This Summary Plan Description (“SPD”) describes benefits for certain salaried, management and non-bargained hourly retirees of Caterpillar Inc. and related companies who retired under the Caterpillar Inc. Retiree Benefit Program on or after February 1, 1991. Benefits of retirees who retired under the Caterpillar Inc. Retiree Benefit Program prior to February 1, 1991 are described in another summary.
# TABLE OF CONTENTS

## INTRODUCTION
- About This Document ............................................................................................................. 1
- Official Plan Document Overview ............................................................................................. 2
- Benefits Not Vested ................................................................................................................. 2
- A Special Note About Medicare ............................................................................................... 2
- Contact The Administrator ..................................................................................................... 2

## ELIGIBILITY AND PARTICIPATION
- Eligibility For The Program .................................................................................................... 3
- Facilities That Have Opted-Out of Retiree Coverage ................................................................. 5
- Dual Coverage ....................................................................................................................... 5
- Qualified Medical Child Support Order (“QMCSO”) ............................................................... 5
- Disabled Children .................................................................................................................. 6
- Reemployment Of Retirees .................................................................................................... 6
- Participation In The Program .................................................................................................. 7
- How to Enroll .......................................................................................................................... 7
- Healthcare Benefits .............................................................................................................. 8
- Cost Of Coverage .................................................................................................................. 11
- Life Benefits ........................................................................................................................ 11
- Traditional Healthcare Benefits ........................................................................................ 11
- HRA Benefits ....................................................................................................................... 11
- How Long Coverage Continues ............................................................................................ 11
- Life Benefits ........................................................................................................................ 11
- Traditional Healthcare Benefits ........................................................................................ 12
- Continuation of Benefits (COBRA) ....................................................................................... 12

## TRADITIONAL MEDICAL COVERAGE
- An Introduction To Your Traditional Medical Coverage ...................................................... 18
- Eligibility For Traditional Medical Coverage ......................................................................... 18
- What’s Covered – Traditional Medical Coverage ..................................................................... 18
- Accessing Benefits ................................................................................................................ 18
- Identification Card (“ID Card”) ............................................................................................. 19
- Eligible Expenses ................................................................................................................ 20
- Notification Requirements .................................................................................................... 20
- Benefits At A Glance ........................................................................................................... 21
- Benefit Information .............................................................................................................. 21
- What’s Not Covered – Exclusions ......................................................................................... 34
- The Use of Section Headings ............................................................................................... 34
- Plan Exclusions .................................................................................................................... 34
- Description Of Network And Non-Network Benefits (Reside In A Caterpillar Network Area) .......................................................................................................................... 41
- Network Benefits ................................................................................................................. 41
- Non-Network Benefits ........................................................................................................ 43
- Emergency Room Health Services ...................................................................................... 43
- Description Of Network And Non-Network Benefits (Reside In A United Healthcare Network Area) .......................................................................................................................... 44
- Network Benefits ................................................................................................................. 44
- Non-Network Benefits ........................................................................................................ 45
- Emergency Room Health Services ...................................................................................... 45
- Obtaining Benefits (Reside Outside A Network Area) .......................................................... 46
- If You Obtain Services from a Network Provider .................................................................. 46
- Designated United Resource Network Facilities and Other Providers .................................. 47
- Emergency Room Health Services ...................................................................................... 47
INTRODUCTION

ABOUT THIS DOCUMENT

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

This SPD describes benefits under the Program for those eligible individuals who retired on or after February 1, 1991. This SPD does not describe benefits under the Program for those eligible individuals who retired prior to February 1, 1991. The benefits of such individuals are described in another summary.

The provisions of this SPD are generally effective January 1, 2011. You are encouraged to read this SPD in its entirety.

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

• **Eligibility and Participation** – This section describes the eligibility requirements of the Program and how to enroll in Program coverage.

• **Traditional Healthcare Benefits** – The following sections describe the Traditional Healthcare Benefits available to Eligible Persons under the Program (Age 64 and Under):
  • *Traditional Medical Coverage* – This section describes the medical and vision coverage available to Eligible Persons under the Program.
  • *Traditional Prescription Drug Coverage* – This section describes the prescription drug coverage available to Eligible Persons under the Program.
  • *Traditional Dental Coverage* – This section describes the dental coverage available to Eligible Persons under the Program.

• **Health Reimbursement Arrangement (HRA) Benefits** – This section describes the HRA benefits available to Eligible Persons under the Program (Age 65 and Older).

• **Life Benefits** – This section describes the life insurance benefits available to Eligible Persons under the Program.

• **General Administration** – This section describes (i) how to file a claim and the appeals process under the Program; (ii) the legal provisions applicable to the Program, and (iii) the Program’s contact information, including contact information for the Plan Administrator and Claims Administrator.

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

OFFICIAL PLAN DOCUMENT OVERVIEW

This SPD is based on the official plan documents for the Program. There are several service agreements, administrative documents and insurance policies that also govern benefits.

In the event of any discrepancy between this SPD and the official plan documents (including the applicable service agreements, administrative documents and insurance policies), those plan documents will govern. Specifically, when this SPD says anything that grants or provides greater rights or benefits than the plan documents, the plan documents control.

This SPD issued May 2011
YEBB3303a
This SPD is not a contract, and is not a guarantee of your benefits.

**BENEFITS NOT VESTED**

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

**A SPECIAL NOTE ABOUT MEDICARE**

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

If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the Program), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don’t enroll and maintain that coverage, and if the Program is the secondary payer as described in the *Coordination of Benefits* section beginning on page 47, the Program will pay benefits as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the expenses that Medicare would have paid and you will incur a larger out-of-pocket expense.

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

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

**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 covered services, any required procedure, or about the Program generally, please contact the Claims Administrator for the particular benefit or the Plan Administrator at the number stated in the section entitled *Contact Information* beginning on page 96.
ELIGIBILITY AND PARTICIPATION

Eligibility For The Program

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

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

<table>
<thead>
<tr>
<th>Individual</th>
<th>Eligibility Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>Generally, retirees who, at the time of their retirement, were classified as a salaried, management or non-bargained hourly employee of Caterpillar or a Participating Company and who were participants in the Employee Program are eligible for participation. This SPD only describes the benefits of those eligible retirees who retired on or after February 1, 1991. When the words “you” and “your” are used in this SPD, they generally refer to people who are Covered Persons as the term is defined in the Definitions section beginning on page 98.</td>
</tr>
</tbody>
</table>
| Retirees    | You are eligible to participate in the Program as a retiree and this SPD describes your benefits if:  
1. You retired from the company on or after February 1, 1991 but prior to January 1, 2011 and you: (a) were a participant in the Program as a retiree on December 31, 2010 or (b) were eligible to participate in the Program as a retiree on December 31, 2010; or  
2. You were hired before January 1, 2003 and you retire from the Company on or after January 1, 2011:  
   • After attaining age 55 and accruing at least 15 years of Credited Eligibility Service.  
   • After attaining age 60 and accruing at least 10 years of Credited Eligibility Service.  
   • After attaining age 65 and accruing at least five years of Credited Eligibility Service.  
   • After accruing at least 30 years of Credited Eligibility Service.  
Provided you were a participant in the Employee Program on the day before your retirement.  
3. You were hired on or after January 1, 2003 and you retire from the Company on or after January 1, 2011:  
   • After attaining age 55 and accruing at least 15 years of Credited Eligibility Service; or  
   • After accruing at least 30 years of Credited Eligibility Service.  
Provided you were a participant in the Employee Program on the day before your retirement. |
<table>
<thead>
<tr>
<th>Individual</th>
<th>Eligibility Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirees Age 65 and Older</td>
<td>Your healthcare benefits under the Program will change when you Reach Age 65. When you Reach Age 65, you are no longer eligible to participate in the Traditional Healthcare Benefits of the Program but rather you will be eligible to participate in a Health Reimbursement Arrangement under the HRA Benefits of the Program.</td>
</tr>
<tr>
<td>Certain facilities of the Company have opted-out of retiree life benefits or have opted-out of retiree healthcare benefits. If you retired from one of these facilities, you may not be eligible for such coverage under the Program. See the subsection entitled Facilities That Have Opted-Out of Retiree Coverage for more information.</td>
<td></td>
</tr>
</tbody>
</table>
| Your Eligible Dependents    | Coverage is also available to your eligible Dependents. A Spouse eligible in their own right is not covered as a Dependent by the Program. Thus, for example, if you have a Spouse who is a retiree and eligible for the Program, you are each covered separately. Your eligible Dependents include your Spouse and any Dependent children who meet the eligibility requirements outlined below. Your Spouse means a person of the opposite sex who is legally married to you. Your children include your natural children, your stepchildren, your adopted children or children placed with you for adoption. To be eligible for coverage, your children must be:

1. Under twenty-six (26) years of age; or
2. Is twenty-six (26) years of age or more but under sixty-five (65) years of age; and

   i. Is unmarried;
   ii. Is incapable of sustaining employment as a result of mental or physical disability as determined by the Plan Administrator;
   iii. Legally reside with you or the non-retiree parent, or in a licensed special care home or facility that specializes in the treatment of physical or mental disabilities; and
   iv. Receive from you more than one-half of their financial support. For purposes of determining whether your dependents are eligible for benefits under the Program, “support” is calculated by dividing the total family expenses for lodging, food and utilities (not including real estate taxes, mortgage interest and insurance), by the number of persons living in your home. Then, add to this quotient the cost of your child’s clothing, education, medical care (not covered by insurance) and travel, and compare that amount to your child’s support from all sources, including support he or she provided. If your share of your child’s total support exceeds one-half of the expenses, the child will be considered your Dependent.

For purposes of HRA Benefits, your eligible Dependents only include your Spouse. Only one parent who is a Covered Person may enroll Dependent children in Traditional Healthcare Benefits. Your eligible Dependents may also include children for whom health care coverage is required through a Qualified Medical Child Support Order (“QMCSO”) or other court or administrative order.

