD") BENEFITS

AMOUNT OF LTD BENEFITS

The amount of your LTD benefits varies according to your employment classification.

- If you are a Management or Salaried/Support Employee, your monthly LTD benefit will be 65% of your Annual Base Salary divided by 12, if you became Disabled on or after January 1, 2012 (not to exceed \$10,000 per month for disabilities incurred on or after April 1, 2020).
- If you are a Non-Bargained Hourly Employee, your monthly LTD benefit will be 55% of your Annual Base Salary divided by 12, if you became Disabled on or after January 1, 2012 (not to exceed \$10,000 per month for disabilities incurred on or after April 1, 2020).

- If you became Disabled prior to January 1, 2012, the amount of your LTD benefits shall be determined in accordance with the terms of the Program (or its predecessor) as in effect on the date you became Disabled.

Except as provided in Exhibit A, LTD benefits will be reduced by:

- Primary benefits paid (or payable) under Social Security;
- Disability benefits under any state or governmental program (other than benefits designed to compensate veterans for disabilities);
- For Non-Management employees, your disability pension under a pension plan sponsored by the Company and in which you participate;
- Benefits (other than hospitalization or medical benefits) under any other employer-sponsored plan which are paid or payable for any period of disability occurring within the same month as a month in which you receive LTD benefits; and
- Benefits paid or payable to you for the same period of disability under any workers' compensation, occupational disease or similar law (except payments under such a law for (i) the loss of, or permanent and complete loss of use of, any bodily member or permanent partial disability payments for a work-related disability, (ii) hospitalization or medical expense, or (iii) disfigurements).

DURATION OF LTD BENEFITS

Benefits will begin after you have provided acceptable evidence of your Disability and otherwise satisfied all of the conditions of eligibility, and after the maximum amount of STD benefits has been paid (or would have been payable, but for another applicable provision of the Program). Your LTD benefits are not be payable for any period during which you are incarcerated as a result of being convicted of a felony. Your benefits will resume once you are no longer incarcerated, provided you remain disabled and eligible for LTD benefits under the Program.

Except as provided in Exhibit A, and subject to the lifetime maximum explained directly below, your LTD benefits will end on the earliest occurrence of the following events (as determined by the Plan Administrator, in its sole discretion):

- Termination of the period of your Disability;
- The date you fail to furnish proof of continuance of total Disability upon 30 days following the Company's or insurance company's written request;
- The date you cease to receive appropriate care and treatment for your Disability;
- The date you voluntarily resign or are involuntarily terminated by the Company;
- For disabilities incurred on or after April 1, 2020, an Employee who has not attained age sixty (60) years at the date his or her Disability commences will be eligible to receive long term disability benefits until the end of the month in which the Disabled Employee attains age sixty-five (65) years; or
- If you are at least age 60 when your Disability commences, the maximum period is as set forth in the following table:

Age at Commencement of Disability	Maximum Duration of LTD Benefits
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Any succeeding periods of Disability that result from the same or a different cause, or multiple causes, will be considered a continuation of your previous period of Disability, unless you have returned to active, full-time employment for not less than 45 calendar days.

LIFETIME MAXIMUM LTD BENEFITS

For disabilities incurred on or after April 1, 2020, LTD benefits for disabilities caused by certain underlying conditions identified by the Plan Administrator, in its sole discretion, will last no longer than the lifetime maximum of twenty-four (24) months, unless terminated earlier pursuant to this SPD. Such underlying conditions will be determined in accordance with the plan documents and include Disability due to (1) alcohol, drug, or substance abuse; (2) mental, nervous and neurological disorders; (3) neuromuscular, musculoskeletal or soft tissue disorders (such as fibromyalgia) or (4) chronic fatigue syndrome and related conditions. A list of conditions that are subject to this 24-month limitation can be found on benefits.cat.com.

SUSPENSION OF BENEFITS

Benefits under the Program may be suspended upon the sole discretion of the Plan Administrator during the 30-day grace period in which you are required to provide proof of continued Disability.

SOCIAL SECURITY DISABILITY INSURANCE BENEFITS AWARD

If you are Disabled, you may be required to file for Social Security disability benefits. The Plan Administrator may reduce your LTD benefits under the Program by the amount it determines would be payable by Social Security if you did make an application for Social Security benefits. STD benefits will not be reduced by any Social Security benefits to which you are entitled. If the Plan Administrator has a good faith belief that you are receiving Social Security benefits while also receiving LTD benefits under the Program, the Plan Administrator may request documentation of a Social Security benefit award (or pending award) or documentation of your denial of Social Security benefits. If you do not provide such documentation to the Plan Administrator, benefits payable under the Program may be retroactively reduced.

If you receive a Social Security disability benefits award as a result from a reconsideration or hearing before an administrative law judge, the amount of disability benefits overpayment will be reduced by the amount of attorney fees associated with the award, provided that:

- You make the repayment within 30 days of the date you are notified of the amount to be repaid;
- The reduction applies only to attorney fees associated with a successful appeal of a denial of Social Security disability benefits and includes only that portion of the attorney's fee associated with the period of time you were entitled to receive benefits under the Program; and

- The reduction for such attorney fees may not exceed 25% of the overpayment.

VOLUNTARY BENEFITS

AN INTRODUCTION TO YOUR BENEFITS

This *Voluntary Benefits* section of the SPD summarizes the voluntary benefit coverage provided under various insurance policies available to Eligible Persons under the Program.

OVERVIEW OF VOLUNTARY BENEFITS

The following voluntary benefits are available under the Program:

- *Accident Insurance.* Accident insurance provides cash benefits in the event of a covered non-occupational injury or accident.
- *Critical Illness Insurance.* Critical illness insurance provides a lump sum cash benefit in the event of a covered critical illness.
- *Hospital Indemnity Insurance.* Hospital indemnity insurance provides cash benefits in the event of a covered hospitalization.
- *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.

ELIGIBILITY FOR VOLUNTARY BENEFITS

You are eligible for voluntary benefits coverage under the Program if you are a Management, Non-Management, Expatriate, Part-Time Employee, Supplemental Employee or Temporary Employee and otherwise satisfy the eligibility requirements of the Program. Inpatriates are not eligible for voluntary benefits.

ENROLLING IN VOLUNTARY BENEFITS

You may elect to participate in voluntary benefit coverage for yourself and any of your eligible Dependents during the Annual Enrollment Period, and such coverage will begin on January 1st of the following year. However, for legal insurance coverage, you may also elect coverage for yourself and any of your eligible Dependents during your first 31 days of employment, and such coverage will begin on your first day of Active Employment. 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. Changes to your voluntary benefit coverage may only be made during the Annual Enrollment Period.

