Caterpillar Inc.
Retiree Group Insurance Plan
Summary Plan Description

* * *

For Certain Caterpillar Inc. Retirees and Former Employees Represented by IAM Local Lodge No. 851: Retired On or After August 20, 2012

This Summary Plan Description ("SPD") describes the benefits for certain retirees and other former employees of Caterpillar Inc. who were covered by the collective bargaining agreement between Caterpillar Inc. and the International Association of Machinists and Aerospace Workers, AFL-CIO, and Local Lodge No. 851 dated August 17, 2012 and certain retirees as indicated herein.

ISSUED FEBRUARY 2021
7732510

TABLE OF CONTENTS

Page

INTRODUCTION

ABOUT THIS DOCUMENT

This document is a summary of certain retiree welfare benefits provided by Caterpillar Inc. (the "Company") under the Caterpillar Inc. Retiree Group Insurance Plan (the "Plan") to retirees and dependents described in this summary. This document is a summary plan description ("SPD"), as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The provisions of this SPD are generally effective January 1, 2020. ***This SPD does <u>not</u> describe benefits for retirees who retired prior to August 20, 2012 <u>or</u> who are age 65 or older and participating in the HRA. If you are such a person, contact the Plan Administrator for a copy of the summary plan description that describes your benefits.***

You are encouraged to read this SPD. Many sections of the SPD are related to other sections of the document, and need to be read together with them. You may not have all of the information you need by reading just one section. Keep your SPD and any attachments for your future reference.

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 98. You should call the Claims Administrator at the number included in the *General Contact Information* section beginning on page 96 if you have questions about the coverage available to you.

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

- *Eligibility* – This section describes the eligibility requirements of the Plan and how to enroll in Plan coverage.
- *Health Insurance Benefits* – The following sections describe the Health Insurance Benefits available to Eligible Persons under the Plan.
  - *Medical Coverage* – This section describes the medical benefit available to Eligible Persons under the Plan.
  - *Prescription Drug Coverage* – This section describes the prescription drug benefit available to Eligible Persons under the Plan.
  - *Dental Coverage* – This section describes the dental benefit available to Eligible Persons under the Plan.
  - *Vision Coverage* – This section describes the vision benefit available to Eligible Persons under the Plan.
- *Death Benefits* – This section describes the life insurance benefits available to Eligible Persons under the Plan.
- *Voluntary Benefits* – This section describes the voluntary benefits available to Eligible Persons under the Plan.
- *General Administration* – This section describes (i) how to file a claim and the appeals process under the Plan; (ii) the important legal provisions; (iii) the Plan's contact information, including contact information for the Plan Administrator and Claims Administrators; and (iv) general Plan information.
- *Definitions* – Certain capitalized words used in this SPD have special meanings. These words are either defined in the section in which they appear or are defined in the *Definitions* section at the end of this SPD. Refer to the *Definitions* section as you read this document to have a clearer understanding of your SPD.

OFFICIAL PLAN DOCUMENT OVERVIEW

This SPD is based on the official Plan documents for the Plan. It describes the provisions of the governing Plan documents.

Every effort has been made to give you the correct and complete information about your benefits. However, if this SPD says anything that grants greater rights or benefits to participants than the Plan documents in effect, then those documents govern.

You may obtain a copy of the Plan documents from the Plan Administrator. See the *General Contact Information* section beginning on page 96 for the full name and address of the Plan Administrator.

This SPD is not a contract, and is not a guarantee of your benefits. It does not vest any benefits not otherwise expressly vested in the Plan documents.

SPECIAL NOTE REGARDING MEDICARE

For information relating to how Medicare works with the Plan, please see the section entitled *When a Covered Person Qualifies for Medicare* beginning on page 18 of this SPD.

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 Plan generally, please contact the Claims Administrator for the particular benefit or the Plan Administrator at the number stated in the section entitled *General Contact Information* beginning on page 96.

ELIGIBILITY

This Eligibility section describes the eligibility requirements for participation in the 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 benefits. Read this section carefully and refer to the section of this SPD that discusses each specific benefit to determine whether you are eligible for a specific benefit.

For purposes of this *Eligibility* section, your hire date is your last date of rehire if it follows a break in Continuity of Service. For example, if you terminated your employment with the Company in 2011 and you are re-hired by the Company on January 1, 2013, your hire date will be January 1, 2013.

ELIGIBILITY FOR THE PLAN

This *Eligibility for the Plan* section describes the eligibility requirements under the Plan. Refer to the *Health Insurance Benefits* section beginning on page 7, the *Death Benefits* section beginning on page 68 and the *Voluntary Benefits* section beginning on page 70 for a description of any additional eligibility requirements for a specific benefit. As described in the table below, the Plan covers only eligible retirees.

Individual	Eligibility Requirements
You	Generally, the Plan covers certain eligible retirees.
Retirees	You are eligible to participate in the Plan if you retired from the Company on or after August 20, 2012, were a participant in the Caterpillar Inc. Group Insurance Plan (n/k/a the Caterpillar Inc. Group Insurance Plan A) ("GIP") on the day before you retired, and at the time of your retirement you had: ▪ Completed at least 30 years of service regardless of your age; ▪ Completed at least 10 years of service and attained age 60; ▪ Completed at least five years of participation in the Caterpillar Inc. Non-Contributory Pension Plan ("NCP") and attained age 65; or ▪ Attained age 55 and the sum of your age and years of service equals at least 85. This SPD does <u>not</u> describe benefits for retirees who retired before August 20, 2012 <u>or</u> who are age 65 or older and participating in the HRA. If you are such a retiree, contact the Plan Administrator for a copy of the summary plan description that describes your benefits.

Individual	Eligibility Requirements
Your Eligible Dependents	Certain coverage is also available to your eligible Dependents. A Spouse who is 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 Plan. If you have a Spouse who is an active employee, former employee or a retiree of the Company covered by the Plan or another welfare benefit plan sponsored by the Company, you are each covered separately. Only one parent who is a Covered Person may elect coverage for the Dependent child(ren). Your eligible Dependents include your Spouse and any Dependent children who meet the eligibility requirements outlined below. 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: (1) Under 26 years of age; or (2) 26 years of age or older; and (i) Unmarried; (ii) Incapable of sustaining employment as a result of mental or physical disability as determined by the Plan Administrator; (iii) Legally resides with you or the non-employee or non-retiree parent, or in a licensed special care home or facility that specializes in the treatment of physical or mental disabilities; and (iv) Receive from you more than one-half of his or her financial support. For purposes of determining whether your dependents are eligible for benefits under the Plan, "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. 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. **Note: You may be required to provide proof of dependent status at any time.**

SAME-SEX DOMESTIC PARTNERS

For purposes of the Plan, the term "Spouse" also includes your Same-Sex Domestic Partner unless otherwise noted. Therefore, you are able to enroll your eligible Same-Sex Domestic Partner in healthcare coverage to the same extent you are able to enroll a spouse. Your Same-Sex Domestic Partner is the sole, same-sex person who is in a civil union, domestic partnership, or legal relationship similar thereto, with you, as recognized under the laws of the federal government or a state government of the United States of America, including its territories and possessions and the District of Columbia (or, with respect to any other country, legally recognized equivalent government(s) thereof). For more information regarding who may qualify as your Same-Sex Domestic Partner under the Plan, please see the definition of "Same-Sex Domestic Partner" in the *Definitions* section of the SPD beginning on page 98.

DUAL COVERAGE

Dual coverage is not permitted under the Plan. As described in the chart found at the beginning of the *Eligibility* section of the SPD on page 3, if you have a Spouse who is an active employee, former employee or a retiree of the Company eligible for or covered by the Plan or another welfare benefit plan sponsored by the Company, you are each eligible and covered separately.

Likewise, if both you and your Spouse are eligible to participate in the Plan 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 his or her own right and as your Dependent.

QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")

The Plan also provides Health Insurance Benefits for your eligible child pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"), even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment season restrictions which might otherwise exist for Dependent coverage. A QMCSO can require the Plan to provide coverage for benefits to a child who meets the Plan eligibility requirements. Additionally, if you have not elected coverage under the Plan, you will be required to cover yourself if you are required to cover your eligible child. If the Plan receives a valid QMCSO and you do not enroll yourself and the child, the state agency may enroll you and the affected child. If neither you nor the state agency take action to enroll yourself and the affected child, the Plan Administrator will enroll you and the affected child into default coverage. If your dependent child does not qualify under Internal Revenue Code Section 152 as your tax dependent or does not fit within the categories of 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 Plan. 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.

DISABLED CHILDREN

Coverage for an unmarried, Enrolled Dependent child whom 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 retiree, the non-retiree parent or in a licensed special care home or facility; and
- Receives more than one-half of his or her financial support from the retiree.

To determine whether your child qualifies for this coverage, complete the Statement of Dependent Eligibility Beyond Limiting Age Due to Mental or Physical Disability form and submit to UnitedHealthcare. You can obtain this form by contacting UnitedHealthcare at (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 Plan. However, coverage will not continue following the retiree's death. Following the retiree's death, coverage for an Enrolled Dependent under the Plan will end in accordance with the section entitled *Survivors Coverage'* beginning on page 11.

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 INSURANCE BENEFITS

AN INTRODUCTION TO YOUR BENEFITS

This *Health Insurance Benefits* section summarizes the medical, prescription drug, dental, and vision benefits provided to eligible retirees under the Plan. As a retiree, both you and the Company pay the costs of your health coverage under the Plan. You pay your share of coverage on an after-tax basis.

If you are enrolled in an Exclusive Provider Organization ("EPO") offered under the Plan, the EPO provides your medical benefits. If you are enrolled in an EPO, 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 prescription drug benefits also applies to you. However, your specific medical benefits and information about coordination of benefits and claims and appeals are not described in this SPD. The EPO will send you, under separate cover, information about the medical benefits provided by the EPO. If you have questions concerning your medical benefits, refer to the phone number on the back of your identification card issued by your 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 *Eligibility* section beginning on page 3 to determine whether you are eligible to participate in the Plan and pay close attention to those instances in this SPD that indicate special provisions relating to a particular benefit. If you have any questions, contact the Caterpillar Benefits Center or the Claims Administrator at the address listed in the *General Contact Information* section beginning on page 96.

PARTICIPATION

HOW TO ENROLL

ENROLLMENT

If you are currently covered under the health benefits of the Plan, such coverage will continue in accordance with its terms. If you were covered as an employee under the health benefits provisions of the GIP on the day preceding your retirement, your (and your Dependent's (if eligible)) health benefit coverage automatically continued in retirement under the Plan in accordance with its terms if you were under age 65 at the time of your retirement.

If you retired on or after August 20, 2012, you were able to waive coverage at the time of retirement. If you waived your coverage at the time of retirement, you may re-enroll in the Plan for coverage during any **one** subsequent Annual Enrollment Period. To enroll, you must show, on a form satisfactory to the Company, that you (and your Dependents) were covered under an employer-sponsored group health plan or comparable private insurance (including COBRA coverage) for the previous 12 months (or for the entire period since your retirement if such period is less than 12 months). **If you did not waive coverage at the time of your retirement, you may drop retiree coverage after your retirement during any Annual Enrollment Period. However, once you drop coverage, you will not be permitted to re-enroll.**

If you enroll a Dependent whose eligibility has not been previously verified by the Plan Administrator in the Plan, you must provide supporting documents, such as a birth certificate or marriage license, to verify that the Dependent meets the eligibility requirements of the Plan. 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 Plan. You may be able to re-enroll the Dependent at a later date such as at annual enrollment or due to a change in status event.

Annual Enrollment

Each year, you may elect coverage for the following calendar year (January 1 through December 31). Typically, this Annual Enrollment Period occurs in the fall of each year. The elections you make during annual enrollment 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 and will describe the enrollment procedure, how to access the options available to you and the 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 annual enrollment 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.

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 must be paid by you 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 also will be automatically enrolled in the Plan. See the *Qualified Medical Child Support Order ("QMCSO")* section beginning on page 5 for additional information.

Your Eligible Dependents

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

Effective Date of Dependents' Coverage	
If you…	**Your Dependents' 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 have "Employee & Child(ren)" or "Family" coverage,	On the child's date of birth.
Have a newborn child and do not have "Employee & Child(ren)" or "Family" coverage but 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 have "Employee & Child(ren)" or "Family" coverage,	On the date you have custody of the child.
Adopted a child or have a child placed with you for adoption and do not have "Employee & Child(ren)" or "Family" coverage but applied for Dependent's coverage within 31 days of the custody** date,	On the date you have custody of the child.
Acquire a Dependent due to a court order or decree of marriage (or similar union with a Same-Sex Domestic Partner) and you have "Employee & Child(ren)" or "Family" coverage,	On the date of such court order or decree of marriage (or similar union with a Same-Sex Domestic Partner).