Note: You may be required to provide proof of dependent status at any time. |

This SPD issued May 2011
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FACILITIES THAT HAVE OPTED-OUT OF RETIREE COVERAGE

The following facilities of the Company have opted-out of retiree coverage (medical, prescription drug, dental and life insurance coverage) under the Program: (i) Cat Logistics Services, Houston, TX – Fac. Code DI (Hourly); (ii) Williams Technologies, Summerville, SC – Fac. Code FF (All Payrolls); (iii) Cat Logistics Services, Norton, MA (Mazda) – Fac. Code WW (Hourly); (iv) Cat Logistics Services, Ontario, CA (Mazda) – Fac. Code YG (Hourly); (v) Cat Logistics Services, Sandston, VA (Mazda) – Fac. Code YV (Hourly); (vi) Cat Logistics Services, Woodland, CA (Mazda) – Fac. Code ZN (Hourly); (vii) Cat Logistics Services, Olive Branch, MS (Mazda) – Fac. Code ZS (Hourly); (viii) Cat Reman Powertrain, IN – Fac. Code YP (Management & Salaried); (ix) Cat Logistics Services, Champaign, IL – Fac. Code 92 (Hourly); (x) Cat Logistics FT Services, Gouldsboro, PA (Mazda) – Fac. Code K9 (Hourly – hired prior to 4/1/04; Hourly employees hired on or after 4/1/04 are not eligible to participate in the Program); (xi) Caterpillar Elkader LLC, Elkader, IA – Fac. Code AE (Hourly); (xii) Caterpillar Remanufacturing Drivetrain LLC, West Fargo, ND – Fac. Code PE (Management & Salaried); (xiii) North America Motor Grader Facility, North Little Rock, AR – Fac. Code UJ (Hourly); (xiv) Cat Logistics Services, North America Motor Grader Facility, Little Rock, AR – Fac. Code ZK (Hourly); (xv) CleanAIR Systems, Inc., Santa Fe, NM – Fac. Code VH (Hourly); (xvi) Cat Logistics Services, Corinth, MS – Fac. Code V7 (Hourly); (xvii) Cat Logistics Services, Mazda-Dallas, TX – Fac. Code V1 (Hourly); (xviii) Cat Logistics Services, Mazda-Bolingbrook, IL – Fac. Code V2 (Hourly); and (xix) Cat Logistics Services, Mazda-McDonough, GA – Fac. Code V3 (Hourly). Notwithstanding, Cat Logistics Services, Tulsa, OK – Fac. Code KN (Salaried) has not opted out of retiree life insurance coverage under the Program.

DUAL COVERAGE

Dual coverage is not permitted under the Program. As described in the Eligibility Requirements chart found at the beginning of the Eligibility section of the SPD on page 3, if you have a Spouse who is an active Employee or a retiree eligible for healthcare coverage offered by Caterpillar or its subsidiaries, you are each eligible for your respective coverage separately. Likewise, if both you and your Spouse are eligible to participate in the Program or other healthcare offered by Caterpillar and its subsidiaries, only one of you may cover your child(ren) as a Dependent under your Caterpillar coverage.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (“QMCSO”)

The Program also provides Traditional Healthcare Benefits for your eligible child pursuant to the terms of a Qualified Medical Child Support Order (“QMCSO”), even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment season restrictions which might otherwise exist for Dependent coverage. A QMCSO can require the Program to provide coverage for benefits to a child who meets the plan eligibility requirements. Additionally, if you have not elected coverage under the Program, you will be required to cover yourself if you are required to cover your eligible child. If the Program receives a valid QMCSO and you do not enroll the child, the state agency may enroll 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, 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 or a judgment from a state court or administrative body directing the Company to cover a child as your Dependent under the Program. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid. The Company or its designee is responsible for determining if an order meets the criteria of a QMCSO. If
you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, contact the Caterpillar Benefits Center at (877) 228-4010.

**DISABLED CHILDREN**

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

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

To determine whether your child qualifies for this coverage, complete the Statement of Dependent Eligibility Beyond Limiting Age Due to Mental or Physical Disability form and submit to United Healthcare. You can obtain this form by contacting United Healthcare at (866) 228-4215 or on www.cathealthbenefits.com.

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

Coverage will continue until the Enrolled Dependent child Reaches Age 65 as long as the Enrolled Dependent is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the Program. However, coverage will not continue following the retiree’s death unless the retiree has a surviving Spouse to provide one-half support to the disabled child.

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 United Healthcare 60 days prior to extended coverage expiration date. You must complete and submit the request for continued coverage. If you do not provide proof of the child’s incapacity and dependency within 31 days of the Claims Administrator’s request as described above, coverage for that child will end.

**REEMPLOYMENT OF RETIREES**

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

If you are a retiree who is rehired by Caterpillar or any of its subsidiaries, you will remain eligible for participation in the Program only if: (1) on the day immediately prior to your re-employment you were participating in the Program; (2) you are re-employed in either a part-time or temporary capacity (as determined by the company in accordance with its uniform and non-discriminatory personnel policies and practices); and (3) during such period of re-employment you are ineligible to participate in the Employee Program. If you are a rehired retiree described in the preceding sentence who remained eligible for participation in the Program during a period of reemployment, you will be ineligible for participation in the Program on the first day of each plan year (January 1) during your period of reemployment. This means, for example, if you become sick and incur medical claims on January 1, such claims will not be eligible for payment under the Program. You will be responsible for 100% of the charges.

This SPD issued May 2011
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When you terminate your employment following a period of reemployment during which you were ineligible for participation in the Program, you will resume participation in the Program. In which case, your most recent termination date (i.e., not your original retirement date) will be used as your retirement date for purposes of administering the Program.

The reemployment of retirees is further explained by the following examples:

Example 1. Mary retired from Caterpillar effective February 1, 2007 and is eligible for benefits under the Program. On June 30, 2011, Mary was enrolled in coverage under the Program. Effective July 1, 2011, Mary became reemployed by Caterpillar in a full-time, temporary position as a file clerk working on a special records retention project. Mary’s temporary position as a file clerk ended on November 30, 2011 when the records retention project was completed. During her period of reemployment as a full-time, temporary file clerk, Mary was ineligible for participation in the Employee Program. Therefore, Mary remained eligible to participate in the Program and her coverage and benefits under the Program were uninterrupted during such reemployment.

Example 2. Paul retired from Caterpillar effective February 1, 2010 and is eligible for benefits under the Program. On June 30, 2011, Paul was enrolled in coverage under the Program. Effective July 1, 2011, Paul became reemployed by Caterpillar in a part-time, regular position as a plant tour guide in East Peoria. Paul’s part-time position as a plant tour guide ended on December 31, 2012 when Paul quit and moved to Arizona. During his period of reemployment as a part-time regular employee, Paul was ineligible for participation in the Employee Program. Therefore, Paul remained eligible to participate in the Program during his reemployment, except that he did not have Traditional Healthcare Benefits coverage under the Program on January 1, 2012 (and any medical claims incurred on such date were denied).

Example 3. Peter retired from Caterpillar effective April 1, 2005 and is eligible for benefits under the Program. Effective January 1, 2011, Peter became reemployed by Caterpillar in a full-time, regular position as an accountant. As a full-time, regular accountant, Peter is eligible for participation in the Employee Program. Accordingly, Peter’s participation in the Program ended effective January 1, 2011 when he became eligible for the Employee Program. Effective July 1, 2015, Peter resumes retirement (i.e., he terminates from his accountant position with Caterpillar). Peter’s eligibility for and his benefits under the Program (including the amount allocated to his HRA Account) will be determined based on a July 1, 2015 retirement date, not his original retirement date of April 1, 2005.

**Participation In The Program**

**HOW TO ENROLL**

**Life Benefits**

No action is necessary on your part to enroll in retiree life coverage under the Program. The basic life coverage you had as an active employee continues in retirement as described in the Life Insurance Benefits section beginning on page 71.

If you retire after January 1, 2003, on your retirement date, you have the option of purchasing group life insurance that will extend your retiree life insurance coverage beyond the date that it expires as described in the Life Insurance Benefits section beginning on page 71. To extend your basic life insurance coverage, you must contact the MetLife National Benefit Center for Caterpillar at the telephone number listed in the section entitled *Contact Information* beginning on page 96 within 31 days of the date of your retirement or, if later, within 31 days of notice from the MetLife National Benefit Center for Caterpillar.
HEALTHCARE BENEFITS

Traditional Healthcare Benefits (Retirees Age 64 And Younger)

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

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

Annual Enrollment

Each year, you may elect Traditional Healthcare Benefits for the following calendar year (January 1 - December 31). Typically this annual enrollment period occurs in the fall of each year. The elections you make during 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, describe the enrollment procedure, how to access the options available to you and applicable costs and any significant changes to the available coverage since the last enrollment. Be sure to read the information carefully. This information may be provided in hard copy form, via the internet or otherwise, as determined by the Plan Administrator.

Note: If you do not enroll during the annual enrollment period but you were enrolled during the prior plan year, your medical, dental, vision, and prescription drug coverage will remain in effect for the following plan year unless the plan administrator informs you otherwise, in which case you will be required to make an active enrollment. If you do not actually enroll during 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 you will be required to pay for such coverage. If you have not elected coverage for yourself, and you are ordered to cover your Dependent child, you will also automatically be enrolled in the Program. See the section entitled Qualified Medical Child Support Order (“QMCSO”) beginning on page 5 for additional information.

Your Eligible Dependents

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

<table>
<thead>
<tr>
<th>If you…</th>
<th>Your Dependent's Coverage is Effective*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are a retiree who enrolled your Dependents within the 31-day period</td>
<td>On the date your coverage is effective</td>
</tr>
<tr>
<td>immediately following the first day you were eligible for coverage,</td>
<td></td>
</tr>
<tr>
<td>Applied for Dependent coverage during an annual enrollment period,</td>
<td>On his or her enrollment effective date.</td>
</tr>
<tr>
<td>Have a newborn child and applied for Dependent’s coverage within 31</td>
<td>On the child’s date of birth.</td>
</tr>
<tr>
<td>days of the newborn child’s date of birth,</td>
<td></td>
</tr>
<tr>
<td>Adopted a child or have a child placed with you for adoption and</td>
<td>On the custody** date.</td>
</tr>
<tr>
<td>applied for Dependent’s coverage within 31 days of the custody** date,</td>
<td></td>
</tr>
<tr>
<td>Acquire a Dependent due to a court order, decree or marriage and</td>
<td>On the date of such court order, decree</td>
</tr>
<tr>
<td>applied for Dependent’s coverage within 31 days of such court order,</td>
<td>or marriage</td>
</tr>
<tr>
<td>decree or marriage,</td>
<td></td>
</tr>
</tbody>
</table>

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

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

Changing Your Coverage

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

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

- You experience a “change in status” - as later described in this section - that affects your or your Dependents’ eligibility for benefits;
- You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as described in the Special Enrollments During the Year section beginning on page 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 their employer and the other employer’s plan either (a) allows your Spouse (or Dependent) to make an election change under that plan; or (b) the plan offered by your Spouse’s employer operates on a different 12-month period and does not conduct its annual enrollment at the same time as the Program;
- You, your Spouse or your Dependent child experience a significant reduction in coverage or a total loss of coverage; and
- The Program 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.