COST OF COVERAGE

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

NO CONTINUATION OF VOLUNTARY BENEFIT COVERAGE

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

GENERAL ADMINISTRATION

CLAIMS PROCEDURE

FILING A CLAIM FOR BENEFITS

Plan/Benefit	Information Needed	Where to Send Your Claim	Deadline* and Initial Decision
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">HEALTH, LIFE, DISABILITY AND VOLUNTARY</p> <p>Medical Benefits</p>	<ul style="list-style-type: none"> • Employee’s name and address • The patient’s name, age and relationship to the Employee • The member and group numbers stated on your ID card • An itemized bill from your Provider that includes: <ul style="list-style-type: none"> - Patient diagnosis code(s) - Date(s) of service - Procedure/treatment 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). 	<p>UnitedHealthcare Insurance Company P.O. Box 740800 Atlanta, GA 30374-0800</p> <p>Customer Service & Personal Health Support Notification: (866) 228-4215 www.myuhc.com</p>	<p>Deadline:</p> <ul style="list-style-type: none"> • One year following the date the expenses were incurred. <p>An expense is incurred on the date you receive the service. Claims filed after this deadline will not be paid.</p> <p>Initial Decision:</p> <ul style="list-style-type: none"> • 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
Prescription Drug Benefits	<p>A receipt that provides:</p> <ul style="list-style-type: none"> • Date Filled • Days Supply • Drug Name and Strength • Price • Patient Name • Rx No. • Quantity <p>Caterpillar Prescription Drug Expense Claim Form</p>	<p>Magellan Health Services Attn: Claims Dept. 11013 W. Broad St. Suite #500 Glen Allen, VA 23060 Tel: (877) 228-7909 Fax: (800) 424-7644</p>	<p>Deadline:</p> <ul style="list-style-type: none"> • One year following the date the expenses were incurred. <p>An expense is incurred on the date you receive the service. Claims filed after this deadline will not be paid.</p> <p>Initial Decision:</p> <ul style="list-style-type: none"> • 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
Dental Benefits	<p>A claim form with the following information:</p> <ul style="list-style-type: none"> • Your 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. <p>Claim forms are available on the internet at benefits.cat.com or can be obtained by calling the Claims Administrator.</p>	<p>CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037 myCigna.com</p>	<p>Deadline:</p> <ul style="list-style-type: none"> • One year following the date the expenses were incurred. <p>An expense is incurred on the date you receive the service. Claims filed after this deadline will not be paid.</p> <p>Initial Decision:</p> <ul style="list-style-type: none"> • 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
Vision Benefits	<p>A claim form with the following information:</p> <ul style="list-style-type: none"> • Your name, address and date of birth • Patient's name and date of birth • The name and telephone number of the Provider of the service(s) • Date(s) of service • Claim information • Itemized receipt(s) <p>Claim forms are available at benefits.cat.com or can be obtained by calling VSP.</p>	<p>VSP P.O. Box 385018 Birmingham, AL 35238-5018 (800) 877-7195 VSP.com</p>	<p>Deadline:</p> <ul style="list-style-type: none"> • One year following the date the expenses were incurred. <p>An expense is incurred on the date you receive the service. Claims filed after this deadline will not be paid.</p> <p>Initial Decision:</p> <ul style="list-style-type: none"> • 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
HEALTH, LIFE, DISABILITY AND VOLUNTARY	FSA Plan	FSA Claim Form and proof of the expenses incurred or services rendered, as described in the <i>Flexible Spending Account Claims</i> subsection beginning on page 116.	UnitedHealthcare Attn: Flexible Spending Unit P.O. Box 981178 El Paso, TX 79998-1178 Fax: (915) 781-1085	Deadline: By March 31 of the following year Initial Decision: Health Care FSA: Within 30 days after claim is filed** Dependent Care FSA: Within 90 days after claim is filed***
	Life Insurance, AD&D	Call the Plan Administrator at (888) 228-1811	MetLife P.O. Box 14406 Lexington, KY 40512-4406 metlife.com/mybenefits	Initial Decision: Within 90 days after claim is filed***
	Disability Benefits	Call the Plan Administrator at (309) 675-1665	Caterpillar Inc. Attn: Disability Administration 100 NE Adams Street Peoria, IL 61629-4320	Deadline: Within 30 days of first day of your Disability Initial Decision: Within 45 days after claim is filed****
	Voluntary Benefits - Accident Insurance, Critical Illness Insurance, Hospital Indemnity Insurance	Call the Claims Administrator at (866) 828-8501	Allstate Benefits American Heritage Life Insurance Company P.O. Box 43067, Jacksonville, FL 32203-3067 https://www.allstatebenefits.com/mybenefits/User/Login/	Initial Decision: Within 90 days after claim is filed***
	Voluntary Benefits - Legal Insurance	Call the Claims Administrator at (800) 247-4184	ARAG Legal 500 Grand Ave, Suite 100 Des Moines, IA 50309 www.araglegalcenter.com	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.

Please note that the Program will avail itself of compliance grace periods issued by the Department of Labor as necessary.

MEDICAL BENEFIT CLAIMS

If a Provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you don't provide this information to the Claims Administrator within one year from the date the expenses were incurred, benefits for that health service will be denied or reduced, in the Claims Administrator's sole discretion. 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 provisions. 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.

PRESCRIPTION DRUG BENEFIT 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 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 110;
- Complete the Caterpillar Prescription Drug Expense Claim Form available under the U.S. RX tab at benefits.cat.com or by calling Magellan Health Services at (877) 228-7909;
- Submit claim form and receipt to Magellan Health Services (via the fax number or address on the claim form);
- Magellan Health Services 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 Health Services system.

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

DENTAL BENEFIT 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 provisions.

VISION BENEFIT 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 provisions.

FLEXIBLE SPENDING ACCOUNT CLAIMS

REQUESTING A REIMBURSEMENT FROM YOUR FLEXIBLE SPENDING ACCOUNT

To be reimbursed from your FSA Plan account simply submit a reimbursement form, called an FSA Claim Form, for the expenses you or your dependent incurred. An FSA Claim Form is available from the Company at benefits.cat.com.

For reimbursement from your HCFSA, you must include 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.

For reimbursement from your Dependent Care FSA, you must submit proof of the services rendered, such as a bill, receipt, cancelled check, or invoice and Social Security or Tax Identification Number.

Only expenses incurred while you are a participant in the FSA Plan may be reimbursed from a flexible spending account. In addition, expenses incurred during one plan year cannot be reimbursed during another plan year. **The plan does not permit any extension beyond the end of the plan year in which to incur eligible expenses.** An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form at any time up to March 31 following the end of the plan year. You will be reimbursed for eligible expenses once the total of those expenses exceeds \$25, except for reimbursement with respect to the last month of the plan year.