Effective Date of Dependents' Coverage	
If you…	**Your Dependents' Coverage is Effective…***
Acquire a Dependent due to a court order or decree of marriage (or similar union with a Same-Sex Domestic Partner) and you do not have "Employee & Child(ren)" or "Family" coverage but applied for Dependent's coverage within 31 days of such court order or decree of marriage (or similar union with a Same-Sex Domestic Partner),	On the date of such court order or decree of marriage (or similar union with a Same-Sex Domestic Partner).

* 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 Plan. 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.

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.

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

- You experience a "change in status" - as described in this section - that affects your or your Dependents' eligibility for benefits;
- You acquire a Same-Sex Domestic Partner or legally dissolve your union with your Same-Sex Domestic Partner;
- 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 10;
- The Claims Administrator receives a Qualified Medical Child Support Order (QMCSO) or other court order, judgment or decree requiring you to enroll a Dependent child;
- You, your Spouse or your Dependent becomes entitled to or loses Medicare or Medicaid coverage;
- You, your Spouse or your Dependent experiences a significant, unexpected and unforeseen increase (or decrease) in the cost of coverage;
- If there is a change in your Spouse's (or your Dependent's) coverage offered by his or her 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 Plan;
- You, your Spouse or your Dependent child experience a significant reduction in coverage or a total loss of coverage; or
- The Plan adds a benefit package option or significantly improves coverage under an existing option.

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 Plan 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 Plan elections as you could if you married or divorced a Spouse, as applicable.

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 Plan. You also may be able to add or remove Dependents from coverage. A change in status is any of the following:

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

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

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

Special Enrollments During the Year

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

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

You must request a change in coverage within 31 days of the special enrollment event, and your election is effective as of the date of the event. If you do not 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 Plan, 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 Plan 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 Plan, 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 Plan not later than 60 days after the date your Dependent is determined to be eligible for such assistance.

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

COST OF COVERAGE

You are required to pay a premium for your Health Insurance Benefits. Your premium will change from time-to-time. The up-to-date premium information will be in your annual enrollment materials or you may contact the Plan Administrator for information.

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

HOW LONG COVERAGE CONTINUES

Subject to the Company's right to change or discontinue the Plan, your health benefits will continue so long as you are eligible to participate in the Plan and you continue to pay any required premiums for coverage. In general, your coverage will end on the earlier of: (1) the date of your death; or (2) the day you cease to pay the required premiums. Your Dependent's coverage will end on the earlier of: (a) the day your coverage ends; or (b) the day in which he or she ceases to be a Dependent.

If you (or your covered Dependent) are confined to a Hospital for an Inpatient Stay when your health benefits coverage under the Plan 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 Plan 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 11 for more information on continuation coverage under COBRA.

SURVIVORS' COVERAGE

If a retiree is covered under the health insurance benefits of the Plan at the time of his or her death, the retiree's surviving Spouse may elect to continue health insurance benefits for himself or herself and any surviving Dependent children that were covered at the time of death. Survivors' coverage is charged at the retiree rate and continues for the life of the surviving Spouse, subject to the Company's right to change or discontinue the Plan.

Survivors' coverage will end if: (1) the survivor stops making any required contributions for coverage or (2) the survivor remarries (or enters into a similar union with a Same-Sex Domestic Partner), in which case, the coverage will end at the end of the month of remarriage. In addition, a surviving Spouse who is receiving this continued coverage may not at any time enroll any subsequent spouse for coverage.

Any period of continuation coverage shall be subject to the Company's right to change or discontinue the Plan. Any such change or termination may affect the benefits available to your survivors.

CONTINUATION OF BENEFITS (COBRA)

If you and your Dependents have health care coverage (*e.g.*, medical, prescription drug, vision and dental) under the Plan and that coverage ends, you may continue coverage for a specified period, depending on the reason coverage ends. An event that allows you to continue health care coverage after it would otherwise end is called a "qualifying event." Continuation coverage is available as required by law under the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

When You and Your Dependents Elect COBRA

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

COBRA coverage takes effect on the date of the qualifying event if a timely election is made. It is your responsibility to notify the COBRA Administrator of a qualifying event (*e.g.*, divorce). Complete address and contact information for the COBRA Administrator can be found in the section entitled *General Contact Information* beginning on page 96. 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 *Special Enrollments During the Year* section beginning on page 10.

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 *General Contact Information* beginning on page 96.

Snapshot of COBRA Continuation Coverage

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

If:	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
You	Die	Your covered Dependents	36 months
	Become divorced or legally separated or legally dissolve Same-Sex Domestic Partner union	Your covered Dependents	36 months
	Become entitled to Medicare while on COBRA	Your covered Dependents	Up to 36 months*
Your covered Dependent	Is no longer an eligible Dependent (due to age limit, divorce or legal separation or legal dissolution)	Your covered Dependent	36 months
	Is no longer an eligible Dependent because of your death	Your covered Dependent	36 months
	Becomes disabled within the first 60 days of COBRA continuation coverage	You and your covered Dependent	Up to 29 months*

*Includes months of COBRA coverage already used.

Important Notes

- If a second qualifying event occurs within the 18- or 29-month period, the COBRA continuation period for health care coverage may be extended up to 36 months from the date you lost coverage on account of the first qualifying event.

- Keep the Plan Administrator informed of any change in your or your covered Dependents' address so that you and your covered Dependents can receive the necessary information concerning your rights to COBRA continuation coverage.

COBRA Coverage for Disabilities

As shown in the chart above, COBRA coverage can be extended from 18 months up to 29 months if you (or another qualified beneficiary) are totally disabled when you (or the other qualified beneficiary) became 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.

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 became 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, become legally separated or legally dissolve your Same-Sex Domestic Partner union;
- 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 Federal 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 will send you and/or your affected covered Dependent a notice, including the cost of coverage, within 14 days of receiving this notification.

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

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

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

Deciding Whether or Not 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 healthcare coverage ends on the day on which the qualifying event occurred.

When COBRA Coverage Ends

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

- The end of the 18-month, 29-month or 36-month continuation period (for medical and dental);
- The date the Company no longer provides coverage to any of its employees;
- When there is a significant underpayment of a premium or when premiums for continuation of group coverage 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 Plan within 30 days of a determination by the Social Security Administration that you or a covered Dependent is no longer disabled).

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

Election Period

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

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

Required Payments

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

Same-Sex Domestic Partners

For purposes of this *Continuation of Benefits (COBRA)* section, the term Dependent shall not include the Same-Sex Domestic Partner of a retiree. Nevertheless, although not required by COBRA, the Plan will extend continuation coverage that is similar to COBRA to Same-Sex Domestic Partners, consistent with the provisions of this section.

OTHER EVENTS ENDING YOUR COVERAGE

When any of the following happen, you may receive written notice that coverage under the Plan 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 Plan.

COORDINATION OF BENEFITS

Benefits When You Have Coverage under More Than One Plan

This section describes how benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

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.

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 (as described in the section

entitled *When a Covered Person Qualifies for Medicare* beginning on page 18) and 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 or 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, an HMO), 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 Usual and Customary fees, any amount in excess of the highest of the Usual 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 Usual 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 or Same-Sex Domestic Partners;
       (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 of the custodial parent;
       (iii) The Coverage Plan of the noncustodial parent; and then
       (iv) The Coverage Plan of the Spouse 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 Plan 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 Plan pays benefits first and Medicare pays benefits second:

- Employees with active 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; and
- Covered Persons with end-stage renal disease, for a limited period of time.

A Special Note About Medicare

Benefits under the Plan 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 Plan. ***If you are eligible for or enrolled in Medicare, please read the following information carefully.***

If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you do not enroll and maintain that coverage, and if the Company is the secondary payer as described in *Coordination of Benefits* section beginning on page 15 of this SPD, the Company will pay benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are a participant in the Plan and you or your Dependent became eligible for Part B, you or your Dependent may be reimbursed for the actual cost of Part B (up to $99.50 per month). If you are eligible to receive this reimbursement, you must call the Caterpillar Benefits Center to enroll when you or your eligible Dependent receive your Medicare ID card.

If you are enrolled in a Medicare+Choice (Medicare Part C) plan on a primary basis (Medicare pays before benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, it will pay any benefits available to you under the plan 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 Plan.

Determining the Allowable Expense When the Plan is Secondary

If the Plan 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 Plan benefits, will not exceed 100% of the total Allowable Expenses.

If you are eligible for, but not enrolled in, Medicare, and the Plan is secondary to Medicare, benefits payable under the Plan 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 entitled to but not enrolled for Medicare. 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 Plan 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 Plan 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 Plan 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.

MEDICAL BENEFITS

OVERVIEW OF MEDICAL BENEFITS

This *Medical Benefits* section presents an overview of your medical benefits under the Plan. You are encouraged to review the benefit limitations of this *Medical Benefits* section by reading the *What's Covered – Benefits* section below and the *What's Not Covered – Exclusions* section beginning on page 41.

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 Plan if you satisfy the eligibility criteria described in the *Eligibility* section beginning on page 3 of this SPD and any additional requirements described in this section.

Please note that there are no discounts available for services that are not covered under the Plan.

WHAT'S COVERED – BENEFITS

ACCESSING BENEFITS

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 Usual and Customary standard will apply. In some cases, a Provider or facility will be subject to further restrictions and expenses incurred may not be eligible for reimbursement under the Plan. Refer to the paragraph below entitled *Non-Network Providers* beginning on page 43. 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 non-Network Hospital or Skilled Nursing Facility, the Usual and Customary standard will apply. 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. An internet 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 *General Contact Information* beginning on page 96. The Claims Administrator, in its sole discretion, may allow a Covered Person to use a Caterpillar Network Provider and reimburse such a 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 up to Usual and Customary limits 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.**

Depending on the geographic area and the service you received, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in the *Definitions* section beginning on page 98 for details about how the Shared Savings Program applies.

OUT-OF-NETWORK PLAN

If you are enrolled in an Out-of-Network plan, depending on the geographic area in which you live, you may have access to some Network Providers. These Providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network Provider, your Co-payment and Co-insurance level will remain the same and you will be reimbursed consistent with these discounted rates. The portion that you owe may be less than if you received services from a non-Network Provider because the Eligible Expense may be a lesser amount. If you use a non-Network Provider, the Usual and Customary standard will apply. 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 *General Contact Information* beginning on page 96.

IDENTIFICATION CARD ("ID CARD")

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

ELIGIBLE EXPENSES

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

The Plan Sponsor has delegated to the Claims Administrator the sole discretion and authority to determine whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan. Amounts that exceed the Usual and Customary charge or the negotiated Network fees are not covered under the Plan. In addition, the Plan will not cover expenses that are not Necessary Covered Health Services. Even if a service, treatment or supply is recommended or prescribed by a Physician or is the only available treatment for your condition, the Plan does not guarantee coverage.

For Network Benefits, you are responsible for the Co-payment and Co-insurance amounts and amounts in excess of any the Plan maximum, but you are not responsible for any difference between the Eligible Expenses and the amount the Provider bills, unless you agreed to reimburse the Provider for such services.

For Non-Network Benefits, except for fees that are negotiated by a non-Network Provider and either the Claims Administrator or one of its vendors, designees or subcontractors, you are responsible for paying, directly to the non-Network Provider, the Co-payment, Co-insurance and any difference between the amount the Provider bills you and the amount the Plan will pay for Eligible Expenses, and any amounts in excess of any Plan maximum.

NOTIFICATION REQUIREMENTS

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

Services for which you should provide prior notification appear in this section under the *Notify Personal Health Support[SM]?* column in the *Benefits Information Grid* beginning on page 24.

To notify Personal Health Support[SM], call the telephone number shown on your ID card or in the section entitled *General Contact Information* beginning on page 96. You should confirm with the Claims Administrator that the services you plan to receive are Covered Health Services, even if not indicated in the *Notify Personal Health Support[SM]?* column because, in some instances, certain procedures may not meet the definition of Covered Health Services 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 Plan.

If you are enrolled for Medicare on a primary basis (Medicare pays before the Plan pays benefits), the notification requirements described in this SPD do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in the *Coordination of Benefits* section beginning on page 15. You are not required to notify Personal Health Support[SM] before receiving Covered Health Services when Medicare is the primary payer. However, you should notify Personal Health Support[SM] if you will be receiving services not covered by Medicare.