**Changes in Status**

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

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

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

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

**Special Enrollments During the Year**

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

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

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

**HRA Benefits (Retirees Age 65 And Older)**

If you were covered as an employee under the Employee Program on the day preceding your retirement and at the time of your retirement you are age 65 or older, you are not eligible for Traditional Healthcare Benefits under the Program, but instead are eligible for HRA Benefits under the Program. Similarly, if you retired prior to age 65 and
you are covered under the Program when you Reach Age 65, you are no longer eligible for Traditional Healthcare Coverage under the Program. Instead, you are eligible for the HRA Benefits of the Program.

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

Cost Of Coverage

LIFE BENEFITS

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

TRADITIONAL HEALTHCARE BENEFITS

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

Several factors are taken into consideration in determining the premium applicable to you and your Dependents, including whether you participate in a wellness program offered by the Company and your coverage choice (e.g., retiree only, retiree and Spouse, retiree and children, or retiree, Spouse and children).

If a retiree and his or her Spouse do not participate in a wellness program offered by the Company, any monthly premium contribution shall be increased by $75 (to be paid on an after-tax basis) for each one of them who is covered by the Program, but not participating in such a wellness program. Participation in a wellness program means completing two health assessments under such program per year. This may also be referred to as a “premium reduction” for those who do participate in a wellness program.

HRA BENEFITS

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

How Long Coverage Continues

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

LIFE BENEFITS

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

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

**TRADITIONAL HEALTHCARE BENEFITS**

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

Your healthcare benefits will change when you Reach Age 65. Your Traditional Healthcare Benefits under the Program will be replaced with the HRA Benefits that are described in the Health Reimbursement Arrangement (HRA) Benefits section beginning on page 66. Healthcare benefits for your Spouse will also change when your Spouse Reaches Age 65. The Traditional Healthcare Benefits under the Program ceases for your non-spouse Dependent upon the earlier of (1) the date your Dependent is no longer an eligible Dependent, or (2) the date your Dependent Reaches Age 65. Your Spouse’s Traditional Healthcare Benefits also will be replaced with HRA Benefits.

**Hospital Confinement**

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

Coverage under the Program may be continued following certain events if you properly elect and pay for continuation coverage provided pursuant to COBRA. Refer to the subsection entitled Continuation of Benefits (COBRA) beginning on page 12 for more information on continuation coverage under COBRA.

**CONTINUATION OF BENEFITS (COBRA)**

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

This SPD issued May 2011
YEBB3303a 12
When You and Your Dependents Elect COBRA

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

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

<table>
<thead>
<tr>
<th>If:</th>
<th>Qualifying Event</th>
<th>Who Is Eligible for COBRA Coverage</th>
<th>Duration of COBRA Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>Die</td>
<td>Your covered Dependents</td>
<td>36 months</td>
</tr>
<tr>
<td></td>
<td>Become divorced or legally separated</td>
<td>Your covered Dependents</td>
<td>36 months</td>
</tr>
<tr>
<td></td>
<td>Become entitled to Medicare while on COBRA</td>
<td>Your covered Dependents</td>
<td>Up to 36 months*</td>
</tr>
<tr>
<td>Your covered Dependent</td>
<td>Is no longer an eligible Dependent (due to age limit, divorce or legal separation)</td>
<td>Your covered Dependent</td>
<td>36 months</td>
</tr>
<tr>
<td></td>
<td>Is no longer an eligible Dependent because of your death</td>
<td>Your covered Dependent</td>
<td>36 months</td>
</tr>
<tr>
<td></td>
<td>Becomes disabled within the first 60 days of COBRA continuation coverage</td>
<td>You and your covered Dependent</td>
<td>Up to 29 months*</td>
</tr>
</tbody>
</table>

*Includes months of COBRA coverage already used.

Important Notes

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

**COBRA Coverage for Disabilities**

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

To be eligible for this extension, the individual must:

• Receive a determination of disability from the Social Security Administration (“SSA”) that the individual was disabled on the date coverage ended, or become disabled during the first 60 days of COBRA coverage, and

• Notify the Plan Administrator within 60 days after the later of:
  • the date of the SSA’s determination of disability; or
  • the date of the qualifying event.

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

**COBRA Coverage for HRA Coverage**

If the Company maintains an HRA Account for your Spouse and you and your Spouse divorce, such former Spouse is eligible for COBRA continuation coverage upon divorce. If your former Spouse elects COBRA continuation coverage, such coverage will continue for a maximum period of 36 months. COBRA continuation coverage takes effect on the date of the divorce and continues until the earliest of the following:

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

**Reporting a Qualifying Event**

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

• You divorce or become legally separated;
• Your child no longer meets the definition of a Dependent (e.g., due to age limit); or
• You (or your covered Dependent) are determined to have been disabled under the Social Security Act when coverage ended or at anytime during the first 60 days of receiving COBRA continuation coverage.
When you or your affected covered Dependent contact the Plan Administrator, be sure to inform the Plan Administrator of the specific event, the date of the event, and who is affected.

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

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

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

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

**Deciding Whether 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. In order to continue coverage under the HRA Coverage, your former Spouse must pay the full cost of the HRA coverage each month, plus a 2% administrative fee. The cost of the HRA coverage is the amount allocated to the former Spouse’s HRA Account each year, multiplied by 102%, and then divided by 12.

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

**When COBRA Coverage Ends**

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

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

Election Period

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

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

Required Payments

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

Trade Adjustment Assistance Rights

You may be eligible for additional COBRA benefits if you are eligible for trade adjustment assistance (“TAA”) under the provisions of the Trade Act of 2002. The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. This special second COBRA election period is available only to individuals who are receiving TAA benefits or “alternative trade adjustment assistance” under a federal law called the Trade Act of 1974. Such Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their coverage ended.

If you qualify for or may qualify for assistance under the Trade Act of 1974, you should contact the Plan Administrator or COBRA Administrator for additional information. You must contact the COBRA Administrator promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost, but begins on the first day of the special second election period.

Survivors Coverage

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

Survivor’s coverage is charged at the retiree rate and continues for the life of the surviving Spouse, subject to the Plan Administrator’s sole discretionary right to change or discontinue the Program at any time. Please note that the medical benefits coverage under the Program for a surviving Spouse who has not Reached Age 65 at the time of your death, will change from Traditional Healthcare Coverage to HRA Benefits when he or she Reaches Age 65.
Survivors’ coverage will end if the survivors stop making any required contributions for coverage. 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 Plan Administrator’s sole discretionary right to change or discontinue the Program at any time. Any such change or termination may affect the benefits available to your survivors.

Other Events Ending Your Coverage

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

<table>
<thead>
<tr>
<th>Ending Event</th>
<th>What Happens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud, Misrepresentation or False Information</td>
<td>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.</td>
</tr>
<tr>
<td>Improper Use of ID Card</td>
<td>You permitted an unauthorized person to use your ID card, or you used another person’s card.</td>
</tr>
<tr>
<td>Failure to Pay</td>
<td>You failed to pay a required contribution.</td>
</tr>
<tr>
<td>Threatening Behavior</td>
<td>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.</td>
</tr>
<tr>
<td>Any Other Material Violation</td>
<td>There was any other material violation of the terms of the Program.</td>
</tr>
</tbody>
</table>

This SPD issued May 2011
YEBB3303a
TRADITIONAL MEDICAL COVERAGE

An Introduction To Your Traditional Medical Coverage

This Traditional Medical Coverage Section summarizes the medical and vision coverage provided under the Traditional Healthcare Benefits of the Program. You are encouraged to review the benefit limitations of this Traditional Medical Coverage section by reading the What’s Covered – Benefits beginning on page 18 and What’s Not Covered – Exclusions section beginning on page 34 that pertain to you.

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

In certain areas or under certain circumstances, you may be able to elect coverage under a HMO or under the United Healthcare Choice Plan. In which case, the HMO or the United Healthcare Choice Plan will send you, under separate cover, information about the medical, prescription drug, and vision (if applicable) benefits provided by the HMO or the United Healthcare Choice Plan. If you have questions concerning such medical, prescription drug, or vision (if applicable) benefits refer to the phone number on the back of your identification card issued by your HMO or the United Healthcare Choice Plan. Please note that it is the responsibility of the HMO or the United Healthcare Choice Plan to provide you with the necessary information about your specific medical, prescription drug, and vision (if applicable) benefits. If you do not receive that information from the HMO or the United Healthcare Choice Plan, contact the Plan Administrator. Please note that if you are enrolled in the HMO administered by Health Alliance Medical Plans in the Peoria and Decatur areas, the prescription drug section of this SPD describes your prescription drug benefits and applies to you.

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

Eligibility For Traditional Medical Coverage

You are eligible for Traditional Medical Coverage under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled Eligibility beginning on page 3 and any additional requirements described in this section. You and your Spouse each become ineligible for Traditional Medical Coverage when you each Reach Age 65.

What’s Covered – Traditional Medical Coverage

ACCESSING BENEFITS

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 Reasonable and Customary standard will apply. In some cases a Provider or facility will be subject to further restriction and expenses incurred may not be eligible for reimbursement under the Program. Refer to the paragraph below entitled Non-Covered Providers beginning on page 38. If you use a Caterpillar Network Physician or facility, you will be reimbursed at the highest level of benefits. You are responsible for ensuring that your Provider is a Caterpillar Network Provider. A list of current Network Providers can be found at www.cathealthbenefits.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 United Healthcare Network Provider and reimburse such Covered Person at the highest level of benefits.