If you have established a HCFSA, your total annual contribution is available immediately. You can request reimbursement for any amount up to your annual contribution once you have incurred an eligible expense in the plan year.

If you have established a Dependent Care FSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional deposits are made to your account, outstanding reimbursements will be processed automatically.

For covered expenses incurred during the plan year, requests for withdrawal will be accepted and processed through March 31 of the following year.

In accordance with IRS regulations, amounts directed to your HCFSA or Dependent Care FSA during the plan year but remaining in your account at the end of the processing period cannot be returned to you, except as described in the FSA Plan section regarding the carryover up to the IRS limit for the HCFSA, or as otherwise permitted for purposes of the 2021 plan year. These amounts are forfeited and applied as directed by the Company in accordance with the FSA Plan.

Remember, you cannot be reimbursed for any expenses paid by employer-sponsored medical or dental plans, and any expenses reimbursed by your HCFSA or Dependent Care FSA cannot be included as a deduction or credit on your income tax return.

DEATH AND DISABILITY CLAIMS

The Claims Administrator has the initial authority to decide whether an individual is eligible for death and Disability benefits under the Program. The Claims Administrator has the authority to decide whether an individual is disabled under the Program and the amount of benefits that are payable to such an individual.

VOLUNTARY BENEFITS CLAIMS

The Claims Administrator has the initial authority to decide whether an individual is eligible for voluntary benefit coverage under the Program.

BENEFIT DETERMINATION

INITIAL DECISION

The *Filing A Claim for Benefits* chart beginning on page 110 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 Claims 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 description of available internal appeals, external review processes (where applicable), and 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:

- The date(s) of service;
- The name of the provider;
- The claim amount;
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning (for prescription drug claims, if provided by you or your authorized representative);
- 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;
- In the case of an Urgent Care claim, a description of the expedited review process; and
- Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act to assist you with the claims and appeals process and external review processes.

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

- A discussion of the decision including an explanation of the basis for disagreeing with or not following: (i) the views presented to the Program of health care professionals treating you or vocational professionals who evaluated you; (ii) the views of the medical or vocational experts whose advice was obtained on behalf of the Program, without regard to whether the advice was relied upon in making the benefit determination; and (iii) the Social Security Administration disability determination presented by you to the Program;
- 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; and
- 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.

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 Disability and 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 appealing your claim. This appeals process is outlined in this *Further Review and Appeals* section below. You must follow this process in order to pursue a claim for benefits 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.

Type of Benefit	Send requests for review to the Claims Administrator at:
Plan Eligibility	Request a Claim Initiation Form by contacting the Caterpillar Benefits Center at (877) 228-4010
Medical Benefits	UnitedHealthcare Insurance Company Attn: Caterpillar Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 (866) 228-4215
Prescription Drug Benefits	Magellan Health Services Attn: Claims Dept. 11013 W. Broad St., Suite #500 Glen Allen, VA 23060 Tel: (877) 228-7909 Fax: (800) 424-7644
Dental Benefits	CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037 (800) 244-6224
Vision Benefits	VSP Member Appeals 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195
Flexible Spending Account Benefits	UnitedHealthcare Attn: Flexible Spending Unit P.O. Box 981178 El Paso, TX 79998-1178 Tel: (866) 288-4215 Fax: (915) 781-1085
Life Insurance and AD&D	MetLife P.O. Box 14406 Lexington, KY 40511 metlife.com/mybenefits (888) 228-1811
Disability Benefits	Caterpillar Inc. Attn: Disability Administration 100 NE Adams Street Peoria, IL 61629-4320 (309) 675-1665
Voluntary Benefits - Accident Insurance, Critical Illness Insurance, Hospital Indemnity Insurance	Request a Claim Initiation Form by visiting https://www.allstatebenefits.com/mybenefits/User/Login/

Type of Benefit	Send requests for review to the Claims Administrator at:
Voluntary Benefits - Legal Insurance	Request a Claim Initiation Form by visiting www.araglegalcenter.com

MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION BENEFIT 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 141.

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 110 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 118 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.

The Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied on or generated by the Claims Administrator (or at the direction of the Claims Administrator) in connection with your claim. The evidence will be provided as soon as possible and sufficiently in advance of the date the Claims Administrator must provide notice of its decision on the appeal in order to allow you time to respond. In addition, before the Claims Administrator can issue an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale.

The rationale will be provided as soon as possible and sufficiently in advance of the date the Claims Administrator must provide notice of its decision on the appeal in order to allow you time to respond.

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 117), 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 117), 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 118.

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 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 the 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 an appeal for any other post-service coverage determination.

Please note that the Claims Administrator's decision is based only on whether 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.

In certain circumstances, you may be entitled to request an expedited external review from an independent third party. See *External Review of Appeals and Expedited External Review* beginning on page 123.

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 date(s) of service;

- The name of the provider;
- The claim amount;
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning (for prescription drug claims, if provided by you or your authorized representative);
- 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 (including external reviews) 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.”
- Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act to assist you with the claims and appeals and external review processes.

External Review of Appeals

You may request an external review by an independent third party if you are not satisfied with the Claims Administrator’s decision on appeal. External review is only for claims involving medical judgment or a rescission (retroactive cancellation) of coverage. For information on how to request an external review, contact the Claims Administrator. Your request must be filed within 4 months after the date of receipt of the final adverse benefit determination. Denials based on eligibility are not eligible for external review.

Within five business days following the date of receipt of the external review request, the Claims Administrator will determine whether the claim is eligible for review under the external review process. The determination will be based on whether:

- You are or were covered under the Program at the time the claim was made or incurred;
- the denial relates to your failure to meet the Program’s eligibility requirements;
- you exhausted the Program’s internal claims and appeal procedures (unless you were not required to exhaust the internal appeals process); and
- you have provided all the information required to process an external review.

Within one business day after completion of this preliminary review, the Claims Administrator will provide written notification to you or your authorized representative of whether the claim is eligible for external review.

If the request for review is complete but not eligible for external review, the Claims Administrator will notify you or your authorized representative of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. You or your authorized representative will have 48 hours or until the last day of the four-month filing period, whichever is later, to submit the additional information.

If the request is eligible for the external review process, the Claims Administrator will assign it to a qualified independent review organization (“IRO”). The IRO is responsible for notifying you, in writing, that the request for external review has been accepted. The notice should include a statement that you may submit in writing, within ten business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Claims Administrator. The Claims Administrator may consider this information and decide to reverse its denial of the claim. If the denial is reversed, the external review process will end.