BENEFITS AT A GLANCE

The tables below outline your Annual Deductible and your Maximum Out-of-Pocket contribution, and provide an overview of Co-payments and Co-insurance that apply when you receive certain Covered Health Services.

Medical Benefit Options														
Network Service Area	Medical Benefit Option	Annual Deductible		Maximum Out-of-Pocket				Program Level Co-insurance - Hospital/Skilled Nursing Facility (Reimbursement Percentage/Co-insurance Amount)		Program Level Co-insurance - Physician (Reimbursement Percentage/Co-insurance Amount)		Preventive (No Deductible Applies)	
		Network & Non-Network		Network		Non-Network							
		Individual	Family	Individual	Family	Individual	Family	Network	Non-Network	Network	Non-Network	Network	Non-Network
Reside in a Network Area	BCBS National EPO	$500	$1,000	$2,000	$4,000	None	None	80%/20%	0%/100%	80%/20%	0%/100%	100%	Not covered
	UHC Choice Plus PPO	$700	$1,400	$2,000	$4,000	None	None	80%/20%	50%/50%	80%/20%	50%/50%	100% Hospital & All Physicians	50% Hospital & All Physicians
Reside in an Out-of-Area	UHC Choice Plus PPO	$700	$1,400	$2,000	$4,000	None	None	80%/20%	80%/20%	80%/20%	80%/20%	100%	100%

BENEFIT INFORMATION

IMPORTANT POINTS TO REMEMBER

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

MEDICAL BENEFITS

- The *Benefits Information Grid* below; and/or
- The *What's Not Covered – Exclusions* section beginning on page 41.

BENEFITS INFORMATION GRID

Note: Co-insurance amounts reflected in the Benefits Information Grid below assume you obtain services from a Network Provider. See the *Description of Network and Non-Network Benefits* sections beginning on pages 47 and 49 to understand which Providers are considered Network Providers in the Caterpillar Network and which are considered Network Providers in the UnitedHealthcare Network.

Description of Covered Health Services	**Notify Personal Health Support℠?**	**Your Co-insurance or Co-payment Amount**	
		Network	**Non-Network**
1. Allergy Services **Testing** Covered Health Services include testing for allergy care in a Physician's office. **Drug Treatment for Allergy Care** Covered Health Services include drug treatment for allergy care in a Physician's office. Injection fees are not covered.	No	Testing 20% after deductible Drug Treatment 20% after deductible	50% after deductible
2. Ambulance **Ground Ambulance:** Covered Health Services include transportation from the place where injured or stricken by illness to the nearest Hospital or from a Hospital where medically required services are not available to the nearest Hospital where such services are available (such as a burn center or trauma center). **Air Ambulance:** Air ambulance transport is covered in the following circumstances: • Patient requires transport from one Hospital to another because the first Hospital does not have the required services or facilities to treat the patient or, when ground transport is not appropriate due to distance or need of rapid transport; and • Such method of transportation is deemed medically required by the attending Physician; and • Such method of transportation is in fact an ambulance service and not a charter flight service. ***Note:** You are not required to notify Personal Health Support℠. However, for air ambulance, the plan suggests you call to verify coverage is available.	No*	20% after deductible	20% after deductible
3. COVID-19 Testing and Related Visit Effective March 1, 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.	No	0% no deductible applies	0% no deductible applies

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
4. Durable Medical Equipment Durable Medical Equipment must meet all of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Can withstand repeated use. • Not of use to a person in the absence of a disease or disability. The Claims Administrator is responsible for determining the coverage criteria for Durable Medical Equipment and has the final determination. If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include, but are not limited to: • Mechanical equipment Necessary for the treatment of chronic or acute respiratory failure or conditions (excluding air conditioners, humidifiers, dehumidifiers, air purifiers and filters). • Delivery pumps for tube feedings. • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen concentrator units and the rental of Necessary equipment to administer oxygen (including tubing and connectors). The Plan provides benefits for a single unit of Durable Medical Equipment (*e.g.*, one insulin pump) and covers the cost of repairing that unit. In some cases, benefits may be provided for the replacement of a type of Durable Medical Equipment. The Claims Administrator in its sole discretion may approve the purchase of such equipment if it can reasonably be assumed that the duration of need is such that the rental price would exceed the purchase price, or said item cannot be made available on a rental basis. ***Note:** It is strongly recommended that you contact Personal Health Support℠ if you have any questions on whether an item will be covered. You are required to contact Personal Health Support℠ for items over $1,000.	Yes, for items over $1,000*	20% after deductible	50% after deductible
5. Emergency Room Health Services Emergency Room Health Services are services required to stabilize or initiate treatment in an Emergency. Emergency Room Health Services must be received on an outpatient basis at a Hospital or Alternate Facility and billed by the Hospital or Alternate Facility. You will find more information about benefits for Emergency Room Health Services in the *Comparison of Network and Non-Network Benefits* charts beginning on pages 47 and 49. Coverage is available for non-Emergency services for diagnostic procedures only. No expenses will be paid for facility or Physician charges for non-Emergency services received.	No*	$100 Co-payment per visit; 20% after deductible	$100 Co-payment per visit; 20% after deductible

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
An emergency room Co-payment of $100 applies. The emergency room Co-payment is waived if you are admitted to the Hospital from the emergency room. Benefits are payable for the Outpatient Observation of a patient. For this purpose, "Outpatient Observation" means a brief hospital stay which (1) is not for the convenience of the patient, the patient's family, or a Physician, or in connection with the patient's admission, (2) lasts up to 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. Outpatient Observation is not considered an admission. ***Note:** Remember that if you are admitted to a Hospital as a result of an Emergency, you should notify Personal Health Support℠ within two business days or the same day of admission, or as soon as reasonably possible.			
6. Gender Dysphoria Benefits for the treatment of Gender Dysphoria limited to the following services: • Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under Mental Health Services in your SPD. • Cross-sex hormone therapy: - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided as described under *Pharmaceutical Products – Outpatient* in your SPD. - Cross-sex hormone therapy dispensed from a pharmacy is provided as described under the Prescription Drug Benefit provided by HomeServices of America. • Puberty suppressing medication injected or implanted by a medical provider in a clinical setting. • Laboratory testing to monitor the safety of continuous cross-sex hormone therapy. Surgery for the treatment for Gender Dysphoria, including the surgeries listed below: *Male to Female:* - 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). *Female to Male:* - Bilateral mastectomy or breast reduction. - Hysterectomy (removal of uterus). - Metoidioplasty (creation of penis, using clitoris).	Yes	Depending upon where the Covered Health Service is provided, benefits will be the same as those stated under each Covered Health Service category in this section	Depending upon where the Covered Health Service is provided, benefits will be the same as those stated under each Covered Health Service category in this section

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
- 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). **Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:** The Covered Person must provide documentation of the following for breast surgery: 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: - 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. The Covered Person must provide documentation of the following for genital surgery: 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: - 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. - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated). 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. **Prior Authorization Requirement for Surgical Treatment** You must obtain prior authorization as soon as the possibility of surgery arises.			

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. **Prior Authorization Requirement for Non-Surgical Treatment** 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. Exclusions: Cosmetic Procedures, including the following: 1. Abdominoplasty. 2. Blepharoplasty. 3. Breast enlargement, including augmentation mammoplasty and breast implants. 4. Body contouring, such as lipoplasty. 5. Brow lift. 6. Calf implants. 7. Cheek, chin, and nose implants. 8. Injection of fillers or neurotoxins. 9. Face lift, forehead lift, or neck tightening. 10. Facial bone remodeling for facial feminizations. 11. Hair removal. 12. Hair transplantation. 13. Lip augmentation. 14. Lip reduction. 15. Liposuction. 16. Mastopexy. 17. Pectoral implants for chest masculinization. 18. Rhinoplasty. 19. Skin resurfacing. 20. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). 21. Voice modification surgery. 22. Voice lessons and voice therapy.			
7. Hearing Care **Audiologist** Coverage is limited to charges by a licensed or certified audiologist for Physician prescribed hearing evaluations to determine location of a disease within the auditory system. The Plan covers tests and treatment due to illness and Injury only. **Hearing Evaluation** Coverage is limited to one hearing evaluation every 36 months for one or both ears. **Audiometric Examination** Coverage is limited to one audiometric examination every 36 months in connection with medical illness.	No	20% after deductible	50% after deductible

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
Hearing Aid Coverage is limited to one hearing aid per ear once every 36 months. Duplicates or replacements for stolen Hearing Aids are not covered.			
8. Home Health Care A patient qualifies for coverage under the home health benefit when a skilled service is required in lieu of a coverable inpatient confinement. Personal Health Support℠ will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.	Yes*	20% after deductible	50% after deductible
Services must be both of the following: • Ordered by a Physician. • Provided by an agency that is licensed by the state as a Home Health Agency and is Medicare certified. If a patient qualifies for coverage under the home health benefit, the following services may be covered: 1. Registered Nurse 2. Licensed Practical Nurse 3. Home Health Aide or Certified Nursing Assistant 4. Physical Therapist/Occupational Therapist/Speech Therapist 5. Medical Social Worker 6. Intravenous medications and TPN 7. Intravenous supplies 8. Wound care supplies 9. Enteral feeding formula and supplies when the enteral feeds are needed due to an inborn error in metabolism 10. Dietician 11. Line maintenance supplies The total combined cost of services 1, 2 and 3 (the nursing component) cannot exceed the room and board cost of a Skilled Nursing Facility. The Home Health benefit is limited to 100 visits per calendar year where any visit up to four hours is considered one visit. The patient must be homebound. ***Note:** Remember that you should notify Personal Health Support℠ five business days before receiving services.			
9. Hospice Care Patient qualifies for hospice when a Physician certifies that he is terminally ill and hospice-appropriate. A patient is terminally ill if the medical prognosis is that the patient's life expectancy is six months or less if the illness runs its normal course.	Yes*	20% after deductible	50% after deductible

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
Services must be provided by an agency that is licensed by the state as a home health or Hospice Agency and is Medicare certified. If a patient qualifies for coverage under the hospice benefit, the following services may be covered in the home: 1. Registered Nurse 2. Licensed Practical Nurse 3. Home Health Aide or Certified Nursing Assistant 4. Medical Social Worker 5. IV medications and supplies related to the terminal condition 6. Wound care supplies The total combined cost of the nursing component (1, 2 and 3 above) cannot exceed the room and board cost of a Skilled Nursing Facility. The Claims Administrator may determine that the patient qualifies for room and board coverage in a Medicare-certified nursing facility. If the patient chooses to use a Medicare-certified nursing facility, services 1-6 above would not apply. Coverage for room and board (combined with any room and board payable to a Medicare-certified nursing facility as described above) is subject to a lifetime limit of 30 days. In addition: • Durable Medical Equipment is covered under the regular Durable Medical Equipment hospice benefit. • For prescription drugs (other than IV), see the *Prescription Drug Benefits* section beginning on page 53. There is no coverage for bereavement counseling or chaplain services. ***Note:** Remember to notify Personal Health Support℠ five business days before receiving services.			
10. Hospital – Inpatient Stay Inpatient Stay in a Hospital: Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Reimbursement for a private room will be made up to the amount of the Semi-private Room rate unless confined to a private isolation room, which is allowable for certain medical conditions (*e.g.*, infectious hepatitis, spinal meningitis, severe burns). ***Note:** Remember that if you are admitted to a Hospital as a result of an Emergency, you should notify Personal Health Support℠ within two business days or the same day of admission, or as soon as reasonably possible.	Yes*	20% after deductible	50% after deductible
11. Infertility Services	No	20% after	50% after

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
Procedures for the diagnosis of infertility and procedures to correct a medical condition causing infertility, including semen analysis for men. The following treatments and services related to those treatments are NOT covered: • Artificial insemination. • Drug therapy. • In-vitro fertilization – gamete (GIFT) and zygote (ZIFT) intrafallopian transfer procedures. • Reversal of tubal ligation or vasectomy.		deductible	deductible
12. Injections received in a Physician's Office Covered Health Services are available for the coverage of drugs injected at a Physician's office. For allergy immunotherapy, see Item 1, *Allergy Services* of this *Benefits Information Grid.* Injection fees are not covered.	No	20% after deductible	50% after deductible
13. Maternity Services Benefits for Pregnancy will be paid at the same level as benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. The Plan will pay benefits for an Inpatient Stay of at least: • 48 hours for the mother and newborn child following a normal vaginal delivery. • 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending Provider may discharge the mother and the newborn child earlier than these minimum time frames. ***Note:** Remember that if you are admitted to a Hospital, you should notify Personal Health Support℠ within two business days or the same day of admission, or as soon as reasonably possible.	No*	20% after deductible	50% after deductible
14. Mental Health and Substance Abuse Services –– Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a Provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy).	No	20% after deductible	50% after deductible