United Healthcare Network Plan

If you are enrolled in a United Healthcare 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 Reasonable and Customary standard will apply. If you use a Network Physician, Network Hospital and Network Skilled Nursing Facility, you will be reimbursed at the highest level of benefits. You are responsible for ensuring that your Provider is a Network Provider. A list of current Network Providers can be found at www.myuhc.com or you can call the Claims Administrator at the telephone number shown on your ID card or in the section entitled Contact Information beginning on page 96. The Claims Administrator, in its sole discretion, may allow a Covered Person to use a Caterpillar Network Provider and reimburse such Covered Person at the highest level of benefits.

Non-Network Providers

If you are enrolled in a Caterpillar Network plan or a United Healthcare Network plan, Eligible Expenses for Covered Health Services performed by non-Network Providers may be covered at the Network level up to Reasonable 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.

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 Reasonable and Customary standard will apply. A list of Network Providers can be found at www.myuhc.com or www.cathealthbenefits.com or you can call the Claims Administrator at the telephone number shown on your ID card or in the section entitled Contact Information beginning on page 96.

Identification Card (“ID Card”)

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

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

The Plan Sponsor has delegated to the Claims Administrator the 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 Program. Amounts that exceed the Reasonable and Customary charge or the negotiated Network fees are not covered under the Program. In addition, the Program 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 Program 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 Program will pay for Eligible Expenses, and any amounts in excess of any Program maximum.

NOTIFICATION REQUIREMENTS

Prior notification is suggested before you receive certain Covered Health Services. You are responsible for notifying Care CoordinationSM before you receive these Covered Health Services.

Services for which you should provide prior notification appear in this section under the section entitled Notify Care CoordinationSM row in the Benefits Information Grid beginning on page 21.

To notify Care CoordinationSM, call the telephone number shown on your ID card or in the section entitled 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 Care CoordinationSM row because, in some instances, certain procedures may not meet the definition of a Covered Health Service and are therefore excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

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

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

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

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

<table>
<thead>
<tr>
<th>Network Service Area</th>
<th>Medical Benefit Option</th>
<th>Annual Deductible</th>
<th>Maximum Out-of-Pocket</th>
<th>Program Level Co-insurance - Hospital/Specialed Nursing Facility (Reimbursement Percentage/Co-insurance Amount)</th>
<th>Program Level Co-insurance - Physician (Reimbursement Percentage/Co-insurance Amount)</th>
<th>Preventive (No Deductible Applies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reide in a Caterpillar Network Area</td>
<td>Option A</td>
<td>$250</td>
<td>$500</td>
<td>Individual</td>
<td>Individual</td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>Option B</td>
<td>$450</td>
<td>$900</td>
<td>Individual</td>
<td>Individual</td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>Option C</td>
<td>$800</td>
<td>$1,600</td>
<td>Individual</td>
<td>Individual</td>
<td>Network</td>
</tr>
<tr>
<td>Reide in a Unified Healthcare Network Area</td>
<td>Option A</td>
<td>$250</td>
<td>$500</td>
<td>Individual</td>
<td>Individual</td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>Option B</td>
<td>$450</td>
<td>$900</td>
<td>Individual</td>
<td>Individual</td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>Option C</td>
<td>$800</td>
<td>$1,600</td>
<td>Individual</td>
<td>Individual</td>
<td>Network</td>
</tr>
<tr>
<td>Reide Out-of-area</td>
<td>Option A</td>
<td>$250</td>
<td>$500</td>
<td>Individual</td>
<td>Individual</td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>Option B</td>
<td>$450</td>
<td>$900</td>
<td>Individual</td>
<td>Individual</td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>Option C</td>
<td>$800</td>
<td>$1,600</td>
<td>Individual</td>
<td>Individual</td>
<td>Network</td>
</tr>
</tbody>
</table>

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

BENEFIT INFORMATION

Important Points to Remember

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

- The Benefits Information grid beginning on page 21
- The What’s Not Covered – Exclusions section beginning on page 34

Benefits Information Grid

<table>
<thead>
<tr>
<th>Description of Covered Health Services</th>
<th>Notify Care CoordinationSM?</th>
<th>Your Co-insurance or Co-payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acupuncture Services</td>
<td>No</td>
<td>20% after deductible</td>
</tr>
</tbody>
</table>

This SPD issued May 2011
YEBB3303a 21
### Description of Covered Health Services

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<tbody>
<tr>
<td>Acupuncture services for pain therapy when both of the following are true: • Another method of pain management has failed. • The service is performed by a Provider in the Provider’s office. Where such benefits are available, acupuncture is a Covered Health Service for the treatment of: • Nausea of Chemotherapy, or • Post-operative nausea, or • Nausea of early Pregnancy.</td>
<td>No</td>
<td>20% after deductible</td>
</tr>
</tbody>
</table>

2. **Allergy Services**

**Testing**
Covered Health Services include testing for allergy care in a Physician’s office.

**Drug Treatment for Allergy Care**
Covered Health Services include drug treatment for allergy care in a Physician’s office.
Coverage for an office visit associated with the allergy treatment described herein shall be determined in accordance with the provisions below regarding Physician’s Services.

3. **Ambulance Services**

**Ground Ambulance:**
Covered Health Services include transportation from place where injured or stricken by illness to the nearest Hospital or from a Hospital where medically required services are not available to the nearest Hospital where such services are available (such as a burn center or trauma center).

**Air Ambulance:**
Air ambulance transport is covered in the following circumstances:
• Patient requires transport from one Hospital to another because the first Hospital does not have the required services and/or facilities to treat the patient; and
• Such method of transportation is deemed medically required by the attending Physician (e.g., because of the individual’s medical condition, land transportation cannot be used); and
• Such method of transportation is in fact an ambulance service and not a charter flight service.

*Note: You are not required to notify Care CoordinationSM. However, for air ambulance, you should call to verify coverage is available.*

4. **Chiropractic Services/Spinal Manipulations**
Covered Health Services include chiropractic therapy and/or adjustments for Sickness or Injury. X-rays and labs performed in the chiropractor’s office are addressed in the Professional Fees for Surgical and Medical Services section of this Benefits Information.

| | No | 20% after deductible |
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<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Grid.</td>
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</tr>
<tr>
<td>Massage therapy is <strong>not</strong> a Covered Health Service.</td>
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</tr>
<tr>
<td>Benefits for spinal treatment are limited to a maximum of $700 per Covered Person per calendar year. You are responsible for any amount exceeding this $700 calendar year maximum.</td>
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</tr>
</tbody>
</table>

**5. Durable Medical Equipment**

Durable Medical Equipment must meet all of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Can withstand repeated use.
- 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, disease, disability or their symptoms.
- Is appropriate for use in the home

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).
- Diabetic supplies (require a Physician’s written prescription):
  - Lancets
  - Test Strips
  - Glucometers

The Program provides benefits for a single unit of Durable Medical Equipment (e.g., one insulin pump) and provides repair for 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...
<table>
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<tbody>
<tr>
<td>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.</td>
<td>No*</td>
<td>$100 Co-pay per visit; 20% after deductible</td>
</tr>
<tr>
<td>*Note: It is strongly recommended that you contact Care Coordination℠ if you have any questions on whether an item will be covered. You are required to contact Care Coordination℠ for items over $1,000.</td>
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</tr>
</tbody>
</table>

6. Emergency Room Health Services

Emergency Room Health Services are services required to stabilize or initiate treatment in an Emergency. Emergency Room Health Services must be received on an outpatient basis at a Hospital or Alternate Facility and billed by the Hospital or Alternate Facility.

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

An Emergency room Co-payment of $100 per visit applies. This Co-payment is in addition to amounts you owe for your Annual Deductible and Co-insurance. The Emergency room Co-payment is waived if you are admitted to the Hospital from the emergency room. Observation is not considered an admission.

Benefits are payable for the Outpatient Observation of a patient. For this purpose, “Outpatient Observation” means a brief hospital stay which (1) is not for the convenience of the patient, the patient’s family, or a Physician, or in connection with the patient’s admission, (2) lasts between 24 and 48 hours, and (3) consists solely of short term treatment, assessment and reassessment before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient or is instead able to be discharged from the hospital.

*Note: Please remember that if you are admitted to a Hospital as a result of an Emergency, you should notify Care Coordination℠ within two business days or the same day of admission, or as soon as reasonably possible.

7. Hearing Care

Audiologist

Coverage limited to charges by a licensed or certified audiologist for Physician-prescribed hearing evaluations to determine location of a disease within the auditory system. The Program covers tests and treatment due to illness and Injury only. An audiometric exam is covered in conjunction with medical illness.

Hearing Aid

Coverage limited to one hearing aid per ear every thirty-six (36) months. The Program will not cover duplicates or replacements for lost or stolen hearing aids.

Hearing Evaluation

Coverage limited to one hearing evaluation every thirty-six (36) months for one or both ears.

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 Stay. Care Coordination℠ will decide if skilled home health care is required by reviewing both the skilled nature of the service and the...
**Description of Covered Health Services**

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>need for Physician-directed medical management. A service will not be determined to be “skilled” simply because there is not an available caregiver.</td>
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<tr>
<td>Services must be both of the following:</td>
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<tr>
<td>• Ordered by a Physician.</td>
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<tr>
<td>• Provided by an agency that is licensed by the state as a Home Health Agency and is Medicare certified.</td>
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<tr>
<td>If a patient qualifies for coverage under the home health benefit, the following services may be covered:</td>
<td></td>
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</tr>
<tr>
<td>1. Registered Nurse</td>
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<tr>
<td>2. Licensed Practical Nurse</td>
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<tr>
<td>3. Home Health Aide or Certified Nursing Assistant</td>
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<tr>
<td>4. Physical Therapist/Occupational Therapist/Speech Therapist</td>
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<tr>
<td>5. Medical Social Worker</td>
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<td></td>
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<tr>
<td>6. Intravenous medications and TPN</td>
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<tr>
<td>7. Intravenous supplies</td>
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<tr>
<td>8. Wound care supplies</td>
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<tr>
<td>9. Enteral feeding formula and supplies when the enteral feeds are needed due to an inborn error in metabolism</td>
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<tr>
<td>10. Dietician</td>
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<tr>
<td>11. Line maintenance supplies</td>
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<tr>
<td>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.</td>
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<tr>
<td>The home health benefit is limited to 100 visits per Covered Person per calendar year where any visit up to 4 hours is considered 1 visit. The patient must be homebound.</td>
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<tr>
<td>*Note: Please remember to notify Care CoordinationSM five business days before receiving services.</td>
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</tbody>
</table>