If the Program does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

- your medical records;
- the attending health care professional’s recommendation;
- reports from appropriate health care professionals and other documents submitted by the plan or issuer, you or your treating provider;
- the terms of the Program;
- appropriate practice guidelines;
- any applicable clinical review criteria developed and used by the Program; and
- the opinion of the IRO’s clinical reviewer.

The IRO must provide written notice to you and the Program of its final decision within 45 days after the IRO receives the request for the external review. The IRO’s decision notice must contain:

- a general description of the reason for the external review, including information sufficient to identify the claim (including date of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial);
- the date the IRO received the assignment to conduct the review and the date of the IRO’s decision;
- references to the evidence or documentation considered by the IRO in reaching its decision;
- a discussion of the principal reason(s) for the IRO’s decision;
- a statement that the determination is binding and that judicial review may be available; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793.

Expedited External Review

Generally, you must exhaust the Program’s claims and appeals procedures in order to be eligible for the external review process. However, you may request an expedited external review if:

- you receive an adverse benefit determination that involves a medical condition for which the time for completion of the Program’s internal claims and appeal procedures would seriously jeopardize your life or health or ability to regain maximum function and you have filed a request for an expedited internal review; or
- you receive a final adverse benefit determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize your life or health or your ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Claims Administrator must determine and notify you whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for an expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as your medical condition or circumstances require, but in no event more

than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both you and the Claims Administrator.

FLEXIBLE SPENDING ACCOUNT CLAIMS

HOW TO APPEAL A HEALTH CARE FSA 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 Plan 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."

HOW TO APPEAL A DEPENDENT CARE FSA 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 60 days from the date the claimant received the notice of denial of the claim or within 60 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. However, if special circumstances require an extension of time to reach a final decision, written notice of the final decision will be sent as soon as possible following the expiration of the initial 60-day period, but no later than 120 days following receipt of the request for review of a denied claim or notice of a complaint or dispute. If special circumstances require such an extension of time, written notice of the extension shall be furnished to you prior to the expiration of the initial 60-day period. The written notice of the final decision will give specific reason(s) for the decision and references to the provision(s) of the plan on which the decision is based. If the final written decision is not furnished to you within 60 days (or if an extension was required, 120 days) from the date of receipt of the request for review of a denied claim or notice of a complaint or dispute, the request for review or the complaint or dispute shall be deemed to be rejected and denied on review.

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 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; 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.”

DEATH, DISABILITY AND VOLUNTARY BENEFITS CLAIMS

HOW TO APPEAL A DEATH, DISABILITY OR VOLUNTARY BENEFITS 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 60 days (180 days for a STD or LTD benefit claim) from the date the claimant received the notice of denial of the claim or within 60 days (180 days for a STD or LTD benefit claim) 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.
- For STD and LTD benefit claims, 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. You will also be provided with any new or additional evidence considered, relied upon, or generated by the Program in connection with your claim, or any new or additional rationale for denying the claim as soon as possible and sufficiently in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision due date.
- A written notice of the decision on appeal will usually be sent to you within 60 days (45 days for a STD or LTD benefit claim) of receipt of the written request for review of a denied claim or notice of a complaint or dispute. However, if special circumstances require an extension of time to reach a decision, written notice of the decision on appeal will be sent as soon as possible following the expiration of the initial 60-day period (45 day period for a STD or LTD benefit claim), but no later than 120 days (90 days for a STD or LTD benefit claim) following receipt of the request for review of a denied claim or notice of a complaint or dispute. If special circumstances require such an extension of time, written notice of the extension shall be furnished to you prior to the expiration of the initial 60-day period (45 day period for a STD or LTD benefit claim). The written notice of the decision on appeal will give specific reason(s) for the decision

and references to the provision(s) of the plan on which the decision is based. If the written decision on appeal is not furnished to you within the time period from the date of receipt of the request for review of a denied claim or notice of a complaint or dispute, the request for review or the complaint or dispute shall be deemed to be rejected and denied on review.

- If you have filed an STD or LTD benefit claim and you are not satisfied with the decision on appeal, 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.

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;
- For STD or LTD benefit claims, a discussion of the decision including an explanation of the basis for disagreeing with or not following: (i) the views presented to the Program of health care professionals treating you or vocational professionals who evaluated you; (ii) the views of the medical or vocational experts whose advice was obtained on behalf of the Program, without regard to whether the advice was relied upon in making the benefit determination; and (iii) the Social Security Administration disability determination presented by you to the Program.
- 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 and for STD or LTD benefit claims, a description of any applicable Program-imposed limitations period, including the calendar date when the limitations period will expire;
- 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. 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 coverages or entitlements. The terms of the plans 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 plans, the plans' 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 plans, including the making of factual determinations. The Plan Administrator shall have the sole discretionary authority to grant or deny benefits under the plans. Benefits under the plans 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 plans.

The Plan Administrator may delegate to other persons responsibilities for performing certain duties of the Plan Administrator under the terms of the plans and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the plans. 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 141 the authority described in this *Plan Administration* section, including the authority to determine eligibility and entitlement to plan benefits and to construe the terms of the plans. 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 and the FSA Plan or any of the component plans, in whole or part, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by the Company. The Company may also delegate the authority to amend the plans by resolutions or other actions of the Board of Directors. This right applies to every aspect of the Program and the FSA Plan, 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 and the FSA Plan, whether or not specifically stated with respect to any particular aspect.

If the plans are modified, amended or terminated, you will be notified of the effect of such change on your plan 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 any of the plans described in this SPD.

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.

COMPANY AUDIT

The Company and the Plan Administrator reserve the right to audit any aspect of the Program or the FSA Plan, including but not limited to eligibility, enrollment and claims. In connection with any such audit, the Plan Administrator may request from you, your Spouse or 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 Same-Sex Domestic Partner's or your Dependent's) coverage or benefits under the Program and/or the FSA Plan.

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 plans except by means of a duly authorized written amendment. No verbal or written representations contrary to the terms of the plans are binding upon the plans, the Plan Administrator or the Company.

NO ASSIGNMENT

- 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, 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 with standing 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 plans' 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 assure you of continued employment with the Company or rights to benefits except as specified under the terms of the plans. Nothing in the plans or this SPD confers any right of continued employment on any employee.

PARTICIPATING COMPANIES

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

IMPLIED PROMISES

Nothing in this SPD states or implies that participation in the plans is a guarantee of continued employment with the Company. No rights accrue to any Employee, Dependent or Beneficiary by reason of any misstatement in, or omission from, this SPD, or by the operation of the plans.

PROTECTION FROM CREDITORS

With certain exceptions, your plan accounts are subject to the claims of your creditors and may not be assigned, pledged or otherwise used as collateral for a loan.