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
• Crisis intervention. • Psychological testing administered by a psychologist or psychiatrist upon order of a Physician specializing in the treatment of nervous or mental disorders and related to treatment.			
15. Nutritional Counseling Covered Health Services for Covered Persons with medical conditions that require a special diet when performed by a registered dietician while in an inpatient Hospital setting. Some examples of such medical conditions include: • Diabetes mellitus. • Gestational diabetes • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias.	No	20% after deductible	50% after deductible
16. Obesity Surgery Benefits under this section include surgical treatment of morbid obesity. Currently, the Plan follows guidelines as defined by the National Institute of Health. Limitations: ▪ Benefits are limited to one surgery per lifetime per Covered Person. ▪ Repeat bariatric or lap band repair are covered only if the following guidelines are adhered to: ▪ For the original procedure, patient met all the screening criteria, including BMI requirements; ▪ The patient has been compliant with a prescribed nutrition and exercise program following the original surgery; and ▪ Significant complications or technical failure (i.e., break down of gastric pouch, slippage, breakage or erosion of gastric band, bowel obstruction etc.) of the bariatric surgery has occurred that requires take down or revision of the original procedure that could only be addressed surgically and Patient is requesting reinstitution of an acceptable bariatric surgical modality. If you are enrolled in a Caterpillar Network plan or a UnitedHealthcare Network plan, you are required to use a Network Hospital. This limitation applies even if your Network Provider refers you to a non-Network Provider or Hospital. No benefits will be paid if you use a non-Network Provider or Hospital unless you	No	20% after deductible	100% after deductible

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
reside outside of a Network area and are enrolled in an Out-of-Network plan. **Note:** It is important to contact the Claims Administrator to determine allowable coverage prior to services being rendered.			
17. Oral Surgery Covered Health Services include dental treatment for dislocations, fracture care and certain incisions and excisions, or any other oral surgery deemed to be medically appropriate; prosthetic devices prescribed for medical reasons; and anesthetics administered in connection with covered oral surgery. Refer to the *Dental Benefits* section beginning on page 59 for additional oral surgery coverage. If more than one procedure can meet your functional needs, benefits are available only for the most cost-effective procedure. The Plan Administrator will determine whether any specific oral-related charges are covered (if at all) under Oral Surgery or as a Dental Benefit. ***Note:** You are not required to notify Personal Health Support℠; however, it is recommended that you contact Personal Health Support℠ to verify that the services you require are covered under this benefit.	No*	20% after deductible	50% after deductible
18. Outpatient Surgery, Diagnostic and Therapeutic Facility Services Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described in Item 20, *Professional Fees for Surgical and Medical Services* of this *Benefits Information Grid*. Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility, including: • Surgery and related services. • Lab and radiology/X-ray. • Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). Benefits are payable for the Outpatient Observation of a patient. For this purpose, "Outpatient Observation" means a brief hospital stay which (i) is not for the convenience of the patient, the patient's family, or a Physician, or in connection with the patient's admission, (ii) lasts between 24 and 48 hours, and (iii) 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.	No	20% after deductible	50% after deductible
19. Physician's Services Emergency first-aid benefits will be payable if a Covered Person sustains an accidental Injury and receives initial first-aid services from a Physician on account of such Injury when payment for such services is not otherwise provided for under the Plan. Emergency first-aid benefits will be covered only if the initial first-aid services are received within 24 hours of the accidental injury. This benefit is provided so	No	20% after deductible	20% after deductible

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
that a Covered Person has access to accidental Injury coverage since Physician's office visits are not covered. Benefits for Physician's services also include: • Hormonal contraceptives requiring injection or implantation (including, but not limited to, Norplant and Depo-Provera) by a Physician. Such hormonal contraceptives approved by the U.S. Food and Drug Administration (FDA) are covered at 100%. • Contraceptive devices requiring fitting and administration (including, but not limited to, an intrauterine device (IUD), diaphragm, and cervical cap), to the extent prescribed by a Physician and administered by a Physician or other approved healthcare provider. Such contraceptive devices approved by the FDA are covered at 100%. • Covered drugs injected at a Physician's office. Effective March 1, 2020 through December 31, 2020, non-COVID-19 telehealth and virtual visits with a Network Provider will be payable for a Covered Person. Not Covered: • Follow up visits for initial Emergency first-aid benefits. • Routine/preventive health checkups (except as described below). • Office visits (except as described above). • Injection fee when billed with other health service.			

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
20. Preventive Care Services The Plan covers preventive care services. Preventive care services are covered at 100% by the Plan 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. **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.* **Well Child Preventive Care –** Covered Health Services are paid for routine pediatric office visits for Dependent children up to and including age six (6). 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.* **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.* **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.* **NOTE:** This section only describes preventive care services. Diagnostic services are covered at the appropriate Co-insurance level without age limits. * For example, if an immunization or service received a recommendation on March 12, 2015, the Plan will cover such immunization or service effective January 1, 2017.	No	0% no deductible applies	50% no deductible applies
21. Professional Fees for Surgical and Medical Services Professional fees for services, surgical procedures and other medical care received at a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, or Alternate Facility, or in a Physician's office include, but are not limited to: • Pathology. • X-ray/diagnostic interpretation. • Anesthesiology.	No	20% after deductible	50% after deductible

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
• Radiation therapy.			
22. Prosthetic Devices Prosthetic devices that replace a limb or body part including: • Artificial limbs. • Artificial eyes. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. • Ostomy and colostomy supplies. • Mandibular advancement devices used to treat sleep apnea. • Special shoes that are an integral part of a leg brace and scoliosis appliance. It is recommended that you contact Personal Health Support℠ if you have any questions on whether an item will be covered. If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of, a Physician. The Plan 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. Orthotic appliances and devices are covered when prescribed by a Physician and are custom manufactured or custom fitted to you by a Physician. However, the following devices are not covered by the Plan: • Foot orthotics, cranial bands, and shoe orthotics except for custom molded shoe inserts prescribed to treat a disease or illness of the foot. • Orthotic appliances for the treatment of flat feet. • Orthotic appliances for the treatment of sublaxation of the foot. • Any braces or orthotic appliances that can be obtained without a Physician's order. • Any other orthotic appliance or device determined unnecessary by the Plan Administrator. Duplicates and replacement of stolen prosthetic devices are not covered.	No	20% after deductible	50% after deductible
23. Reconstructive Procedures Reconstructive Procedures -- Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. Improving or restoring physiologic function means that the target organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored. Cosmetic Procedures -- Services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a	Yes*	20% after deductible	50% after deductible

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
reconstructive procedure. Reshaping a nose with a prominent "bump" is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function such as breathing. The Plan does not provide benefits for Cosmetic Procedures. Some services are considered cosmetic in some circumstances and reconstructive in others. This means there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations the purpose would be to improve appearance, and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision while on other occasions improvement in appearance is the primary purpose of the procedure. Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. For more information about benefits for mastectomy-related services, contact the Claims Administrator at the telephone number on your ID card or in the *General Contact Information* section beginning on page 96. Cosmetic Procedures are always excluded from coverage. ***Note:** You should notify Personal Health Support℠ before receiving services. When you provide notification, Personal Health Support℠ can verify that the services are a reconstructive procedure rather than a Cosmetic Procedure.			
24. Rehabilitation Services – Outpatient Therapy Rehabilitation services must be performed by a licensed therapy Provider, under the direction of a Physician. Outpatient rehabilitation services for: • Physical therapy/massage therapy. • Occupational therapy. • Cardiac rehabilitation therapy. If surgery is performed, the limits described above are <u>not</u> renewed for physical therapy, occupational therapy and cardiac therapy. Outpatient rehabilitation services for physical therapy, occupational therapy, cardiac rehabilitation therapy, and pulmonary rehabilitation therapy are limited to **60 visits** per type of therapy per Covered Person per calendar year. You are responsible for any amount exceeding this 60 visit per calendar year maximum.	No	20% after deductible	50% after deductible
25. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Covered Health Services include services for an Inpatient Stay in a Skilled Nursing Facility or non-acute Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Services must be received from a Provider who is both Medicare certified and	Yes*	20% after deductible	50% after deductible

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
licensed by the state. In general, the intent of skilled nursing is to provide benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting. The Covered Person is expected to improve to a predictable level of recovery. Benefits are available when skilled nursing or rehabilitation services are needed on a daily basis. Accordingly, benefits are NOT available when these services are required intermittently (such as physical therapy three times a week). Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence. If Medicare requirements are not met (*e.g.* not being admitted to a nursing home directly from a Hospital admission), and you have Medicare as the primary carrier, the Plan will estimate what Medicare would have paid and then pay as secondary. ***Note:** You must notify Personal Health Support℠ as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible.			
26. Speech Therapy Covered Health Services for speech therapy services will be payable, as defined as medically necessary by the Claims Administrator, if such speech therapy is prescribed by a Physician and 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. Speech therapy is limited to 60 visits per Covered Person, per calendar year.	No	20% after deductible	50% after deductible
27. Temporomandibular Joint Dysfunction (TMJ) Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or oropathology. **Please note that Benefits are not available for charges for services that are Dental in nature.**	No	20% after deductible	50% after deductible
28. Transplantation Services	Yes*	20% after	50% after

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a Designated Provider or a Caterpillar designated facility to receive full benefits. Designated Providers may change from time to time. For information on current Designated Providers, contact the Claim Administrator at the number on your ID card or in the section entitled *Contact Information* beginning on page 96. It is your responsibility to determine what facilities qualify as a Designated Provider before you receive services or treatment. Generally, services by radiologists, anesthesiologists and pathologists are included in covered expenses and subject to limitations. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service and is not an Experimental or Investigational Service or an Unproven Service: • Bone marrow/peripheral stem cell transplants (not all bone marrow transplants meet the definition of a Covered Health Service). • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Pancreas transplants. • Kidney/pancreas transplants. • Liver transplants. • Cornea transplants (it is not required that a cornea transplant be performed at a designated facility). The Claims Administrator will determine if the transplant is a Covered Health Service. Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Personal Health Support℠ to be a proven procedure for the involved diagnoses. Under the Plan, there are specific guidelines regarding benefits for transplant services. For information about these guidelines, contact Personal Health Support℠ at the telephone number on your ID card or in the *Contact Information* section beginning on page 96. Covered organ transplants means transplantation of only procedures pre-approved by the Claims Administrator in its discretion and shall not include any transplantation of any non-human organs or artificial devices.		deductible	deductible

Description of Covered Health Services	Notify Personal Health Support℠?	Your Co-insurance or Co-payment Amount	
		Network	Non-Network
If the transplant is a Covered Health Service and it is: • Received at a Designated Provider or a Caterpillar designated facility, benefits will be payable at 80% of Eligible Expenses (after you meet your deductible). • Received at a non- Designated Provider, benefits will be payable at 50% of Eligible Expenses (after you meet your deductible). ***Note:** Personal Health Support℠ notification is required for all transplant services. You must notify Personal Health Support within seven (7) business days before the scheduled date of any of the following: • The evaluation. • The donor search. • The organ procurement/tissue harvest. • The transplant. You should notify Personal Health Support℠ as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).			
29. Urgent Care Center Services Covered Health Services received at an Urgent Care Center as a result of Sickness or Injury are allowed. Initial office calls are covered for administration of first aid or for a medical Emergency only. Follow up visits are not covered.	No	20% after deductible	50% after deductible

WHAT'S NOT COVERED – EXCLUSIONS

THE USE OF SECTION HEADINGS

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

PLAN EXCLUSIONS

The Plan 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 21 or through an amendment to this SPD.

ALTERNATIVE TREATMENTS

- Acupressure and acupuncture;
- 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.

CHIROPRACTIC SERVICES/SPINAL MANIPULATIONS

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 devices 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 59 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;
  - Medical or surgical treatments of dental conditions – see Item 16 (Oral Surgery) of the *Benefits Information Grid* beginning on page 24; 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 transplant preparation, initiation of immunosuppressive, direct treatment of an acute traumatic Injury, cancer or cleft palate and oral surgery – see Item 16 (Oral Surgery) of the *Benefits Information Grid* beginning on page 24); and
- 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 53 because benefits may be payable under that section.