**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.

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

<p>| Yes* | 20% after deductible |</p>
<table>
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| 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. The benefits of this section are subject to a 30-day lifetime limitation. Note:  
- Durable Medical Equipment is covered under the regular Durable Medical Equipment benefit.  
- For prescription drugs (other than IV), see the Prescription Drug Benefits section beginning on page 53 of this SPD.  
- There is no coverage for bereavement counseling or chaplain services.  
*Note: Please remember to notify Care CoordinationSM five business days before receiving services. | | |
| 10. Hospital – Inpatient Stay  
Benefits are available for:  
- Services and supplies received during the Inpatient Stay.  
- Room and board in a Semi-private Room (a room with two or more beds). Reimbursement for a private room will be made up to the amount of the Semi-private Room rate unless confined to a private isolation room, which is allowable for certain medical conditions (e.g., infectious hepatitis, spinal meningitis, severe burns).  
*Note: Please remember that if you are admitted to a Hospital, you should notify Care CoordinationSM within two business days or the same day of admission, or as soon as reasonably possible. | Yes* | 20% after deductible |
| 11. Infertility Services  
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. | No | 20% after deductible |
| 12. 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. When referred by your primary obstetrician/gynecologist to a specialist for Pregnancy complications, the office visit will be paid at the global maternity benefit level.  
The Program will pay benefits for an Inpatient Stay of at least:  
- 48 hours for the mother and newborn child following a normal vaginal delivery. | No* | 20% after deductible |
## Description of Covered Health Services

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<th>Description</th>
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<tbody>
<tr>
<td>• 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/or the newborn child earlier than these minimum time frames. <em>Note:</em> Please remember that if you are admitted to a Hospital, you should notify Care Coordination&lt;sup&gt;SM&lt;/sup&gt; within two business days or the same day of admission, or as soon as reasonably possible.</td>
<td>No</td>
<td>20% after deductible</td>
</tr>
</tbody>
</table>

### 13. 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).
- Crisis intervention.
- Psychological testing administered by a psychologist or psychiatrist upon order of a physician specializing in the treatment of nervous or medical disorders and related to treatment.

### 14. 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.

### 15. Obesity Surgery

Benefits under this section include surgical treatment of morbid obesity received on an Inpatient basis. Currently the Program follows guidelines as defined by the National Institute of Health. Currently the following criteria must be met in order to be eligible for

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This SPD issued May 2011
YEBB3303a 27
coverage for obesity surgery:
  • Covered Person must have a minimum body mass index ("BMI") of 40.
  • Covered Person must have documentation of a diagnosis of morbid obesity for a minimum of five (5) years from a Physician.

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:
    o For the original procedure, patient met all the screening criteria, including BMI requirements;
    o The patient has been compliant with a prescribed nutrition and exercise program following the original surgery; and
    o 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 reinstition of an acceptable bariatric surgical modality.

A Roux-en-Y procedure following vertical banded gastroplasty or laparoscopic adjustable banded gastroplasty is not eligible for coverage for patients who have been substantially noncompliant with a prescribed nutrition and exercise program following the original procedure.

If you are enrolled in a Caterpillar Network Plan or a United Healthcare Network Plan, you are required to use a Network Hospital. This limitation applies even if your Network Provider refers you to a non-Network Provider or Hospital. No benefits will be paid if you use a non-Network Provider or Hospital unless you reside outside of a Network area and are enrolled in an Out-of-Area Plan.

16. Oral Surgery
Covered Health Services include dental treatment for dislocations, fracture care and certain incisions and excisions, or any other oral surgery deemed to be of a medical nature and medically appropriate; prosthetic devices prescribed for medical reasons; anesthetics administered in connection with covered oral surgery. Refer to the Dental Benefits section beginning on page 57 of this SPD for additional oral surgery coverage.

If more than one procedure can meet your functional needs, benefits are available only for the most cost-effective procedure. The Plan Administrator will determine whether any specific oral-related charges are covered (if at all) under oral surgery or as Dental Benefits.

*Note: You are not required to notify Care CoordinationSM; however, it is strongly recommended that you contact Care CoordinationSM to verify that the services you require are covered under this benefit.

17. 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

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<td>o 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 reinstition of an acceptable bariatric surgical modality.</td>
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<td></td>
</tr>
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<td>16. Oral Surgery</td>
<td>No*</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Covered Health Services include dental treatment for dislocations, fracture care and certain incisions and excisions, or any other oral surgery deemed to be of a medical nature and medically appropriate; prosthetic devices prescribed for medical reasons; anesthetics administered in connection with covered oral surgery. Refer to the Dental Benefits section beginning on page 57 of this SPD for additional oral surgery coverage.</td>
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<tr>
<td>If more than one procedure can meet your functional needs, benefits are available only for the most cost-effective procedure. The Plan Administrator will determine whether any specific oral-related charges are covered (if at all) under oral surgery or as Dental Benefits.</td>
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</tr>
<tr>
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<td>20% after deductible</td>
</tr>
<tr>
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surgery, diagnostic and therapeutic services are described in Item 20 (Professional Fees for Surgical and Medical Services).

Covered Health Services received on an Outpatient basis at a Hospital or Alternate Facility, including:
- Surgery and related services
- Lab and radiology/X-ray services
- Other diagnostic tests and therapeutic treatments (including intravenous cancer chemotherapy or other intravenous infusion therapy).

18. Physician's Services

Benefits for Physician’s services include:
- Evaluation and management services provided in the Physician’s office, Hospital or other ambulatory facility.
- Covered Health Services as a result of Sickness or Injury.
- Hormonal contraceptives requiring injection or implantation (including, but not limited to, Norplant and Depo-Provera) by a Physician
- 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.
- Injection services at a Physician’s office and covered drugs injected at a Physician’s office.

Not Covered:
- Routine/preventive health checkups (except as described below).
- Routine immunizations, including well child immunizations.
- Immunizations associated with Employer-required travel.

19. Preventive Care Services

The Program covers only the following preventive care services:

Mammography Testing – Screening mammography is limited to the following schedule:
- One between ages 35 – 39
- One every calendar year from age 40 and over

Diagnostic services are covered at the appropriate Co-insurance level without age limits.

Well Adult Preventive Care:

Colonoscopy Screening – Screening is limited to the following schedule:
- One annual Stool occult blood screening between ages 50 – 54
- One colonoscopy screening at age 55 and over.

Expenses incurred as a result of the screening colonoscopy and related to a diagnosed
### Description of Covered Health Services

<table>
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</thead>
</table>

- Condition are subject to deductible and Co-insurance.

**Lipid screening and blood sugar screening** are covered as follows:
- For males age 35 and over, one test every five (5) years
- For females age 45 and over, one test every five (5) years

#### Well Child Preventive Care:
Covered Health Services are paid for routine pediatric office visits for Dependent children up to and including age six (6). The lifetime maximum is $800 per child. You are responsible for any amount exceeding the $800 lifetime maximum per child. Routine immunizations are not covered.

**Well Woman Preventive Care:**
Covered Health Services are paid for one annual routine gynecological exam which includes a physician pelvic and breast exam and a PAP smear.

#### 20. Professional Fees for Surgical and Medical Services
Professional fees for services, surgical procedures and other Medical Care received at a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, or Alternate Facility, or in a Physician’s office include, but are not limited to:

- Pathology.
- X-ray/diagnostic interpretation.
- Anesthesiology.
- Radiation therapy.

- No 20% after deductible

#### 21. 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.

It is recommended that you contact Care Coordination<sup>SM</sup> if you have any questions on whether an item will be covered.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of, a Physician. The Program provides benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of unusable prosthetic device.

Duplicates and replacement of stolen prosthetic devices are **not** covered.
<table>
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</table>

### 22. Reconstructive Procedures

**Reconstructive Procedures** -- Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. Improving or restoring physiologic function means that the target organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

**Cosmetic Procedures** -- Services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent “bump” would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function such as breathing. The Program does not provide benefits for Cosmetic Procedures.

Some services are considered cosmetic in some circumstances and reconstructive in others. This means there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations the purpose would be to improve appearance, and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision while on other occasions improvement in appearance is the primary purpose of the procedure.

Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women’s Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. For more information about benefits for mastectomy-related services, contact the Claims Administrator at the telephone number on your ID card or in the section entitled Contact Information beginning on page 96.

Cosmetic Procedures are always excluded from coverage.

*Note: You should notify Care Coordination℠ before receiving services. When you provide notification, Care Coordination℠ can verify that the services are a reconstructive procedure rather than a Cosmetic Procedure.

### 23. Rehabilitation Services – Outpatient Therapy

Rehabilitation services must be performed by a licensed therapy Provider, under the direction of a Physician.

Outpatient rehabilitation services for:
- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy.
- Pulmonary rehabilitation therapy.

Outpatient rehabilitation services for physical therapy, occupational therapy, cardiac rehabilitation therapy, and pulmonary rehabilitation therapy are limited to **60 visits** per type of therapy per Covered Person per calendar year. You are responsible for any amount exceeding this 60 visit per calendar year maximum.
<table>
<thead>
<tr>
<th>Description of Covered Health Services</th>
<th>Notify Care Coordination℠?</th>
<th>Your Co-insurance or Co-payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>24. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Health Services include services for an Inpatient Stay in a Skilled Nursing Facility or non-acute Inpatient Rehabilitation Facility. Benefits are available for:</td>
<td>Yes*</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>• Services and supplies received during the Inpatient Stay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Room and board in a Semi-private Room (a room with two or more beds).</td>
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<td></td>
</tr>
<tr>
<td>Services must be received from a Provider who is both Medicare certified and licensed by the state. In general, the intent of skilled nursing is to provide benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of Skilled Nursing, rehabilitation and Facility services which are less than those of a general acute Hospital but greater than those available in the home setting. The Covered Person is expected to improve to a predictable level of recovery. Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, benefits are NOT available when these services are required intermittently (such as physical therapy three times a week). Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence. *Note: Please remember to notify Care Coordination℠ five business days prior to your admission.</td>
<td>20% after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>25. Speech Therapy</strong></td>
<td>No</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Covered Health Services for speech therapy services will be payable 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 sixty (60) visits per Covered Person, per calendar year.</td>
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</tr>
<tr>
<td><strong>26. Temporomandibular Joint Dysfunction (TMJ)</strong></td>
<td>No</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>27. Transplantation Services</strong></td>
<td>Yes*</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a Designated United Resource Network (URN) Facility or a Caterpillar designated facility to receive full benefits. URN Facilities may change from time to time. For information on current URN facilities, 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</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
facilities qualify as URN Facilities 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 Care CoordinationSM to be a proven procedure for the involved diagnoses. Under the Program, there are specific guidelines regarding benefits for transplant services. For information about these guidelines, contact Care CoordinationSM at the telephone number on your ID card or in the section entitled Contact Information beginning on page 96.