CHANGE OF ADDRESS

It is important that you notify 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 and you are an active employee, you may update your records under the Program by updating PeopleSoft or by contacting the Caterpillar HR Service Center – Americas at (800) 447-6434.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A participant may appoint, in accordance with the Plan Administrator's procedures, 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.

SEVERABILITY

If any provision of the plans 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 plans 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 plans 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, or the Company may (whether or not upon the request of the Claims Administrator) make any appropriate deduction(s) from your future compensation.

FORFEITURE OF UNCLAIMED OR ABANDONED BENEFIT PAYMENTS

If you receive a medical, vision, prescription drug, or dental benefit payment by check, or if you receive a benefit payment by check from the FSA Plan, 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 plan pays benefits for expenses incurred on your account, you or any other person or organization that was paid, must make a refund to the plan 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 plan made exceeded the benefits under the plans.

The refund equals the amount the plan paid in excess of the amount the plan should have paid under the plans. 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 plan may reduce the amount of any future benefits that are payable under the applicable plan. The reductions will equal the amount of the required refund. The plan may have other rights in addition to the right to reduce future benefits.

SUBROGATION

MEDICAL BENEFITS

The following provisions apply to benefits administered by UnitedHealthcare. If you are enrolled in the Blue Cross Blue Shield National EPO, 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 (i) construe and enforce the terms of the Program's subrogation and reimbursement rights and (ii) make determinations with respect to the subrogation amounts and reimbursements owed to the Program.

DISABILITY BENEFITS

The following subrogation provisions are added and apply to disability benefits under the Program.

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. If you receive a benefit payment from the Program for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, the Program has the right to recover any payments made by the Program to you. This process of recovering earlier payments is called subrogation. In case of subrogation, you may be asked to sign and deliver information or documents necessary for the Program to protect its right to recover benefit payments made. You agree to provide the Program all assistance necessary as a condition of participation in the Program, including cooperation and information submitted to or supplied by a workers' compensation, liability insurance carrier, and any medical benefits, no-fault insurance, or school insurance coverage that are paid or payable.

The Program shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits it provided to you from any or all of the following:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity 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 (these third parties and persons or entities are collectively referred to in this section as "Third Parties").
- This right of subrogation does not apply against insurers of policies of insurance issued to, and in the name of, the Employee or covered Dependent.

You agree as follows:

- To assign to the Program all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits it provided, plus reasonable costs of collection.
- To cooperate with the Program in a timely manner protecting its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
 - Providing any relevant information requested by the Program.
 - Signing and 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.
 - Appearing at dispositions and in court.
 - Obtaining the consent of the Program or its agents before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and the institution of legal action against a Covered Person.
- That the Program has the authority and sole discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That the rights of the Program will be considered as the first priority claim against Third Parties, to be paid before any other of your claims are paid.
- That you will do nothing to prejudice the rights of the Program under this provision, either before or after the need for services or benefits under the Program.

- That the Program may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name.
- That regardless of whether you have been fully compensated or made whole, the Program may collect from 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, the reasonable value of services provided under the Program.
- To hold in trust for our benefit under these subrogation provisions any proceeds of settlement or judgment.
- That the Program shall be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you.
- That you will not accept any settlement that does not fully compensate or reimburse the Program without written approval.
- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records), and provide such help (including responding to requests for information about any Accident or injuries and making court appearances) as the Program may reasonably request from you.
- That the Program may set off from any future benefits otherwise allowed by the Program the value of benefits paid or advanced under this section to the extent not recovered by the Program.
- That the rights of the Program will not be reduced due to the Covered Person's own negligence.
- That the Program shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.
- That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.
- That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Beneficiary, this section applies to the personal representative of the deceased Beneficiary.

The Program will not pay fees, costs or expenses you incur with any claim or lawsuit, without our prior written consent.

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 or Disability 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 coverage.

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

FSA PLAN

The FSA Plan is funded by general assets of the Company, based on the salary reduction elections made by participating Employees.

	Self-Insured	Fully Insured	
Benefits	Medical Prescription Drug Dental Vision Care	Short term Disability Flexible Spending Account Long term Disability	Life insurance benefits AD&D Voluntary Benefits
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 on 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 as well as Employee payroll deductions.	

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 and/or FSA Plan, you may bring action in court to recover benefits after you have exhausted the Program's or FSA Plan's claims procedures, as applicable. 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 plans are 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 you receive a final adverse benefit determination under the claims procedures. You should 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) and the HCFSA, 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 is 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 Employee, 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 141. They can advise whether your Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

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 Administrator may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you 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 Employee'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.

WORKERS' COMPENSATION NOT AFFECTED

Benefits provided under the Program do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

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] CatBenefitsCenter.com
COBRA Administrator	Caterpillar Benefits Center (877) 228-4010 [Outside the U.S. 718-354-1345] CatBenefitsCenter.com
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
Voluntary Benefits	Caterpillar Benefits Center (877) 228-4010 [Outside the U.S. 718-354-1345] CatBenefitsCenter.com

Plan Sponsor:	Agent for Legal Service:
Caterpillar Inc. 510 Lake Cook Road, Suite 100 Deerfield, IL 60015 (224) 551-4000 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. Employee Health, Life and Disability Benefit Program	541	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 Health Services Attn: Claims Dept. 11013 W. Broad St. Suite #500	Caterpillar Inc. Attn: Plan Administrator – Employee Health, Life and Disability 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
		<p>Glen Allen, VA 23060 Tel: (877) 228-7909 Fax: (800) 424-7644</p> <p>Dental benefit claims are administered by: CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037 (800) 244-6224 myCigna.com</p> <p>Vision benefit claims are administered by: VSP P.O. Box 385018 Birmingham, AL 35238-5018 (800) 877-7195 VSP.com</p> <p>Life insurance and AD&D claims are administered by: MetLife P.O. Box 14406 Lexington, KY 40511 (888) 228-1811 metlife.com/mybenefits</p> <p>Disability benefit claims are administered by: Caterpillar Inc. Attn: Disability Administrator 100 NE Adams Street Peoria, IL 61629-4320 (309) 675-1665</p> <p>Voluntary benefit claims for accident insurance, critical illness insurance and hospital indemnity insurance are administered by: Allstate Benefits American Heritage Life Insurance Company P.O. Box 43067 Jacksonville, FL 32203-3067 (866) 828-8501 https://www.allstatebenefits.com/mybenefits/User/Login/</p> <p>Voluntary benefit claims for legal insurance are administered by: ARAG Legal 500 Grand Ave, Suite 100 Des Moines, IA 50309 (800) 247-4184 www.araglegalcenter.com</p>		

Plan Name/Type	Plan Number	Funding/Claims Administrator	Plan Administrator	Plan Year
Caterpillar Inc. Flexible Spending Account Plan	531	The plan is administered by: UnitedHealthcare Attn: Flexible Spending Unit P.O. Box 981178 El Paso, TX 79998-1178 (866) 228-4215 benefits.cat.com	Caterpillar Inc. Attn: FSA Plan Administrator 100 NE Adams Street Peoria, IL 61629 (309) 675-1000	The 12-month period ending December 31

DEFINITIONS

Accident – An unexpected, unintentional, and unforeseen traumatic experience by an outside force, specific as to time and place that results in the inability of the participant to return to work with a Participating Company.