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

EXPERIMENTAL OR INVESTIGATIONAL SERVICES OR UNPROVEN SERVICES

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

FOOT CARE

- Except when needed for severe systemic disease:
  - Routine foot care (including the cutting or removal of corns and calluses); and
  - Nail trimming, cutting, or debriding;
- Hygienic and preventive maintenance foot care. Examples include the following:
  - Cleaning and soaking the feet;

- Applying skin creams in order to maintain skin tone; and
- Other services that are performed when there is not a localized illness, Injury or symptom involving the foot;

- Treatment of flat feet;
- Treatment of subluxation of the foot;
- Shoe orthotics; and
- Special shoes unless they are an integral part of a leg brace or scoliosis appliance as described under Item 21 (Prosthetic Devices) of the *Benefits Information Grid* beginning on page 24.

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 (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 4 (Durable Medical Equipment) of the *Benefits Information Grid* beginning on page 24.

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 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;
- 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
- 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 Plan. This means that any expenses incurred from a Non-Covered Provider are not covered under the Plan 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 Plan. 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 under Item 14 (Nutritional Counseling) of the *Benefits Information Grid* beginning on page 24, 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 98 for the definition of Cosmetic Procedures.) Examples include:
  - Pharmacological regimens, nutritional procedures or treatments;
  - Tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); and
  - Scar or keloid removal or revision procedures except when:

    (i) The scar or keloid was caused by an accidental Injury or a covered surgical procedure; or
    (ii) The scars were a result of acne or other severe scarring disorders;

- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Item 22 (Reconstructive Procedures) of the *Benefits Information Grid* beginning on page 24;
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation;
- Weight-loss programs whether or not they are under medical supervision. Weight-loss programs for medical reasons are also excluded;
- Wigs regardless of the reason for the hair loss;
- Non-surgical treatment of obesity;
- Services received from a personal trainer; and
- Liposuction.

PROVIDERS

- Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other Provider;
- Services that are self-directed to a freestanding or Hospital-based diagnostic facility; and

- Services ordered by a Physician or other Provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other Provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received.

  This exclusion does not apply to mammography testing.

REPRODUCTION

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

SERVICES PROVIDED UNDER ANOTHER PLAN

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

TRANSPLANTS

- Health services for organ and tissue transplants, except those described under Item 27 (Transplantation Services) of the *Benefits Information Grid* beginning on page 24;
- 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 27 (Transplantation Services) of the *Benefits Information Grid* beginning on page 24.

TRAVEL

- Travel or transportation expenses, even though prescribed by a Physician; and
- Immunizations required for travel except for those covered under Item 19 (Preventive Care Services) of the *Benefits Information Grid* beginning on page 24.

VISION

Refer to the Vision Benefits section beginning on page 67 of this SPD because benefits may be payable under that section.

- Eye exercise therapy;
- Frames;
- 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.

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 98 of this SPD);
- Physical, psychiatric or psychological exams, testing, or treatments that are otherwise covered under the Plan 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 Plan;
- 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 21.

COMPARISON OF NETWORK AND NON-NETWORK BENEFITS

	Network	**Non-Network**
Benefits	Discounted charges means less cost to you. See the *What's Covered – Benefits* section beginning on page 21.	Charges based upon Usual and Customary allowance means a lower level of benefits and more cost to you. See the *What's Covered – Benefits* section beginning on page 21.
Who Should File Claims?	You are responsible for ensuring that a claim has been filed; however, a Provider may file claims on your behalf. See the *Filing a Claim for Benefits* section beginning on page 72.	You are responsible for ensuring that a claim has been filed; however, a Provider may file claims on your behalf. See the *Filing a Claim for Benefits* section beginning on page 72.
Outpatient Emergency Room Health Services	Emergency Room Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means if you seek Emergency care at a non-Network facility, you are not required to pay any difference between Eligible Expenses and the amount the Provider bills.	

PROVIDER NETWORK

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

These Network Providers have agreed to discount their charges for Covered Health Services. Network Providers are independent practitioners. They are not employees of the Plan 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.

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 *General Contact Information* section beginning on page 96, 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 by the Plan.

Designated Provider and Other Providers

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

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

NON-NETWORK BENEFITS

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by non-Network Physicians or non-Network Providers. Non-Network Benefits are also payable for Covered Health Services that are provided at non-Network facilities. However, if you are traveling or on vacation, office-based services for a non-Emergency situation may be payable at the Network level. Facility-based services will be subject to the Plan's 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 up to Usual and Customary limits. 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 *General Contact Information* beginning on page 96. 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 Plan provides benefits for Emergency Room Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

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

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

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

Note: The emergency room Co-payment for covered Emergency Room Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the Hospital. In this case, the emergency room Co-payment will apply. The emergency room Co-payment information can be found in Item 5 (Emergency Room Health Services) of the *Benefits Information Grid* beginning on page 24.

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 21.

COMPARISON OF NETWORK AND NON-NETWORK BENEFITS

	Network	Non-Network
Benefits	Discounted charges mean less cost to you. See the *What's Covered – Benefits* section beginning on page 21.	Charges based upon Usual and Customary allowance mean a lower level of benefits and more cost to you. See the *What's Covered – Benefits* section beginning on page 21.

	Network	Non-Network
Who Should File Claims?	You are responsible for ensuring that a claim has been filed; however, a Provider may file claims on your behalf. See the *Filing a Claim for Benefits* section beginning on page 72.	You are responsible for ensuring that a claim has been filed; however, a Provider may file claims on your behalf. See the *Filing a Claim for Benefits* section beginning on page 72.
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 Hospital or Skilled Nursing Facility in order to receive Network Benefits. A Hospital or Skilled Nursing Facility outside of the UnitedHealthcare Network is considered a non-Network Provider and will be paid at the non-Network level (with the exception of Emergency Room Health Services). However, the Claims Administrator, in its sole discretion, may permit you to use a Caterpillar Network Provider and still receive Network benefits.

These Network Providers have agreed to discount their charges for Covered Health Services. Network Providers are independent practitioners. They are not employees of the Plan 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.

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 *General Contact Information* section beginning on page 96, 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 by the Plan.

Designated Provider and Other Providers

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

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

MEDICAL BENEFITS

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 Plan's 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 up to Usual and Customary limits. 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 *General Contact Information* beginning on page 96. 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 Plan provides benefits for Emergency Room Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

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

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

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

Note: The emergency room Co-payment for covered Emergency Room Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the Hospital. In this case, the emergency room Co-payment will apply. The emergency room Co-payment information can be found in Item 5 (Emergency Room Health Services) of the *Benefits Information Grid* beginning on page 24.

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 Plan 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.

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 *General Contact Information* section beginning on page 96, or by using one of the above web sites.

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

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

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

DESIGNATED PROVIDERS AND OTHER PROVIDERS

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

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

EMERGENCY ROOM HEALTH SERVICES

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

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

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

Note: The emergency room Co-payment for covered Emergency Room Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the Hospital. In this case, the emergency room Co-payment will apply. The emergency room Co-payment information can be found in Item 5 (Emergency Room Health Services) of the *Benefits Information Grid* beginning on page 24.

PRESCRIPTION DRUG BENEFITS

ELIGIBILITY FOR PRESCRIPTION DRUG BENEFITS

You are eligible for prescription drug benefits under the Plan if you satisfy the eligibility criteria described in the *Eligibility* section beginning on page 3 and any additional requirements described in this section.

OVERVIEW OF PRESCRIPTION DRUG BENEFITS

This section of the SPD describes the prescription drug benefits provided under the Plan. It is divided into two sections. The first section describes the prescription drug benefits available if you are enrolled in the preferred provider option ("PPO") of the Plan. The second section describes the prescription drug benefits available if you are enrolled in the EPO administered by Blue Cross Blue Shield of Illinois.

PRESCRIPTION DRUG BENEFITS (PPO OPTION)

OVERVIEW

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

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

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

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

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

PRESCRIPTION DRUG CO-PAYMENTS

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";
- $7 Co-payment for each prescription drug designated as "Tier 1" ($2 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 amount charged by the Network Pharmacy *if that amount is less* than the amount charged 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 Plan will be reduced. For a list of the prescription drugs covered by the Plan and the designation of each such prescription drug, please refer to benefits.cat.com. You may also obtain a list of Network Pharmacies at benefits.cat.com or by calling Magellan Rx Management at (877) 228-7909.

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

- $22 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 amount charged by the Out-of-Network Pharmacy *if that amount is less* than the amount charged for "Tier 1," or less than the co-insurance minimum amount for "Tier 2," "Tier 3," a compounded drug or "Tier 4."

MAIL SERVICE PROGRAM

- Prescription drugs can be purchased through the mail from an approved mail-order pharmacy, currently 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 Plan.
- 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";
  - $21 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", 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 Magellan Rx Management at (877) 228-7909.

BENEFIT LIMITATIONS

- Your prescription drug benefits are limited as follows:

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

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

- Administration charges;
- Any refill dispensed after one year from the date of the Physician's latest order;
- Charges for any covered prescription drugs for which payment is otherwise provided under the other benefits of the Plan;
- Charges for prescription drugs incurred prior to the date coverage became effective under the Plan;
- 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 BENEFITS (BCBS OF ILLINOIS EPO)

OVERVIEW

You are eligible for the following prescription drug benefits under the Plan if you are eligible for the exclusive provider organization ("EPO") medical option currently administered by Blue Cross Blue Shield of Illinois.

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

- The expenses are incurred for products listed on the Caterpillar Drug Formulary (the "Formulary");

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

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

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

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

PRESCRIPTION DRUG CO-PAYMENTS

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";
- $7 co-payment for each prescription drug designated as "Tier 1"; ($2 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 amount charged by the Network Pharmacy if that amount is less than the amount charged 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 Plan will be reduced. For a list of the prescription drugs covered by the Plan and the designation of each such prescription drug, please refer to benefits.cat.com. You may also obtain a list of Network Pharmacies at benefits.cat.com or by calling Magellan Rx Management at (877) 228-7909.

The co-payment or co-insurance amounts for drugs purchased at an Out-of-Network Pharmacy are as follows:

- $22 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 amount charged by the Out-of-Network Pharmacy if that amount is less than the amount charged for "Tier 1," or less than the co-insurance minimum amount for "Tier 2," "Tier 3," a compounded drug or "Tier 4."

MAIL SERVICE PROGRAM

- Prescription drugs can be purchased through the mail from an approved mail-order pharmacy, currently 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 Plan.
- 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";
  - $21 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", 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 Magellan Rx Management at (877) 228-7909.

BENEFIT LIMITATIONS

Your prescription drug benefits are limited as follows:

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

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

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

SPECIAL RULE FOR DRUGS PURCHASED OUTSIDE OF THE UNITED STATES

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

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

MEDICARE PART D

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

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

MORE INFORMATION

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

DENTAL BENEFITS

ELIGIBILITY FOR DENTAL BENEFITS

You are eligible for dental benefits under the Plan if you satisfy the eligibility criteria described in the *Eligibility* section beginning on page 3 and any additional requirements described in this section.

OVERVIEW OF DENTAL BENEFITS

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

Only Necessary dental services are Covered Dental Services under the Plan. The Plan 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

You may be required to show your ID card at the time you request Covered Dental Services. If you do not show your card when requested, the Providers have no way of knowing that you are covered under the Plan.

A dental ID card can be obtained by contacting the Cigna customer service team at (800)244-6224. A dental ID card can also be obtained on My Cigna.com as well as the free MyCigna app available on all smart phones.

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 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 Plan.

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

The Claims Administrator will decide if the proposed treatment is a Covered Dental Service under the Plan 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 Plan. 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 BENEFITS

The following *Schedule of Benefits* outlines (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 below.

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

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

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

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 98);
- 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 64.

Covered Dental Services are subject to satisfaction of the Annual Deductible and applicable waiting periods as described in the *Schedule of Benefits* on page 60.

PREVENTIVE DENTAL SERVICES (100% OF ELIGIBLE EXPENSES)

Benefit Description	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.
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.
Sealants	Limited to one treatment per Covered Person under the age of 14 years every three calendar years on unrestored primary or permanent bicuspid or molars.
Space Maintainers that replace prematurely lost teeth	Limited to Covered Persons under the age of 19 years for the replacement of prematurely lost teeth.

BASIC DENTAL SERVICES (80% OF ELIGIBLE EXPENSES)

Benefit Description	Limitations
Minor Restorative Services	
Amalgam Restorations (for example, fillings)	
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 Plan.
Cosmetic Bonding	For Covered Persons 8 through 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.