Covered organ transplants means transplantation of only procedures pre-approved by the Claims Administrator in its sole discretion and shall not include any transplantation of any non-human organs, or artificial devices.

If the transplant is a Covered Health Service and it is:

- Received at a Designated United Resource Network Facility or a Caterpillar designated facility, benefits will be payable at the appropriate Network level (after you meet your deductible).
- Received at a non-Designated United Resource Network Facility, benefits will be payable at 50% of Eligible Expenses (after you meet your deductible).

*Note: Care CoordinationSM notification is required for all transplant services. You must notify Care CoordinationSM 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 Care CoordinationSM as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).
### Description of Covered Health Services

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#### 28. Urgent Care Center Services
Covered Health Services received at an Urgent Care Center as a result of Sickness or Injury are allowed. When services to treat urgent health care needs are provided in a Physician's office, benefits are available as described under Item 19 (Physician’s Services) earlier in this section.

#### 29. Vision Services
The Program will pay benefits for Covered Health Services up to $150 every other calendar year for any combination of lenses, frames and eye exams.

**Plan Year Timeframe**

- **Amount available**
  - 1/1/2010-12/31/2011: $150
  - 1/1/2012-12/31/2013: $150

If you do not use the amount available by the end of the Program Year Timeframe, it will not carry over into the next Program Year Timeframe.

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1 See the Description of Network and Non-Network Benefits section beginning on page 44 to understand which Providers are considered Network Providers in the Caterpillar Network and which are considered Network Providers in the United Healthcare Network.

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### What's Not Covered – Exclusions

**THE USE OF SECTION HEADINGS**

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

**PLAN EXCLUSIONS**

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

- It is recommended or prescribed by a Physician; or
- It is the only available treatment for your condition.
The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in the What’s Covered – Benefits section beginning on page 18 or through an amendment to this SPD.

**Alternative Treatments**

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

**Comfort or Convenience**

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

**Dental**

Refer to the Dental Benefits section beginning on page 57 of this SPD because benefits may be payable under that section.

- Dental care;
- Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
  - Periodontal treatment and endodontic services;
  - Extraction (including wisdom teeth), restoration and replacement of teeth; and
  - Services to improve dental clinical outcomes;
- Dental braces;
• Dental implants or any treatment to improve the ability to chew or speak;

Dental x-rays, supplies and appliances, including hospitalization and anesthesia, except for

• Charges for hospitalization and anesthesia where dental services are administered in a Hospital due to an underlying Injury, illness, mental condition or age that precludes such dental services from being delivered adequately and safely in an office setting;
• Transplant preparation,
• Initiation of immunosuppressive, direct treatment of an acute traumatic Injury, cancer or cleft palate; and
• Oral surgery (see Item 16, Oral Surgery, of the Benefits Information Grid beginning on page 21 for coverage information)
• Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly.

**Drugs**

Refer to the Prescription Drug Benefits section beginning on page 53 of this SPD because benefits may be payable under that section.

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

**Experimental or Investigational Services or Unproven Services**

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

**Foot Care**

• Except when needed for severe systemic disease:
  • Routine foot care (including the cutting or removal of corns and calluses); and
  • Nail trimming, cutting, or debriding;
• Hygienic and preventive maintenance foot care. Examples include the following:
  • Cleaning and soaking the feet;
  • Applying skin creams in order to maintain skin tone; and
  • Other services that are performed when there is not a localized illness, Injury or symptom involving the foot;
• Treatment of flat feet;
• Treatment of subluxation of the foot;
• Shoe orthotics; 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 21.

Medical Supplies and Appliances

• Devices used specifically as safety items or to affect performance in sports-related activities;
• Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  • Elastic stockings;
  • Ace bandages;
  • Gauze and dressings; and
  • Syringes;
• Orthotic appliances that straighten or reshape a body part for cosmetic reasons (including some types of braces); and
• Tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment as described under Item 5 (Durable Medical Equipment) of the Benefits Information Grid beginning on page 21.

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;
• Services for Mental Health and Substance Abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention;
• Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis;
• 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;
• Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alfa-Acetyl-Methadol), Cyclazocine, or their equivalents;
• Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangement;
• Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that are any of the following:
  • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
  • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; and
  • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective;
• Pastoral counselors;
• Treatment provided in connection with autism; and
• Treatment provided in connection with tobacco dependency.
Non-Covered Providers

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

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

Nutrition

• Megavitamin and nutrition-based therapy;
• Except as described in the Nutritional Counseling section of the Benefits Information Grid beginning on page 21, 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 of this SPD for the definition of Cosmetic Procedures.) Examples include:
  • Pharmacological regimens, nutritional procedures or treatments;
  • Tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); and
  • Scar or keloid removal or revision procedures except when:
      (i) The scar or keloid was caused by an accidental Injury or a covered surgical procedure; or
      (ii) The scars were a result of acne or other severe scarring disorders;
• Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Item 22 (Reconstructive Procedures) of the Benefits Information Grid beginning on page 21;
• Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation;
• Weight-loss programs whether or not they are under medical supervision. Weight-loss programs for medical reasons are also excluded;
• Wigs regardless of the reason for the hair loss;
• Non-surgical treatment of obesity;
• Surgical treatment of obesity unless the patient is morbidly obese as currently defined by the National Institute on Health. If a patient qualifies, surgical treatment will be covered only once per lifetime;
• Services received from a personal trainer; and
• Liposuction.

Providers

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

This exclusion does not apply to mammography testing.

Reproduction

• 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;
• 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 21;
• 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 21.
Travel

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

Vision

- 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.

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.);
- Vaccinations and immunizations that are routine, preventative or associated with Employer-required travel;
- Physical, psychiatric or psychological exams, testing, or treatments that are otherwise covered under the Program when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
  - Related to judicial or administrative proceedings or orders;
  - Conducted for purposes of medical research; and
  - Required to obtain or maintain a license of any type;
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
- Health services received after the date your coverage ends, including health services for medical conditions arising before the date your coverage ends;
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Program;
- In the event that a Provider waives Co-payments or Co-insurance for a particular health service, no benefits are provided for the health service for which the Co-payments or Co-insurance are waived;
- Charges in excess of Eligible Expenses or in excess of any specified limitation;
- Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a congenital anomaly and learning disabilities and developmental delays;
- Growth hormones;
- Sex transformation operations;
- 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;
- Speech therapy to treat stuttering, stammering, or other articulation; 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 18 of this SPD.
### Comparison of Network and Non-Network Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
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<td>Who Should File Claims?</td>
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<td>Outpatient Emergency Room Health Services</td>
<td>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.</td>
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</tbody>
</table>

### Provider Network

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

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

The credentialing process confirms public information about the Providers’ licenses and other credentials, but does not assure the quality of the services provided.

You have access to the directory of Illinois Caterpillar Network Providers on www.cathealthbenefits.com. The Network of Providers is subject to change. Before obtaining services, you should always verify the Network status of a Provider. A Provider’s status may change. You can verify the Provider’s status by calling the Claims Administrator at the number on your ID card or in the section entitled Contact Information beginning on page 96, or by using the www.cathealthbenefits.com website.

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

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

There are no Network or other discounts for services, treatments, items or supplies that are not covered under the Program.
Designated United Resource Network Facilities and Other Providers

If you have a medical condition that Care Coordination℠ believes needs special services, they may direct you to a Designated United Resource Network Facility or other Provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Care Coordination℠ 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 United Resource Network Facility or other Provider chosen by Care Coordination℠.

NON-NETWORK BENEFITS

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

If there is no Network Provider within a 30-mile radius of your home zip code, you may be eligible to receive benefits for certain Covered Health Services paid at the Network level up to Reasonable 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 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 Program provides benefits for Emergency Room Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Room Health Services, even if a non-Network Provider provides the services. If you are confined in a non-Network Hospital after receiving Emergency Room Health Services, Care Coordination℠ must be notified within two business days or on the same day of admission if reasonably possible. Care Coordination℠ 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 Care Coordination℠ decides a transfer is medically appropriate, Non-Network Benefits will be available if the continued stay is determined to be a Covered Health Service.

Note: The Emergency room Co-pay for covered Emergency Room Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an Inpatient in the Hospital. In this case, the Emergency room Co-pay will apply. The Emergency room Co-pay information can be found in the tables located in the Benefits at a Glance section beginning on page 21.
Description Of Network And Non-Network Benefits (Reside In A United Healthcare 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 18 of this SPD.

Comparison of Network and Non-Network Benefits

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</table>

| 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 74. | 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 74. |
| 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 United Healthcare Network Hospital and Skilled Nursing Facility in order to receive Network Benefits. A Hospital or Skilled Nursing Facility outside of the United Healthcare 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 United Healthcare Network Hospital or Skilled Nursing Facility and still receive Network Benefits.

These Network Providers have agreed to discount their charges for Covered Health Services. Network Providers are independent practitioners. They are not employees of the Program or employees of the Claims Administrator. It is your responsibility to select your Provider. If you use a Network Provider, your Co-insurance amount will generally be less than it would be if you use a non-Network Provider. Since the total amount of Eligible Expenses may be less when you use a Network Provider, the portion that you owe will be less.
The credentialing process confirms public information about the Providers’ licenses and other credentials, but does not assure the quality of the services provided.

You have access to the directory of UHC Network Providers on www.myuhc.com. You can request a directory of UHC Network Providers at no cost to you. The Network of Providers is subject to change. Before obtaining services, you should always verify the Network status of a Provider. A Provider’s status may change. You can verify the Provider’s status by calling the Claim Administrator at the number on your ID card or in the section entitled Contact Information beginning on page 96, or by using the www.myuhc.com website. (For an Illinois Caterpillar Network Provider, visit the www.cathealthbenefits.com website.)