Actively at Work and Active Employment – The employment status of an Employee who currently works at his or her assigned place of employment for a Participating Company during assigned working hours. An Employee shall be deemed to be Actively at Work on a day that is not a regularly scheduled work day or a day that is eligible for pay under the Company’s vacation, sick pay, paid time off or Leave of Absence policies, provided that he or she performed, in the customary manner, all of the regular duties of his or her job on the last preceding scheduled work day.

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 Base Salary – Regular compensation, excluding any bonus, incentive compensation, overtime pay and/or extra shift or night shift premiums. For Solar Employees who are on sales incentive and service incentive plans, annual base salary means 100% of the relevant Target Total Cash Compensation [TTCC].

Annual Deductible – If you are enrolled in a traditional PPO or EPO 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 drug expenses in a calendar year before the Program will begin paying for benefits in 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 plan, 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 73.

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, formerly Aon Hewitt) for eligibility, change in status events and COBRA continuation coverage under the Program.

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 plans.

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.

Continuous Service – The time elapsed since your last date of hire or last date of rehire as a Full-Time Employee after a break in service; provided, however, that Continuous Service shall not include service as an Employee of an Employer for any period of time during which the Employer was not an Affiliate. A break in service is caused by any event considered a termination of service by the Company (or other participating employer last employing you), in its sole discretion.

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 SupportSM (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 72 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 31 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 Employee 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.

Covered Person Under Their Own Right – If you are covered under a plan sponsored by the Company (including any collectively bargained plan) and your Spouse is covered (or is eligible to be covered) by a plan sponsored by the Company or an Affiliate (including any collectively bargained plan), you will each be covered by your separate plans. If you are covered by a plan sponsored by the Company (including any collectively bargained plan) and your Spouse is a former Employee or a retiree covered by a plan sponsored by the Company or an Affiliate (including any collectively bargained plan), you are each covered by your separate plans.

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 Participants, the Employee’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 Employee or the Employee’s Spouse or Same-Sex Domestic Partner. For Solar Participants, the Employee’s (a) legal Spouse or Same-Sex Domestic Partner or (b) Dependent child of the Employee or the Employee’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 child will be deemed to be under 26 years of age until the last day of the month he or she turns age 26.

The Employee must reimburse the Company for any benefits that it pays for a child at a time when the child did not satisfy these conditions.

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

Dependent Care Flexible Spending Account or Dependent Care FSA – The account established for an Employee to record the contributions which the Employee has elected to make to such account and the reimbursements made to such Employees for eligible dependent care expenses.

Designated Provider(s) – A Hospital, provider and/or facility 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, or a Physician is a Network Physician, does not mean that the Hospital or Provider is a Designated Provider.

Disability and Disabled –

Short Term Disability Benefits: For purposes of short term disability benefits, “Disability” and “Disabled” mean an Employee is wholly and continuously disabled by an Injury or Sickness so as to be prevented from performing any and every duty of his or her occupation from the time the Injury or Sickness occurs, as determined by the Claims Administrator, in its sole discretion.

Long Term Disability Benefits: For purposes of long term disability benefits, “Disability” and “Disabled” mean an Employee is not engaged in regular employment or occupation for remuneration or profit (excluding employment or occupation which is determined to be for purposes of rehabilitation) and it is determined by the Claims Administrator, in its sole discretion, on the basis of medical evidence satisfactory to the Claims Administrator that such Employee is totally disabled by bodily Injury or disease so as to be prevented thereby from engaging in any regular occupation or employment.

For purposes of determining whether a Solar Participant is on a Disability Leave of Absence, “Disability” and “Disabled” shall be determined in accordance with the Solar Turbines Incorporated Group Insurance Program or, for those employees eligible to participate in the California State Disability Insurance Program, in accordance with the California State Disability Insurance Program.

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) and must 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, as 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.

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; or
- 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 3.

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.

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 – An Eligible Person who is properly enrolled under the Program. The Employee is the person (who is not a Dependent) on whose behalf the plan is established. An Employee who is totally and permanently Disabled shall be considered an Employee until the Employee’s Disability Leave of Absence terminates.

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

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

Evidence of Insurability – A statement provided by the participant to the Claims Administrator regarding the health history of the participant and any Dependents who are Covered Persons to determine insurability for life insurance benefits under the Program. The Claims Administrator, in its sole discretion, shall determine if such Evidence of Insurability is satisfactory.

Expatriate – An employee of the Company or an Affiliate who is classified by the Company, in its sole discretion, as an expatriate in accordance with the Company’s human resources policies and procedures. For purposes of medical, prescription drug, dental, and vision benefits, “Expatriate” means an employee of the Company or an Affiliate who is classified by the Company, in its sole discretion, as an expatriate in accordance with the Company’s human resources policies and procedures and is not eligible to participate in any other medical plan sponsored by the Company or an Affiliate.

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, except as otherwise provided under the Program.

To the extent you qualify for an approved clinical trial, the Program will cover the associated routine patient costs at the normal Program cost-sharing levels to the extent required by the PPACA. An approved clinical trial includes phase I, II, III, or IV trial if it is conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted.

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.

Family Leave of Absence – An absence from Active Employment taken by an Employee pursuant to the Family and Medical Leave Act of 1993 for the purpose of 1) caring for your child after birth or placement for adoption or foster care; 2) caring for your spouse, child, or parent who has a serious health condition; or 3) your serious health condition that makes you unable to perform your job.

Full-time Employee – A regular Employee of the Company who is employed for work on the prevailing schedules of the department to which he or she is assigned.

GPFSA – A type of Health Care Flexible Spending Account that can be used to reimburse the Employee for eligible medical, dental, and vision expenses.

Health Care Flexible Spending Account or HCFSA – The account established and maintained for an Employee to record the contributions that the Employee has elected to make to such account and the reimbursements made to such employee for eligible medical care expenses. The HCFSA includes both the General Purpose FSA (“GPFSA”) and the Limited Purpose FSA (“LPFSA”).

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 or FSA Plan and is not an employee welfare benefit 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.

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 plan.

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.