Benefit Description	Limitations
Endodontics	
Apexification Apicoectomy and Retrograde filling Hemisection Root Canal Therapy Root Resection Therapeutic Pulpotomy	
Injection of Antibiotic Rugs	
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.
Periodontal Maintenance	Limited to two times per calendar year, following active and adjunctive periodontal therapy. Frequency limitation is subject to the regular prophylaxis frequency either or not in combination. Deductible does not apply.
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 Item 16 (Oral Surgery) of the *Benefits Information Grid* beginning on page 21 for additional coverage for Oral Surgery (*e.g.*, treatment of fractures and reduction of dislocation). Refer to *Major Dental Services* section beginning on page 63 for implants.
Adjunctive Services	
Anelgesia Desensitizing Medicament General Anesthesia Intraveinous Sedation and Analgesia Injection of antibiotics Occlusal Adjustment	Coverage for general anesthesia only when administered in connection with oral surgery or other Covered Dental Services. Coverage for analgesia is limited to children 0 – 6 years of age.
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	Limitations
Crowns Inlay or Onlay Gold Fillings Post & Cores for Single Tooth Crown (only for teeth that have had root canal therapy)	Limited to one per tooth every 60 consecutive months. Covered only when a filling cannot restore the tooth. However, if a tooth can be restored with a less expensive material such as 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 Plan.
Fixed Bridges	Limited to one time per 60 consecutive months. This includes bridgework done in connection with periodontal treatment and other diseases of the gums and tissues of the mouth.
Dentures - Full	Limited to one time per 60 consecutive months. Includes precision attachments for dentures. Includes adjustments during the six-month period following installation. If the patient and Dentist decide on personalized restoration or specialized techniques as opposed to standard dental procedures, dental expense benefits will be allowed for the appropriate amount for standard denture service toward such elected treatment. The balance of the treatment charge will not be payable under the Plan.
Dentures - Partial	Limited to one time per 60 consecutive months. Includes adjustments during the six-month period following installation. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, dental expense benefits will cover the applicable percentage of the cost of such procedure toward a more elaborate or precision appliance that the patient and Dentist may choose to use and the balance of the cost will not be payable under the Plan.
Implants	If considered dental necessity by review, will be covered. If not considered dental necessity by review, will be covered as the least expensive appropriate treatment. **Pre-authorization is required prior to services.**
Orthodontic Treatment	Limited to Covered Person age 21 and younger.
Provisional Splinting	
Re-cement Bridges	
Re-cement Crowns	
Re-cement Inlays	
Relining Dentures	Limited to relining done more than six months after the initial insertions.
Repairs to Full Dentures, Partial Dentures, Bridges	

ORTHODONTIC SERVICES

ORTHODONTIC SERVICES

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.

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 Plan 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 Plan. 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 and under. This maximum is determined separately from the Annual Maximum Benefit for Covered Dental Expenses.

LEVEL OF REIMBURSEMENT

The Plan 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 59 does not apply to Orthodontic Services.

GENERAL EXCLUSIONS

Except as may be specifically provided in the *Covered Dental Services* section beginning on page 59 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 Benefit*s section beginning on page 21 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 Plan.

- 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 53 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 bone fractures and any treatment associated with the dislocation of facial skeletal hard tissue. (Refer to Item 16 (Oral Surgery) of the *Benefits Information Grid* beginning on page 24 of this SPD 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 16 (Oral Surgery) of the *Benefits Information Grid* beginning on page 23 of this SPD for possible coverage under the oral surgery benefit.)
- Replacement of complete or partial dentures, fixed bridgework, or crowns previously submitted for payment under the Plan 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 16 (Oral Surgery) of the *Benefits Information Grid* beginning on page 23 of this SPD for possible coverage under the oral surgery benefit.)
- Charges for failure to keep a scheduled appointment.
- Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.
- 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 Plan.
- Full-mouth radiograph series in excess of once every 60 consecutive months. Panoramic radiographs in excess of once every 60 consecutive months.
- 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 Plan, 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 *Extended Coverage* section on page 59. 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.
- Diagnostic casts, bacteriologic studies and caries susceptibility tests.
- 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 beginning on page 61.
- Charges set forth as exclusions in any other sections of the Plan.

VISION BENEFITS

ELIGIBILITY FOR VISION BENEFITS

You are eligible for vision benefits under the Plan if you satisfy the eligibility criteria described in the *Eligibility* section beginning on page 3 and any additional requirements described in this section.

OVERVIEW OF VISION BENEFITS

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

IDENTIFICATION ("ID") CARD

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

VISION BENEFITS

The Plan will pay benefits up to $150 in any 24 consecutive month period for any combination of lenses and eye exams. You are responsible for any amount exceeding this maximum. For example, if you receive $150 in benefits on January 5, 2018, you will not be eligible for coverage for lenses and/or eye exam until January 6, 2020.

The $150 maximum does not apply to Participants under age 18 years of age. For Participants under 18 years of age, the Plan will pay for one eye exam and either one pair of lenses or 12 months of contact lenses during the 24 consecutive month period.

GENERAL EXCLUSIONS

Except as may be specifically provided above or through an amendment to this SPD, the following are not eligible vision expenses. However, the Claims Administrator may, in its sole discretion amend this list of general exclusions.

- Frames;
- 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 (frames and/or lenses).

DEATH BENEFITS

AN INTRODUCTION TO YOUR BENEFITS

This *Death Benefits* section of the SPD summarizes the life insurance benefits available to Eligible Persons under the Plan.

ELIGIBILITY FOR LIFE BENEFITS

You are eligible for life insurance benefits under the Plan if you satisfy the eligibility criteria described in the *Eligibility* section beginning on page 3 and any additional requirements described in this section.

RETIREE LIFE INSURANCE BENEFITS

AMOUNT AND DURATION OF COVERAGE

If you retired after August 19, 2012, but before January 1, 2015 and are covered by the Plan, your retiree life insurance benefits will be equal to the basic life insurance coverage in effect on the day preceding your retirement date and are provided at no additional cost to you. Your basic life insurance benefits will continue until the day preceding the first anniversary of your retirement date.

EXTENDED RETIREE COVERAGE

On your retirement date, you will have the option of purchasing group life insurance that will extend your basic life insurance coverage beyond the first anniversary of your retirement date. If you elect to continue your coverage, your benefits will continue at the amount in effect on the day preceding the termination of your coverage. You will be required to pay the full group rate for the life insurance coverage, as determined by the Insurance Carrier and the Company. To extend your basic life insurance coverage, you must contact MetLife at the telephone number listed in the section entitled *General Contact Information* section beginning on page 96 within 31 days of the date of your retirement or, if later, within 31 days of notice from MetLife. You may extend your basic life insurance coverage without providing evidence of insurability if you carry optional life insurance coverage at the time you actually retire. In all other cases, you will be required to provide satisfactory evidence of insurability to extend your basic life insurance coverage.

BENEFICIARY DESIGNATION

NAMING A BENEFICIARY

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

To change or designate a beneficiary, go to the website at www.MetLife.com/mybenefits and complete the form online. Alternatively, you may obtain a beneficiary designation form by calling MetLife at the telephone number listed in the *General Contact Information* section beginning on page 96. You may complete and submit your beneficiary designation form to MetLife at the address listed in the section entitled *General Contact Information* section beginning on page 96. 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.

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 at www.MetLife.com/mybenefits or 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 Claims Administrator, in its discretion, your new designation takes effect on the date you sign the form, even if you are not alive on the date your form is received. A beneficiary change form can be obtained by calling MetLife at the telephone number listed in the *General Contact Information* section beginning on page 96.

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, 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.

OTHER EVENTS ENDING YOUR COVERAGE

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because you knowingly gave the Plan Administrator or the Claims Administrator false, material information. Examples include false information relating to another person's eligibility.
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, or a Provider.
Any Other Material Violation	There was any other material violation of the terms of the Plan.

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 Plan.

OVERVIEW OF VOLUNTARY BENEFITS

The following voluntary benefits are available under the Plan:

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

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

ELIGIBILITY FOR VOLUNTARY BENEFITS

You are eligible for voluntary benefits under the Plan if you satisfy the eligibility criteria described in the *Eligibility* section beginning on page 3 and any additional requirements described in this section. Surviving Spouses of a retiree are not eligible for voluntary benefits.

ENROLLING IN VOLUNTARY BENEFITS

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

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

MID-YEAR CHANGES NOT PERMITTED

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

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.

WHEN COVERAGE ENDS

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

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.

OTHER EVENTS ENDING YOUR COVERAGE UNDER THE PLAN

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because you knowingly gave the Plan Administrator or the Claims Administrator false, material information. Examples include false information relating to another person's eligibility.
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, or a Provider.
Any Other Material Violation	There was any other material violation of the terms of the Plan.

.

GENERAL ADMINISTRATION

CLAIMS AND APPEALS

FILING A CLAIM FOR BENEFITS

Plan Benefit	Information Needed	Where to Send Your Claim	Deadline* and Initial Decision
Medical Benefits	• Retiree's name and address • The patient's name, age and relationship to the retiree • The member and group numbers stated on your ID card • An itemized bill from your Provider that includes: - Patient diagnosis code(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)	UnitedHealthcare Insurance Company P.O. Box 740800 Atlanta, GA 30374-0800 Customer Service & Personal Health Support℠ Notification: (866) 228-4215 www.myuhc.com	Deadline: • One year following the date the expenses were incurred. An expense is incurred on the date you receive the service. Claims filed after this deadline will not be paid. Initial Decision: • Urgent care claim: Within 72 hours after claim is filed • Pre-service claim (not urgent): Within 15 days after claim is filed** Post-service claim: Within 30 days after claim is filed**

Plan Benefit	Information Needed	Where to Send Your Claim	Deadline* and Initial Decision
Prescription Drug Benefits	A receipt that provides: • Date Filled • Days Supply • Drug Name and Strength • N.D.C. Code and Price • Patient Name • Rx No. • Quantity Caterpillar Prescription Drug Expense Claim Form	Magellan Rx Management Attn: Claims Dept. 11013 W. Broad Street Suite #500 Glen Allen, VA 23060 Fax: (800) 424-7644	Deadline: • One year following the date the expenses were incurred. An expense is incurred on the date you receive the service. Claims filed after this deadline will not be paid. Initial Decision: • Urgent care claim: Within 72 hours after claim is filed • Pre-service claim (not urgent): Within 15 days after claim is filed** Post-service claim: Within 30 days after claim is filed**
Dental Benefits	A claim form with the following information: • 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 dental 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) Claim forms are available on the internet at benefits.cat.com or can be obtained by calling the Claims Administrator.	CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037	Deadline: • One year following the date the expenses were incurred. An expense is incurred on the date you receive the service. Claims filed after this deadline will not be paid. Initial Decision: • Urgent care claim: Within 72 hours after claim is filed • Pre-service claim (not urgent): Within 15 days after claim is filed** • Post-service claim: Within 30 days after claim is filed **

Plan Benefit	Information Needed	Where to Send Your Claim	Deadline* and Initial Decision
Vision Benefits	A claim form with the following information: • Your name, address and date of birth • Patient's name and date of birth • The name and phone number of the Provider of the service(s) • Date(s) of service • Claim information • Itemized receipt(s) Claim forms are available at benefits.cat.com or can be obtained by calling VSP.	VSP P.O. Box 385018 Birmingham, AL 35238-5018 (800) 877-7195 VSP.com	Deadline: • One year following the date the expenses were incurred. An expense is incurred on the date you receive the service. Claims filed after this deadline will not be paid. Initial Decision: • Urgent care claim: Within 72 hours after claim is filed • Pre-service claim (not urgent): Within 15 days after claim is filed** Post-service claim: Within 30 days after claim is filed **
Life Insurance Benefits	Call the Claims Administrator at (888) 228-1811	MetLife P.O. Box 14406 Lexington, KY 40512-4406 www.metlife.com/mybenefits	Initial Decision: Within 90 days after claim is filed***
Voluntary Benefits - Accident Insurance	Call the Claims Administrator at (800) 521-3535	Allstate Benefits American Heritage Life Insurance Company 1776 American Heritage Life Drive Jacksonville, FL 32224 https://allstatevoluntary.com/yourchoice/	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.

MEDICAL BENEFIT CLAIMS

If a Provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you do not provide this information to the Claims Administrator within one calendar year following the date expenses were incurred, benefits for that health service will be denied or reduced, in the Claims Administrator's sole discretion 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. The Plan will not reimburse third parties who have purchased or been assigned benefits by Physicians or other Providers.

GENERAL ADMINISTRATION

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 either of the following is true:

- The Provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to the Provider.
- You make a written request for the non-Network Provider to be paid directly at the time you submit your claim.

PRESCRIPTION DRUG BENEFIT CLAIMS

IF DISPENSED BY A NETWORK PHARMACY

- Show your Drug Card to the pharmacist;
- Sign the Signature Log the pharmacist will give you;
- Pay the pharmacist no more than the Co-payment for each prescription or refill; and
- The participating pharmacy will bill the Company for all prescriptions covered under the Plan.