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

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

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

**Designated United Resource Network Facilities and Other Providers**

If you have a medical condition that Care Coordination℠ believes needs special services, they may direct you to a Designated United Resource Network Facility or other Provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Care Coordination℠ 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 United Resource Network Facility or other Provider chosen by Care Coordination℠.

**NON-NETWORK BENEFITS**

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

If there is no Network Provider within a 30-mile radius of your home zip code, you may be eligible to receive benefits for certain Covered Health Services paid at the Network level up to Reasonable 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 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 Program provides benefits for Emergency Room Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.
Network Benefits are paid for Emergency Room Health Services, even if the services are provided by a non-Network Provider.

If you are confined in a non-Network Hospital after receiving Emergency Room Health Services, Care CoordinationSM must be notified within two business days or on the same day of admission if reasonably possible. Care CoordinationSM 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 Care CoordinationSM decides a transfer is medically appropriate, Non-Network Benefits will be available if the continued stay is determined to be a Covered Health Service.

**Note:** The Emergency room Co-pay for covered Emergency Room Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an Inpatient in the Hospital. In this case, the Emergency room Co-pay will apply. The Emergency room Co-pay information can be found in the tables located in the *Benefits at a Glance* section beginning on page 21.

**Obtaining Benefits (Reside Outside A Network Area)**

**IF YOU OBTAIN SERVICES FROM A NETWORK PROVIDER**

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

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

The credentialing process confirms public information about the Providers’ licenses and other credentials, but does not assure the quality of the services provided.

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 www.cathealthbenefits.com. The Network of Providers is subject to change. Before obtaining services, you should always verify the Network status of a Provider. A Provider’s status may change. You can verify the Provider’s status by calling the Claims Administrator at the number on your ID card or in the section entitled *Contact Information* beginning on page 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.

This SPD issued May 2011
YEBB3303a 46
**DESIGNATED UNITED RESOURCE NETWORK FACILITIES AND OTHER PROVIDERS**

If you have a medical condition that Care Coordination℠ believes needs special services, they may direct you to a Designated United Resource Network Facility or other Provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Care Coordination℠ 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 United Resource Network Facility or other Provider chosen by Care Coordination℠.

**EMERGENCY ROOM HEALTH SERVICES**

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

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

*Note:* The Emergency room Co-pay for covered Emergency Room Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an Inpatient in the Hospital. In this case, the Emergency room Co-pay will apply. The Emergency room Co-pay information can be found in the Plan Option tables located in the Benefits at a Glance section beginning on page 21.

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**Coordination Of Medical Benefits**

**BENEFITS WHEN YOU HAVE COVERAGE UNDER MORE THAN ONE PLAN**

This section describes how benefits under the Program 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. Failure to comply with the Primary Coverage Plan provisions to utilize a required network will deem the services not allowable under the Program for secondary coverage. If enrolled for secondary coverage in a Network Benefits plan, use of a Network Provider is required to receive maximum reimbursement from the Program.
DEFINITIONS

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

• “Coverage Plan” is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
  • “Coverage Plan” includes group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare (see the section entitled When a Covered Person Qualifies for Medicare beginning on page 50) or other governmental benefits, as permitted by law.
  • “Coverage Plan” does not include individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental Plans, unless permitted by law.

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

• The order of benefit determination rules determine whether this Coverage Plan is a “Primary Coverage Plan” or “Secondary Coverage Plan” when compared to another Coverage Plan covering the person. When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan’s benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan’s benefits.

• “Allowable Expense” means a health care service or expense, including deductibles Co-payments, and Co-insurance that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services (for example, 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 Reasonable and Customary fees, any amount in excess of the highest of the Reasonable and Customary fees for a specific benefit is not an Allowable Expense.
  • If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
  • If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of Reasonable and Customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan’s payment arrangements shall be the Allowable Expense for all Coverage Plans.
  • The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions is not an Allowable Expense. Examples of these
provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

• “Closed Panel Plan” is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.

• “Custodial Parent” means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

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

1. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

2. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide Non-Network Benefits.

3. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

4. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

• Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a Dependent (for example, as an employee, member, subscriber or retiree) is primary and the Coverage Plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a Dependent and primary to the Coverage Plan covering the person as other than a Dependent (e.g., a retired employee), then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

• Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:

  • The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

    (i) The parents are married;

    (ii) The parents are not separated (whether or not they ever have been married); or

    (iii) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

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

    • If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the Coverage Plan of that parent has actual
knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
  (i) The Coverage Plan of the custodial parent;
  (ii) The Coverage Plan of the Spouse 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 to an individual as a retired employee and as a Dependent of an actively working Spouse will be determined under the rule labeled “Non-Dependent or Dependent.”

- Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person’s Dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.

- Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

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

WHEN A COVERED PERSON QUALIFIES FOR MEDICARE

Determining Which Plan is Primary

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

- Employees with active Full-time current employment status age 65 or older;
- Covered Spouses of Employees with active current employment status regardless of whether the Employee or his or her Spouse is age 65 or older; and
- Covered Persons with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When the Program is Secondary

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

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

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

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

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

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

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

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

Benefits under the HRA Coverage of the Program are intended to reimburse expenses not previously reimbursable under other insurance programs or other medical plans. If a medical expense is payable or reimbursable from another plan, the HRA Coverage will not pay or reimburse the expense until after the other plan has paid its required portion. Additionally, if medical expenses are covered by both the HRA Coverage of the Program and by a health FSA, then the Program will not reimburse the medical expenses until after amounts available for reimbursement under the health FSA have been exhausted.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. The Claims Administrator may get the facts it needs
from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits.

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

**PAYMENTS MADE**

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, the Program may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. The Program will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

**RIGHT OF RECOVERY**

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

You are eligible for Traditional Prescription Drug Coverage under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled Eligibility beginning on page 3 and any additional requirements described in this section.

Additionally, the prescription drug benefits described in this Traditional Prescription Drug Coverage section apply to you if you are enrolled in the HMO administered by Health Alliance Medical Plans in the Peoria and Decatur areas. If you are enrolled in another HMO or the United Healthcare Choice Plan, the HMO or the United Healthcare Choice Plan will send you, under separate cover, information about the prescription drug benefits provided by the HMO or the United Healthcare Choice Plan. If you have questions concerning your prescription drug benefits refer to the phone number on the back of your identification card issued by your HMO or the United Healthcare Choice Plan. Please note that it is the responsibility of the HMO or the United Healthcare Choice Plan to provide you with the necessary information about your specific prescription drug benefits. If you do not receive that information from the HMO or the United Healthcare Choice Plan, contact the Plan Administrator.

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

Overview Of Traditional Prescription Drug Coverage

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

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

You may obtain a copy of the Formulary at www.cathealthbenefits.com or by contacting RESTAT 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 RESTAT to determine if your particular prescription drug will be covered under the Program.

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

- 100% of the charge, less the applicable Co-payment, if dispensed by a Network Pharmacy or Preferred Network Pharmacy;
• 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 RESTAT for reimbursement of up to 50% of the actual medication and dispensing charge imposed by a non-Network Pharmacy. For more information, please see the section If Dispensed by a Non-Network Pharmacy beginning on page 77.

MAIL SERVICE PROGRAM

• Prescription drugs can be purchased through the mail from Walgreens Mail Service of Orlando, Florida. You can elect to obtain by mail maintenance prescription drugs that you take on a regular basis, are stabilized on a given dosage and are covered under the Program.
• These medications will be delivered to your home either by U.S. Postal Service or United Parcel Service (UPS). Prescriptions can be shipped overnight for an additional charge to you.
• Maintenance drugs are available through the mail service program for up to a 90-day supply at the applicable Co-payments.
• If you have questions about the mail service program, contact Walgreens Mail Service at (866) 840-1222 (TTY for deaf: (800) 925-0178), Monday through Friday from 8:00 a.m. to 10:00 p.m. and Saturday 8:00 a.m. to 5:00 p.m. (Eastern Standard Time). Order forms and instructions are available at www.cathealthbenefits.com under the “Drug Benefit” tab, or you can call RESTAT at (877) 228-7909.

BENEFIT LIMITATIONS

Your prescription drug benefits are limited as follows:

• Prescription drugs must meet approved indications established by the FDA or the Claims Administrator.
• The Claims Administrator may limit quantities for dosage optimization.
• The Claims Administrator may require the use of a generic if an equivalent A/B Rated generic drug is available.
• The Claims Administrator may limit quantities as determined by the FDA or the Claims Administrator.
• Certain prescription drug products require prior authorization for coverage. (A list of these products is available at www.cathealthbenefits.com under the Drug Benefit tab, or you can call RESTAT 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, will 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 Program:

• Administration charges;
• Any refill dispensed after one year from the date of the Physician’s latest order;

This SPD issued May 2011
YEBB3303a 54
• Charges for any covered prescription drugs for which payment is otherwise provided under the other benefits of the Program;
• Charges for prescription drugs incurred prior to the date coverage became effective under the Program;
• Charges for which the cost of the prescription drug is less than the Co-payment amount;
• Charges for quantities exceeding the amount specified by the Provider;
• Drugs purchased as replacement prescriptions. Including for example, drugs purchased resulting from loss, theft, or breakage;
• More than a 30-day supply at any one time of any covered prescription non-maintenance drug, except when the mail service program is utilized (as described above) and except in the case of extended travel outside the United States in accordance with rules and procedures established by the Claims Administrator, and
• Drugs which are experimental, investigational, unproven or cosmetic in nature.

Prescription Drug Co-Payments

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

• $0 for each prescription drug designated as “Tier 0”;
• $0 for each prescription drug designated as “Tier 1”;
• $20 for each prescription drug designated as “Tier 2”;
• $20 for each prescription and/or refill of a Compounded Drug;
• $35 for each prescription drug designated as “Tier 3”;
• the amount charged by the Preferred Network Pharmacy if that amount is less than the amount charged for Tier 1, Tier 2, Compounded Drug, Tier 3.

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

• $0 for each prescription drug designated as “Tier 0”;
• $5 for each prescription drug designated as “Tier 1”;
• $20 for each prescription drug designated as “Tier 2”;
• $20 for each prescription and/or refill of a Compounded Drug;
• $35 for each prescription drug designated as “Tier 3”;
• the amount charged by the Preferred Network Pharmacy if that amount is less than the amount charged for Tier 1, Tier 2, Compounded Drug, Tier 3.