Inpatriate - An employee of a foreign Affiliate who is classified by the Company, in its sole discretion, as an inpatriate in accordance with the Company’s human resources policies and procedures. For purposes of medical, prescription drug, dental, and vision benefits, “Inpatriate” means an employee of a foreign Affiliate who is classified by the Company, in its sole discretion, as an inpatriate in accordance with the Company’s human resources policies and procedures and is not eligible to participate in any other medical plan sponsored by the Company or an Affiliate.

Insurance Carrier – A legal reserve life 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.

International Service Employee – An Employee of Caterpillar or related company who, for employment purposes is so designated by Caterpillar, in its sole discretion, including but not limited to Expatriates and Inpatriates.

Layoff – A Participating Company-initiated separation of an Employee from Active Employment, or termination of an Employee’s employment, for economic or business reasons, while there is an expectation that the Employee may be recalled to Active Employment or rehired when business conditions improve to the extent the Plan Administrator, in its sole discretion, determines that the separation or termination constitutes a Layoff.

Leave of Absence – A period of absence from Active Employment that is not treated as a termination of employment in accordance with the Participating Company’s policy.

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.

LPFSA - A type of Health Care Flexible Spending Account that can be used to reimburse the Employee for eligible dental and vision expenses.

Management Employee – An individual employed by an Employer on a regular, Full-Time basis who for employment purposes, is designated by the company, in its sole discretion, as a Management Employee and who is exempt from the wage and hour provisions of the Fair Labor Standards Act.

Maximum Out-of-Pocket – The maximum amount of Annual Deductible and Co-insurance you pay out-of-pocket every calendar year.

For a Covered Person enrolled in an EPO or 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 an EPO or 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;
- 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.

If you are enrolled in a traditional PPO or EPO 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. In no event will the combined prescription drug coverage maximum out-of-pocket and medical benefits coverage Maximum Out-of-Pocket exceed the annual federal limit provided under the PPACA. For examples of how the prescription drug coverage maximum out-of-pocket is determined, please refer to the *Overview of Prescription Drug Benefit* section beginning on page 68.

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 Non-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.

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.

Monthly Base Salary – Annual Base Salary divided by 12.

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, disease, illness, or injury does not mean that it is a Necessary Covered Health Service or Covered Dental Service for purposes of the Program. This definition of Necessary relates only to Covered Health Services and Covered Dental Services and differs from the way in which a Provider 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 is designated by the Company as a Network Pharmacy.

Non-Bargained Hourly Employee – An individual employed by an Employer on a regular, Full-Time basis who is (a) employed for work on the prevailing schedule of the department to which he or she is assigned; (b) for employment purposes, designated by the Company, in its sole discretion, as a Non-Bargained Hourly Employee; and (c) not covered by a collective bargaining agreement with a union.

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-Management Employee – Any Employee other than a Management Employee or an employee for whom benefits are covered by a collective bargaining agreement with a union, unless such agreement specifically provides for participation in the Program or in certain benefits available under the Program. Non-Management Employees include Salaried/Support Employees and Non-Bargained Hourly Employees.

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 employees with the approval of Caterpillar Inc.

Part-Time Employee – An individual employed by an Employer on a regular, part-time basis who is classified by the Company, in its sole discretion, as a part-time employee.

Personal Health SupportSM – A program provided by the Program Claims Administrator designed to encourage an efficient system of care for 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 (except with respect to disability claims and certifications thereof) 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. For purposes of disability claims and certifications thereof, physician assistants, certified nurse practitioners and podiatrists will be considered on the same basis as a Physician.

Plan Administrator – Caterpillar Inc. or its designee as that term is defined under ERISA. The Plan Administrator for each of the plan components included in this SPD is listed in the *Plan Information* chart beginning on page 141.

Plan Sponsor – Caterpillar Inc. and any of its subsidiaries that adopt the plans described in this SPD.

PPACA – Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, as such amends the applicable provisions of the Internal Revenue Code and ERISA, and the applicable regulations promulgated from time to time pursuant thereto.

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 Health Services 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 first day of the month immediately preceding the month during which the individual’s 65th birthday occurs if the birthday occurs on the first day of the month; or (2) the first day of the month during which the individual’s 65th birthday occurs if the birthday occurs on any day other than the first day of the month.

Rehabilitative Employment – Employment with the Company on a reduced-hour work schedule following a period of disability leave, provided (i) you are authorized by a physician to return to work, (ii) the Company is able to accommodate a reduced-hour work schedule at your location; and (iii) your return to work includes a plan to increase your work hours with the intent that you will ultimately return to your regular work schedule and duties. Whether you are eligible for Rehabilitative Employment will be determined by the Company in its sole discretion.

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.

Retiree Program – Caterpillar Inc. Retiree Benefit Program, as it may be amended from time to time. The Retiree Program provides health and life benefits to eligible retirees of Caterpillar and certain subsidiaries.

Salaried/Support Employee – An individual employed by an Employer on a regular, Full-Time basis who is (a) employed for work on the prevailing schedule of the department to which he or she is assigned; and (b) for employment purposes, designated by the Company, in its sole discretion, as a Salaried/Support Employee.

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 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:

- An Employee’s relationship will be treated as a Same-Sex Domestic Partnership, regardless of whether the Employee 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 Employee, then the Same-Sex Domestic Partner is the person who first met the criteria in this definition.
- In any case in which an Employee has a Spouse, no person will qualify as the Employee’s Same-Sex Domestic Partner unless the Employee’s marriage to his or her Spouse is first lawfully dissolved. If an Employee has a Same-Sex Domestic Partner, such Same-Sex Domestic Partnership must be lawfully dissolved before any other individual can qualify as such Employee’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 Employee (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, organ donation (other than for purposes of short term disability benefits), or maternity services.

Skilled Nursing Facility – A Hospital or nursing facility that is licensed and operated as required by law.

Solar Employee – An Employee of Solar Turbines Incorporated or TurboFab who is employed on a regular, full-time basis. Solar Employees shall not include Employees who are designated as International Service Employees.

Solar Participant – A Solar Employee who is a Covered Person or the Covered Dependent of such person, who is eligible to participate in the Program and, if required for the benefit coverage under the Program, has enrolled in such coverage.

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 the Program specifically excludes those services. 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.

Supplemental Employee – An individual employed by an Employer on a full-time basis who is (i) classified by the Company, in its sole discretion, as a supplemental employee; and (i) covered by a collective bargaining agreement that provides for participation in the Program.

Temporary Employee – An individual employed by an Employer on a part-time or full-time temporary basis who is classified by the Company, in its sole discretion, as a temporary employee.

Temporary Layoff – A Layoff that the Company has determined, in its discretion, is temporary.