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 72;
- Complete the Caterpillar Prescription Drug Expense Claim Form available under the "U.S. RX" tab at benefits.cat.com or by calling Magellan Rx Management at (877) 228-7909;
- Submit claim form and receipt to Magellan Rx Management (via the fax number or address on the claim form); and
- A check will be mailed to you at the address listed in the Magellan Rx Management system for benefits payable.

If you do not submit your claim for prescription drug benefits to the Claims Administrator within one calendar year following the date expenses were incurred, benefits will be denied or reduced, in the Claims Administrator's sole discretion.

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.

LIFE INSURANCE CLAIMS

The Claims Administrator has the initial authority to decide whether an individual is eligible for death benefits under the Plan. The Claims Administrator has the authority to decide whether an individual is disabled under the Plan 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 Plan.

BENEFIT DETERMINATION

INITIAL DECISION

The *Filing A Claim for Benefits* chart beginning on page 72 describes the deadlines for the Claims Administrator's initial decision.

EXPEDITED DECISIONS FOR MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION BENEFIT CLAIMS

As explained in the chart, the following rules apply to expedite initial decisions under the Plan, 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 notice in writing or electronically 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 do not 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 15 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 do not 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 earlier of:

- 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.

NOTICE OF 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 that you are entitled to receive, upon request, 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.

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 Plan's administrative processes or safeguards; or
- In the case of health benefits, constitute a statement of the Plan'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 Plan 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 desire further review of such determination.

REQUESTS FOR REVIEW

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 Rx Management Attn: Claims Dept. 11013 W. Broad Street Suite #500 Glen Allen, VA 23060 Fax: (800) 424-7644 (877) 228-7909
Dental Benefits	CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037 (800) 244-6224
Vision Benefits	VSP P.O. BOX 385018 Birmingham, AL 35238-5018 (800) 877-7195
Life Insurance Benefits	MetLife P.O. Box 14406 Lexington, KY 40512-4406 (888) 228-1811
Voluntary Benefits	Request a Claim Initiation Form by visiting www.YourChoiceVoluntaryBenefits.com/us

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 96.

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 72 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 on page 82 and contact the Claims Administrator immediately.

GENERAL ADMINISTRATION

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 all 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 Medical and Prescription Drug Benefit Claim Appeals:*
  - For appeals of pre-service claims (as defined in the section entitled *Benefit Determination* beginning on page 76), 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 76), 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* below.

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.

- *For Dental and Vision Benefit Claim Appeals:*

  For appeals of post-service claims (as defined in the section entitled *Benefit Determination* beginning on page 76), your appeal request should be submitted to the Claims Administrator within 180 days after you receive the claim denial. There is one level of appeal. You will be notified by the Claims Administrator of the decision within 30 days from the receipt of an appeal for a post-service medical necessity determination. You will be notified by the Claims Administrator of the decision within 60 days of receipt of an appeal for any other post-service coverage determination.

  For procedures associated with urgent claims, see *Urgent Claim Appeals That Require Immediate Action* below.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan 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 discretionary authority to the Claims Administrator to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

Notice of Denial of Appeal

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

- The date(s) of service;
- The name of the Provider:
- The claim amount;
- A discussion of the decision including the specific reason(s) for the adverse determination, the denial code and its corresponding meaning, and a description of the standard, if any, that was used in denying the claim;
- The specific plan provisions on which the determination was based;
- A statement that you are entitled to receive, upon request, the diagnosis code and its corresponding meaning (for prescription drug claims, if provided by you or your authorized representative);
- A statement that you are entitled to receive, upon request, the treatment code and its corresponding meaning (for prescription drug claims, if provided by you or your authorized representative);
- 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;
- 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"; 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.

LIFE INSURANCE AND VOLUNTARY BENEFITS CLAIMS

How to Appeal a Life Insurance 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 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 timeframes 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 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 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."

GENERAL ADMINISTRATION INFORMATION

LEGAL PROVISIONS

PLAN DOCUMENT

This SPD presents an overview of your benefits under the Plan. In the event of any discrepancy between this SPD and the official Plan documents, the Plan documents shall govern. Specifically, when this SPD 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 Plan 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 Plan, the Plan's terms will control. It is your responsibility to confirm the accuracy of statements made by the Company or its designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

PLAN ADMINISTRATION

The Plan Administrator has the sole and complete discretionary authority to determine eligibility and entitlement to Plan benefits and to construe the terms of the Plan, including the making of factual determinations. The Plan Administrator shall have the sole discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan 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 Plan.

The Plan Administrator may delegate to other persons responsibilities for performing certain duties of the Plan Administrator under the terms of the Plan and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the Plan. 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 96 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 Plan. The Plan Administrator may adopt uniform rules for the administration of the Plan from time to time, as it deems necessary or appropriate.

In certain circumstances, for purposes of overall cost savings or efficiency, the Company may, in its discretion, offer benefits under the Plan 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

Subject to the terms of the Plan documents and applicable law, the Company reserves the discretionary right to modify, amend or terminate the Plan in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by its Board of Directors or their designee and duly authorized on behalf of the Company.

If the Plan is modified, amended or terminated, you will be notified of the effect of such change on your Plan benefits or coverage. Subject to the terms of the Plan documents and collective bargaining agreements, no consent of any employee or any other person will be necessary for the Company to modify, amend or terminate the Plan described in this SPD.

BENEFITS NOT VESTED

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

COMPANY AUDIT

The Company and the Plan Administrator reserve the right to audit any aspect of the 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 your covered Dependent child(ren) information relating to eligibility, enrollment or claims. Failure to provide any requested information may affect your (or your Spouse's or your Dependent's) coverage or benefits under the 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 Plan except by means of a duly authorized written amendment. No verbal or written representations contrary to the terms of the Plan are binding upon the Plan, the Plan Administrator or the Company.

NO ASSIGNMENT

Except as permitted by the SPD or the Plan Administrator:

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

Except as may be required by law, your benefits under the Plan 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 Plan to a Provider. Direct payments to a Network Provider by the Plan do not constitute a waiver of any anti-assignment provisions. Medical Providers are not third-party beneficiaries under the Plan. 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 Plan, the Plan Sponsor, any participating subsidiary, the Plan Administrator, any Plan fiduciary, any party-in-interest with respect to the Plan, or anyone else with respect to the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS ("QMCSO")

The Plan's procedures for handling 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 Plan does not grant you employment with the Company or rights to benefits except as specified under the terms of the Plan. Nothing in the Plan or this SPD confers any right of employment on any person.

IMPLIED PROMISES

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

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 (other than a loan from the Plan itself).

CHANGE OF ADDRESS

It is important that you notify the Claims Administrator (and the Company) of any change in your address so you will be assured of receiving future benefit communications that the Plan may send to you. You also should ensure that your beneficiary's address is kept current.

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 Plan 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 Plan shall continue in full force and effect.

RECOVERY OF PAYMENTS MADE BY MISTAKE

You will be required to return to the Company any benefits, or portion thereof, paid under the Plan 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, 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 the 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 Plan.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. 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 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

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

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the Plan has paid benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that the Plan 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 Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible.

The right to reimbursement means that if it is alleged that a 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 Plan 100% of any benefits you received for that Sickness or Injury.

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 that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, 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 Plan.
  - Signing and/or delivering such documents as the Plan 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 Plan'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 comply with these subrogation provisions gives the Plan 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 Plan 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 Plan due to you or your representative not cooperating with the Plan or its designee. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan 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 Plan.

The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan'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 Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan 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 Plan's recovery without the Plan'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 Plan 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 Plan 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 Plan's subrogation and reimbursement rights.

Benefits paid by the Plan 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 Plan alleges some or all of those funds are due and owed to the Plan, you and your representative shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account.

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

Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the Sickness or Injury.

By participating in and accepting benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy – including no-fault benefits, PIP benefits and/or medical payment benefits, other coverage or against any third party, to the full extent of the benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, regardless of whether you choose to pursue the claim, and you agree to this assignment voluntarily.

The Plan 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 paid on your behalf out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name, which does not obligate the Plan 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 Plan is governed by a six-year statute of limitations.

GENERAL INFORMATION

You may not accept any settlement that does not fully reimburse the Plan, 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.

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 Plan for 100% of its interest unless the Plan 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 a 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 a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Plan, 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 Plan pertaining to reimbursement, the Plan may terminate benefits to you, your dependents or the participant, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan 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 Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan 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 Plan.

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

REIMBURSEMENT TO THE PLAN

If you or your covered Dependent is injured as a result of the act of a third party and you or your covered Dependent's legal representative files a claim for benefits, that same person must, as a condition of receipt of Plan benefits, reimburse the Plan for money received from the third party, or its insurer, to the extent of the amount paid by the Plan on the claim. The right of reimbursement provides the Plan 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 Plan will be reimbursed from your future benefits, to the extent necessary.

PLAN FUNDING

The Plan 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 Code, or through a combination of these means. The Plan requires you to contribute to the cost of coverage.

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

	Self-Insured	**Fully Insured**
Benefits	Medical Prescription Drug Dental Vision Care	Life Insurance Voluntary Benefits

	Self-Insured	Fully Insured
Definition	As claims are made, covered benefits are paid from the Company's general assets. In addition, the Company has administrative services contracts with third-party administrators to decide on and to process claims.	An Insurance Carrier is an 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 retiree contributions.

APPLICABLE LAW

The Plan is 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 Plan, you may bring action in court to recover benefits after you have exhausted the 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 Plan is administered.

HIPAA PRIVACY AND SECURITY

As a participant in the Plan (including the medical, prescription drug, dental and vision benefits under the Plan), 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, the Plan has 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 benefits 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 PLAN PROVIDERS

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

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

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

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 Plan.

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

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

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

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 *General Contact Information* section beginning on page 96. 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 Plan. 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 Plan, 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 have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the retiree's enrollment form. The Company and the Claims Administrator agree that such information and records will be considered confidential.

The Company and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, 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 Plan, 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 Plan examine you at its expense.

WORKERS' COMPENSATION NOT AFFECTED

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

HOLD HARMLESS PROVISION

For purposes of medical, dental and vision benefits under the Plan, provision will be made to "hold the Covered Person harmless" in the event of legal action for a Physician's or Dentist's charges in excess of the Usual and Customary charge, where it is clearly established that the Covered Person has neither agreed to nor ratified the Physician's or Dentist's charges.

It is your choice whether or not to pay the amount in excess of the Usual and Customary charge. Remember that the Plan Sponsor will become involved only when legal action commences. However, before legal action commences, the following may have occurred:

- You may continue to be billed by the Provider;
- You may be sent to collection by the Provider;
- You may receive numerous collection notices and phone calls;
- Your credit rating may be negatively impacted; or
- You may eventually be summoned to appear in court.

You should contact the Claims Administrator as soon as collections commence in order to avoid a negative impact on your credit rating and potential court expenses and costs. Once notified, the Claims Administrator will work with the Provider to attempt to resolve the dispute. If you have questions concerning the hold harmless provision, contact the Claims Administrator.

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 Plan 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 and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the 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 Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("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 and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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 Plan, including insurance contracts and collective bargaining agreements, 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 Plan's 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 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. 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 Plan, 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 CONTACT INFORMATION

In most cases, you can find the information you need at benefits.cat.com or by contacting the Caterpillar Americas HR Regional Service Center listed below.

General Contact Information	
Personal Health Support[SM] Notification	UnitedHealthcare (866) 228-4215 www.myuhc.com
Caterpillar Benefits Center	(877) 228-4010 [Outside the U.S. (718) 354-1345] http://CatBenefitsCenter.com
COBRA Administrator	Caterpillar Benefits Center (877) 228-4010 [Outside the U.S. (718) 354-1345] http://CatBenefitsCenter.com
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 www.metlife.com/mybenefits
Blue Cross Blue Shield of Illinois	This SPD does not describe the specific benefit terms that apply if you are in a medical plan option administered by Blue Cross Blue Shield of Illinois. To request a copy of the benefits booklet that applies to that plan option, contact Blue Cross Blue Shield of Illinois at (844) 228-2227.
General Voluntary Benefits Information	www.YourChoiceVoluntaryBenefits.com/us

Plan Sponsor and Employer:	Agent for Legal Service:
Caterpillar Inc. 510 Lake Cook Road, Suite 100 Deerfield, IL 60015 (224) 551-4000 Employer Identification Number: 37-0602744	CT Corporation Systems 208 S. LaSalle Street, Suite 814 Chicago, IL 60604 (877) 564-7529

PLAN INFORMATION

Plan Name/Type	Plan Number	Funding/Claims Administrator	Plan Administrator	Plan Year
Retiree Group Insurance Plan	542	Medical benefit claims are administered by: UnitedHealthcare Insurance Company P.O. Box 150450 450 Columbus Blvd. Hartford, CT 06115-0450	Caterpillar Inc. Attn: Plan Administrator – Retiree Group Insurance Plan 100 NE Adams Street	The 12-month period ending December 31

Plan Name/Type	Plan Number	Funding/Claims Administrator	Plan Administrator	Plan Year
		(866) 228-4215 www.myuhc.com Prescription drug benefit claims are administered by: Magellan Rx Management Attn: Claims Dept. 11013 W. Broad Street Suite #500 Glen Allen, VA 23060 Fax: (800) 424-7644 (877) 228-7909 benefits.cat.com Dental benefit claims are administered by: CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037 (800) 244-6224 myCigna.com Vision benefit claims are administered by: VSP P.O. BOX 385018 Birmingham, AL 35238-5018 (800) 877-7195 Life insurance benefit claims are administered by: MetLife P.O. Box 14406 Lexington, KY 40511 (888) 228-1811 www.metlife.com/mybenefits Voluntary benefit claims for accident insurance are administered by: Allstate Benefits American Heritage Life Insurance Company 1776 American Heritage Life Drive Jacksonville, FL 32224 (800) 348-4489 https://allstatevoluntary.com/yourchoice/ Voluntary benefit claims for legal insurance are administered by: ARAG Legal 500 Grand Ave, Suite 100 Des Moines, IA 50309 1-800-247-4184 www.araglegalcenter.com	Peoria, IL 61629 (309) 675-1000	

DEFINITIONS

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

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

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

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

Annual Deductible – The amount you must pay for Covered Health Services or Covered Dental Services in a calendar year before the Plan will begin paying for benefits in that calendar year. 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.

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 Plan. The Annual Maximum Benefit is stated in the *Schedule of Benefits* section beginning on page 60.

Bargaining Unit – Local Lodge No. 851 of the International Association of Machinists and Aerospace Workers, AFL-CIO.

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

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

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

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

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

Code – The Internal Revenue Code of 1986, as amended.

Co-insurance – The charge you are required to pay for certain Covered Health Services or Covered Dental Services, generally after satisfaction of the Annual Deductible. Co-insurance is typically a percentage of Eligible Expenses.

Company – Caterpillar Inc.

Congenital Anomaly – A physical developmental defect that is present at birth, and is identified within the first 12 months of birth.

Continuity of Service – Means service with the Company until it is broken by (i) your death or retirement, (ii) the date you quit or are discharged, unless you are rehired before the end of the month in which you quit or are discharged, or (iii) the expiration of your recall rights under the applicable provisions of the agreement between the Company and the Union. If your employment with the Company changes because you move from employment in a group covered by the plan to employment in a group that is not covered by the plan (or vice versa), this employment change will not be considered a break in Continuity of Service. Your Continuity of Service is used to determine your eligibility.

Co-payment – 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 the Co-insurance amounts, even after satisfaction of the Annual Deductible or the Maximum Out-of-Pocket.

Cosmetic Procedures – Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Personal Health Support[SM].

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 the *Covered Dental Services* section beginning on page 59 as a Covered Dental Service, which is not excluded as set forth herein. Covered Dental Services must be provided:

- When the Plan is in effect;
- 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 Plan.

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 the *What's Covered – Benefits* section beginning on page 21 as a Covered Health Service, which is not excluded as set forth herein. Covered Health Services must be provided:

- When the Plan is in effect;
- 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 Plan.

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 medical research, based on well-conducted, randomized trials or cohort studies.

Covered Person – Either the retiree, former employee or an Enrolled Dependent, beneficiary or alternate payee, but this term applies only while the person is enrolled under the applicable plan. References to "you" and "your" throughout this SPD 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 by a plan sponsored by the Company (including any collectively bargained plan), you are each 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 (including any collectively bargained plan), you are each covered by your separate plans. This rule also applies to all Dependents.

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
- 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 – The retiree's or former employee's (a) legal Spouse who is not eligible in his or her own right or a Covered Person Under Their Own Right, or (b) Dependent child of the retiree or former employee or such person's Spouse. 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 retiree 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 a retiree or employee in any Company-sponsored plan. No one can be a Dependent of more than one retiree or employee.

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

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

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

Eligible Expenses – Eligible Expenses (whether for Medical or Dental Benefits) must be a Covered Health Service or a Covered Dental Service (as applicable) 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 Plan, the amount the Company will pay (and the amount of the Covered Person's Co-insurance or Co-payment) for Covered Health Services, incurred while the Plan is in effect, is determined as stated below:

Eligible Expenses are based on the following:

- When Covered Health Services are received from Network Providers, Eligible Expenses are the contracted fee(s) with that Provider.

- When Covered Health Services are received from non-Network Providers, unless you receive services as a result of an Emergency, Eligible Expenses are determined at the Claims Administrator's discretion by either (i) calculating Eligible Expenses based on available data resources of competitive fees in that geographic area (Usual and Customary), or (ii) applying the negotiated rates agreed to by the non-Network Provider and either the Claims Administrator or one of its vendors, designees, or subcontractors.

Eligible Expenses are determined in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim 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.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that the Claims Administrator accepts.

Dental Benefits: For purposes of dental benefits under the Plan, 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 Plan 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 discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

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

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 of this SPD.

Emergency – A serious medical condition or symptom resulting from Injury, Sickness or Mental Illness that:

- Arises suddenly; and
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

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 – Health care services and supplies necessary for the treatment of an Emergency in a Hospital emergency room.

Enrolled Dependent – A Dependent who is properly enrolled under the applicable plan. A Dependent who is an Eligible Person must enroll in coverage in their own right.

ERISA – The Employee Retirement Income Security Act of 1974, as amended, which establishes certain rights and protection for participants as well as rules for employers to qualify benefit plans for special tax considerations.

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

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

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment), the Claims Administrator may, in its 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.

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 Agency – A program or organization authorized by law to provide health care services in the home, and which (i) 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 affiliated with a Hospital or Skilled Nursing Facility affiliated with or a freestanding not-for-profit or for-profit; (ii) 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; (iii) keeps clinical records on each patient; and (iv) is approved by the Plan Administrator, in its sole discretion.

Hospice Agency – An agency approved by Medicare and licensed by the state to provide hospice-related services.

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 Rehabilitation Facility – A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Insurance Carrier – An insurance company, as selected by the Company in its discretion.

Level of Reimbursement – The percentage of Eligible Expenses paid for Covered Dental Services under the Plan. You are responsible for the payment of any percentage that is not covered by the Plan directly to the Provider of the Covered Dental Services at the time of service or when billed by the Provider.

Maximum Out-of-Pocket – The maximum amount you pay out-of-pocket every calendar year after the Annual Deductible is met. The Annual Deductible applies towards both the Network Individual and Family Out-of-Pocket Maximum. Once you reach the Maximum Out-of-Pocket, benefits for those Covered Health Services that apply to the Maximum Out-of-Pocket are payable at 100% of Eligible Expenses during the remainder of that calendar year. The following costs will never apply to the Maximum Out-of-Pocket:

- Any charges for non-Covered Health Services;
- Any Co-payments and Co-insurance for Covered Health Services that do not apply to the Maximum Out-of-Pocket;
- The amount of any reduced benefits if you do not notify Personal Health Support℠ as described in *What's Covered--Benefits* under the *Notify Personal Health Support℠*? column of the *Benefits Information Grid* beginning on page 24.
- Charges that exceed Eligible Expenses; and
- Non-Network expenses incurred when you are required to use a Network Provider to obtain the highest level of reimbursement.

You are responsible for these amounts even after the Maximum Out-of-Pocket has been satisfied.

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 Plan.

Necessary – Covered Health Services and Covered Dental Services and supplies which are determined by the Claims Administrator, in its discretion, to be appropriate and:

- Necessary to meet the basic needs of the Covered Person;
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the services;

- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Claims Administrator;
- Consistent with the diagnosis, care or treatment of the condition;
- Required for reasons other than the convenience of the Covered Person or his or her Provider; and
- Demonstrated through prevailing, peer-reviewed medical and dental literature to be either:
  - safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or
  - safe with promising efficacy:
    (i) for treating a life threatening dental disease or condition;
    (ii) in a clinically controlled research setting; and
    (iii) using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe a disease or condition that is more likely than not to cause death within one year of the date of the request for treatment.) 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 disease does not mean that it is a Necessary Covered Health Service or Covered Dental Service as defined in this SPD. 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.

Network – When used to describe a Provider of health care services, this means a Provider that has a participation agreement in effect with the Claims Administrator or a designee of the Plan Sponsor or a designee (directly or through one or more other organizations) 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 to provide prescription drugs under the Plan at a rate agreed upon between the Physician, pharmacy or other organization and the Plan Administrator and that is designated by Caterpillar, in its role as Plan sponsor and as a matter of Plan design, as a Network Pharmacy. Caterpillar shall make the determination of whether a pharmacy is a Network Pharmacy, in its sole discretion.

Non-Covered Provider – A Network or Non-Network Provider of services, treatments, items or supplies that the Claims Administrator deems ineligible to provide Covered Health Services or Covered Dental Services.

Non-Network Benefits – Benefits for Covered Health Services that are provided by a non-Network Physician or other non-Network Provider.

Non-Network Pharmacy – Any Physician, pharmacy or other organization licensed to dispense drugs that is not a Network Pharmacy or an approved mail-order pharmacy.

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

Personal Health Support℠ – A program provided by the Plan's 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 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.

Plan Administrator – Caterpillar Inc. or its designee as that term is defined under ERISA.

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

Preferred Network Pharmacy – A network Pharmacy that is designated by the Company as such.

Pregnancy – Includes all of the following:

- Prenatal care;
- Postnatal care;
- Childbirth; and
- Any complications associated with Pregnancy.

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 his or her license that may be subject to reimbursement under the Plan.

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

- An eligible retiree's relationship will be treated as a same-sex domestic partnership, regardless of whether the eligible retiree and his or her Same-Sex Domestic Partner remain in the jurisdiction where the relationship was legally entered into. In the event more than one person meets this definition for a given eligible retiree, then the Same-Sex Domestic Partner is the person who first met the criteria in this definition.
- In any case in which an eligible retiree has a Spouse, no person will qualify as the eligible retiree's Same-Sex Domestic Partner unless the eligible retiree's marriage to his or her Spouse is first lawfully dissolved.
- For purposes of any fully insured benefit under the Plan, a Same-Sex Domestic Partner will include a civil union partner under state law, a domestic partner, or other similar partner relationship with the eligible retiree (including an opposite-sex partner), but solely to the extent mandated by applicable state insurance law.

- Nothing in the Plan or this SPD shall create a right or remedy for (i) any Same-Sex Domestic Partner under COBRA, USERRA or any other federal law or (ii) a leave related to a Same-Sex Domestic Partner under the Family and Medical Leave Act of 1993.

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.

Shared Savings Program – A program in which UnitedHealthcare may obtain a discount to a non-Network Provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network Provider. When this happens, you may experience lower out-of-pocket amounts. Plan Co-insurance and any applicable Annual Deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare. This means, when contractually permitted, the Plan may pay the lesser of the Shared

Savings Program discount or an amount determined by the Claims Administrator, such as a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar services within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the Provider. In this case the non-Network Provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID card. Shared Savings Program providers are not Network Providers and are not credentialed by UnitedHealthcare.

Sickness – Physical illness, disease or Pregnancy.

Skilled Nursing Facility – A Hospital or nursing facility that is licensed and operated as required by law which (i) meets every one of the requirements for registration and continuing recognition as an Extended Care Facility as set forth by The Joint Commission, and (ii) is recognized under the Health Insurance for the Aged Act of the United States (Medicare) as an Extended Care Facility.

Spouse – The person of the opposite sex or same sex who is considered married to you for federal tax purposes, pursuant to Internal Revenue Service guidance.

Substance Abuse Services – Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. 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.

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.

Union – The International Association of Machinists and Aerospace Workers, AFL-CIO, and Local Lodge No. 851.

Unproven Services – Services that, in the sole discretion of the Claims Administrator, (i) 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 (ii) 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.

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 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 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.

Usual and Customary – The lesser of the following:

- the usual charge made by the Physician, person or organization providing the service or supply; or
- the charge the Claims Administrator determines in its discretion to be reasonable for the service or supply, taking into consideration the prevailing range of fees in the local geographic area of providers of similar training or experience for like services or supplies.

In the case of a Network Provider, when there is a negotiated network charge for the service or supply, "Usual and Customary" for all purposes means that negotiated network charge.