Uniformed Service – Service in the U.S. Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, full-time National Guard Duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of war or emergency, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

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.

**EXHIBIT A
LONG TERM DISABILITY BENEFITS**

	Duration	Reduction in Benefits
Management Employees		
Claims incurred on or after January 1, 2012 but prior to April 1, 2020	<p>Long Term Disability Benefits Will Be Continued as Follows:</p> <p>For a Management Employee who has not attained age sixty (60) years at the date his or her Disability commences: (i) the end of the month in which the Disabled Employee attains age sixty-five (65) years, if such Employee was hired prior to January 1, 2012 and was a Management Employee prior to January 1, 2012; or (ii) the expiration of a period (including within such period, the period during which short term disability benefits were paid or payable) equivalent to the greater of (A) the Employee's Continuous Service when first Disabled, or (B) one and one-half years, if such Employee was hired on or after January 1, 2012 or first became a Management Employee on or after January 1, 2012. However, in no event shall long term disability benefits be paid to an Employee after the end of the month in which the Employee attains age sixty-five (65) years.</p>	
Hired prior to January 1, 2012 with claims incurred prior to January 1, 2012	<p>(1) For a Management Employee who has not attained age sixty (60) years at the date his or her Disability commences, the end of the month in which the Disabled Employee attains age sixty-five (65) years.</p> <p>(2) For a Management Employee who has attained at least age sixty (60) years at the date his or her Disability commences, the earlier of (A) the expiration of a 60-month period (including the period of salary continuation payments), and (B) the end of the month in which the Disabled Employee attains age seventy (70), but in no event shall such period be less than 6 months.</p>	Long term disability benefits will be reduced by the amount of primary benefits paid or payable under the Federal Social Security Act to the extent necessary to limit the total benefits received from Social Security and monthly disability benefits to seventy-five percent (75%) of the Employee's Annual Base Salary, divided by twelve (12).
Non-Management Employees		
Claims incurred on or after January 1, 2012 but prior to April 1, 2020	<p>Long Term Disability Benefits Will Be Continued as Follows:</p> <p>For a Non-Management Employee who has not attained age sixty (60) years at the date his or her</p>	

	Duration	Reduction in Benefits
	Disability commences, the expiration of a period (including within such period, the period during which short term disability benefits were paid or payable) equivalent to the greater of: (i) the Employee's Continuous Service when first Disabled; or (ii) one and one-half years. However, in no event shall long term disability benefits be paid to such Employee after the end of the month in which the Employee attains age sixty-five (65) years.	
Claims incurred prior to January 1, 2012 but on or after January 1, 2006	<p>(1) For a Non-Management Employee who has not attained age sixty (60) years at the date his or her Disability commences and who (i) has one or more years of Continuous Service at the date his or her Disability Commences, and (ii) is eligible to receive short term disability benefits for a twenty-six (26) week period, the expiration of a period (including within such period the period during which weekly accident and sickness benefits were paid) equivalent to the greater of (A) the Employee's Continuous Service when first Disabled, or (b) one and one-half years. However, in no event shall long term disability benefits be paid to such Employee after the end of the month in which the Employee attains age sixty-five (65) years.</p> <p>(2) For a Non-Management Employee who has not attained age sixty (60) years at the date his or her Disability commences and who (i) has one or more years of Continuous Service at the date his or her Disability Commences, and (ii) is eligible to receive short term disability benefits for a fifty-two (52) week period, the expiration of a period (including within such period the period during which weekly accident and sickness benefits were paid) equivalent to the greater of (1) the Employee's Continuous Service when first Disabled, or (B) two (2) years. However, in no event shall long term disability benefits be paid to such Employee after the end of the month in which the Employee attains age sixty-five (65) years.</p> <p>For a Non-Management Employee who has attained age sixty (60) years at the date of his or her Disability, the maximum period is as follows:</p>	

	Duration	Reduction in Benefits																		
	<table border="1"> <thead> <tr> <th>Employee's Age When Disability Commenced</th> <th>Maximum Duration of Benefits</th> </tr> </thead> <tbody> <tr> <td>60 and 0 month but less than 63 and 0 month</td> <td>48 months</td> </tr> <tr> <td>63 and 0 month but less than 68 and 1 month</td> <td>12 months</td> </tr> <tr> <td>68 and 1 month but less than 68 and 2 months</td> <td>11 months</td> </tr> <tr> <td>68 and 2 months but less than 68 and 3 months</td> <td>10 months</td> </tr> <tr> <td>68 and 3 months but less than 68 and 4 months</td> <td>9 months</td> </tr> <tr> <td>68 and 4 months but less than 68 and 5 months</td> <td>8 months</td> </tr> <tr> <td>68 and 5 months but less than 68 and 6 months</td> <td>7 months</td> </tr> <tr> <td>68 and 6 months and over</td> <td>6 months</td> </tr> </tbody> </table> <p>Any benefits due for periods other than a whole calendar month shall be such proportion of the monthly benefit as the number of workdays that the Employee is Disabled in such calendar month bears to the entire number of workdays in that calendar month. "Workdays" as used in the preceding sentence shall include any holidays falling within an Employee's regular workweek.</p>	Employee's Age When Disability Commenced	Maximum Duration of Benefits	60 and 0 month but less than 63 and 0 month	48 months	63 and 0 month but less than 68 and 1 month	12 months	68 and 1 month but less than 68 and 2 months	11 months	68 and 2 months but less than 68 and 3 months	10 months	68 and 3 months but less than 68 and 4 months	9 months	68 and 4 months but less than 68 and 5 months	8 months	68 and 5 months but less than 68 and 6 months	7 months	68 and 6 months and over	6 months	
Employee's Age When Disability Commenced	Maximum Duration of Benefits																			
60 and 0 month but less than 63 and 0 month	48 months																			
63 and 0 month but less than 68 and 1 month	12 months																			
68 and 1 month but less than 68 and 2 months	11 months																			
68 and 2 months but less than 68 and 3 months	10 months																			
68 and 3 months but less than 68 and 4 months	9 months																			
68 and 4 months but less than 68 and 5 months	8 months																			
68 and 5 months but less than 68 and 6 months	7 months																			
68 and 6 months and over	6 months																			
Claims incurred prior to January 1, 2006	For a Non-Management Employee who has not attained age sixty (60) years at the date his or her Disability commences and who has one or more years of Continuous Service at the date the Disability commences, the expiration of a period (including within such period the 52-week period during which weekly accident and sickness benefits were paid) equivalent to the greater of (1) the Employee's Continuous Service when first disabled or (2) years. However, in no event shall long term disability benefits be paid to such Employee after the end of the month in which the Employee attains age sixty-five (65) years.																			