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

• $15 for each prescription drug designated as “Tier 0”;
• $15 for each prescription drug designated as “Tier 1”;
• $40 for each prescription drug designated as “Tier 2”;
• $40 for each prescription and/or refill of a Compounded Drug;
• $70 for each prescription drug designated as “Tier 3”;

This SPD issued May 2011
YEBB3303a 55
• the amount charged by the Network Pharmacy if that amount is less than the amount charged for Tier 1, Tier 2, Compounded Drug, Tier 3.

By having your prescription filled at a Network Pharmacy or a Preferred Network Pharmacy, you will pay no more than the required Co-payment for each prescription or refill as listed above. If you have your prescription filled at a pharmacy that is neither a Network Pharmacy or a Preferred Network Pharmacy, your coverage under the Program will be reduced. For a list of the prescription drugs covered by the Program and the designation of each such prescription drug, please refer to www.cathealthbenefits.com. You may also obtain a list of participating pharmacies at www.cathealthbenefits.com or by calling RESTAT at (877) 228-7909.

WALGREENS MAIL SERVICE PROGRAM AND CO-PAYMENTS

The Program will provide up to a 90-day supply of maintenance drugs after you pay one of the following Co-payments:

• zero Co-payments for a prescription drug designated as “Tier 0”;
• one $5 Co-payment for a prescription drug designated as “Tier 1”;
• two $20 Co-payments for a prescription drug designated as “Tier 2”; and
• three $35 Co-payments for a prescription drug designated as “Tier 3”

PRESCRIPTION DRUG COST SHARE

For drugs purchased from a Network Pharmacy or a Preferred Network Pharmacy, a $100 cost share will apply to each prescription where the cost of the prescription drug exceeds $1,000. In the case of maintenance-type drugs obtained through the Walgreens Mail Service, a $300 cost share will apply to each prescription where the cost of a 90-day supply exceeds $3,000.

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

If you qualify for Medicare and you are enrolled in PPO coverage under the Program, prescription drug coverage under the Program is, on average, as good as or better than standard Medicare Part D prescription drug coverage. This means you can keep the coverage under the Program and not pay more for Medicare Part D if you later decide to enroll in Part D. However, under certain circumstances, Medicare Part D may be a better choice for you. You should evaluate very carefully which prescription drug coverage is right for you. Refer to the notice you received regarding your prescription drug coverage under the Program and Medicare.

For up-to-date information regarding prescription drug coverage under the Program, please visit the website at www.cathealthbenefits.com.
Eligibility For Traditional Dental Coverage

You are eligible for Traditional Dental Coverage under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled Eligibility beginning on page 3 and any additional requirements described in this section.

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

Overview Of Traditional Dental Coverage

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

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

IDENTIFICATION (“ID”) CARD

You must show your ID card every time you request Covered Dental Services. If you do not show your card, the Providers have no way of knowing that you are covered under the Program.

EXTENDED COVERAGE

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

Procedures For Obtaining Dental Benefits

COVERED DENTAL SERVICES

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

PRE-DETERMINATION OF BENEFITS

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

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

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

Schedule Of Dental Benefits

The following Schedules outline (i) the Levels of Reimbursement, (ii) the Deductibles that you are required to pay for Covered Dental Services and (iii) any maximum benefit that may apply. Covered Dental Services are described more completely in the Covered Dental Services section beginning on page 59.

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

Please note that due to a change in service providers, some dental benefit limits were reset effective January 1, 2010. Please contact the Plan Administrator for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Level Of Reimbursement After The Annual Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Dental Services</td>
<td>100% of Eligible Expenses. Annual Deductible does not apply.</td>
</tr>
<tr>
<td>Basic Dental Services</td>
<td></td>
</tr>
<tr>
<td>Minor Restorative</td>
<td>80% of Eligible Expenses</td>
</tr>
<tr>
<td>Endodontics</td>
<td>80% of Eligible Expenses</td>
</tr>
<tr>
<td>Periodontics</td>
<td>80% of Eligible Expenses</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>80% of Eligible Expenses</td>
</tr>
<tr>
<td>Adjunctive Services</td>
<td>80% of Eligible Expenses</td>
</tr>
<tr>
<td>Major Dental Services</td>
<td>50% of Eligible Expenses</td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>50% of Eligible Expenses. Annual Deductible does not apply.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible/Annual Maximum</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Individual Deductible</td>
<td>$50</td>
</tr>
<tr>
<td>Annual Family Deductible</td>
<td>$100</td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>$1,500 per Covered Person</td>
</tr>
<tr>
<td>Lifetime Orthodontic Maximum Benefit</td>
<td>$1,500 per Covered Person</td>
</tr>
</tbody>
</table>
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 of this SPD);
- Provided by or under the direction of a Dentist or other appropriate Provider as specifically described;
- The least costly, clinically accepted treatment; and
- Not excluded as described in the General Exclusions section beginning on page 63.

Covered Dental Services are subject to satisfaction of the Annual Deductible and applicable waiting periods as described in the Schedule of Benefits beginning on page 58.

Preventive Dental Services (100% of Eligible Expenses)

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Special Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bite-Wing Radiographs</td>
<td>Limited to one series of films per calendar year.</td>
</tr>
<tr>
<td>Complete Series or Panorex Radiographs</td>
<td>Limited to one time per 60 consecutive months.</td>
</tr>
<tr>
<td>Dental Prophylaxis</td>
<td>Limited to two times per calendar year.</td>
</tr>
<tr>
<td>Emergency Palliative Treatment</td>
<td>Covered as a separate benefit only if no other service, other than exam and x-rays, were done during the visit. Subject to deductible.</td>
</tr>
<tr>
<td>Extraoral Radiographs</td>
<td></td>
</tr>
<tr>
<td>Fluoride Treatments</td>
<td>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.</td>
</tr>
<tr>
<td>Individual Periapical Radiographs</td>
<td>Done in conjunction with diagnosis of a specific condition requiring treatment.</td>
</tr>
<tr>
<td>Intraoral Occlusal Radiographs</td>
<td></td>
</tr>
<tr>
<td>Oral Examinations</td>
<td>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.</td>
</tr>
<tr>
<td>Sealants</td>
<td>Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every 60 consecutive months.</td>
</tr>
<tr>
<td>Space Maintainers that replace prematurely lost teeth</td>
<td>Limited to Covered Persons under the age of 19 years for the replacement of prematurely lost teeth.</td>
</tr>
</tbody>
</table>
**Basic Dental Services (80% of Eligible Expenses)**

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Special Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minor Restorative Services</strong></td>
<td></td>
</tr>
<tr>
<td>Amalgam Restorations</td>
<td></td>
</tr>
<tr>
<td>Composite Resin Restorations</td>
<td>If a tooth can be restored with a less expensive material such as amalgam, appropriate payment for that procedure will be made toward the charge for another type of restoration selected by you and your Dentist. The balance of the treatment charge will not be payable under the Program.</td>
</tr>
<tr>
<td>Cosmetic Bonding</td>
<td>For children 8 - 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.</td>
</tr>
<tr>
<td>Pin Retention</td>
<td>Not covered in addition to cast restoration.</td>
</tr>
<tr>
<td><strong>Endodontics</strong></td>
<td></td>
</tr>
<tr>
<td>Apexification</td>
<td></td>
</tr>
<tr>
<td>Apicoectomy and Retrograde filling</td>
<td></td>
</tr>
<tr>
<td>Hemisection</td>
<td></td>
</tr>
<tr>
<td>Root Canal Therapy</td>
<td></td>
</tr>
<tr>
<td>Root Resection</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Pulpotomy</td>
<td></td>
</tr>
<tr>
<td><strong>Injection of antibiotic Drugs</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Periodontics</strong></td>
<td></td>
</tr>
<tr>
<td>Hard or Soft Tissue Surgery</td>
<td>*Only one of these procedures per quadrant or site per 36 months.</td>
</tr>
<tr>
<td>Crown Lengthening</td>
<td></td>
</tr>
<tr>
<td>Gingivectomy</td>
<td></td>
</tr>
<tr>
<td>Osseous Graft</td>
<td></td>
</tr>
<tr>
<td>Osseous Surgery</td>
<td></td>
</tr>
<tr>
<td>Periodontal Maintenance</td>
<td>Limited to two times per calendar year, following active and adjunctive periodontal therapy (within the prior 24 months, exclusive of gross debridement). Covered in combination with regular prophylaxis, deductible does not apply.</td>
</tr>
<tr>
<td>Provisional Splinting</td>
<td></td>
</tr>
<tr>
<td>Scaling and Root Planning</td>
<td></td>
</tr>
</tbody>
</table>
### Benefit Description

**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

**Adjunctive Services**
- Analgesia
- Desensitizing Medicament
- General Anesthesia
- Intravenous Sedation and Analgesia
- Injection of antibiotics
- Occlusal Adjustment

**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.

### Special Limitations

Refer to the *Traditional Medical Coverage* section beginning on page 18 of this SPD for additional coverage for Oral Surgery (e.g., treatment of fractures and reduction of dislocation).

Refer to *Major Dental Services* beginning on page 61 for implants.

Refer to 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.

Major Dental Services *(50% of Eligible Expenses)*

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Special Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crowns</strong></td>
<td>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 Program.</td>
</tr>
<tr>
<td><strong>Gold Inlay or Onlay</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Porcelain Onlays</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Post &amp; Cores for Single Tooth Crown (only for teeth that have had root canal therapy)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Fixed Bridges</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
### Benefit Description

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

### Orthodontic Services

**OVERVIEW**

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

Although the installation of a space maintainer is not included, generally any treatment related to treatment of the temporomandibular joint or a surgical procedure to correct a malocclusion is included in orthodontic services.

**PREDETERMINATION OF BENEFITS**

If a dental exam reveals the need for orthodontia, you should notify the Claims Administrator of such treatment before treatment begins. If requested, the Dentist must provide the Claims Administrator with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.
The Claims Administrator will decide if the proposed treatment is a Covered Dental Service under the Program and estimate the amount of payment. The estimate of benefits payable will be sent to the Dentist and will be subject to all terms, conditions and provisions of the Program. If a treatment plan is not submitted, the Covered Person will be responsible for payment of any dental treatment not approved by the Claims Administrator. Pre-determination of benefits is not an agreement to pay for expenses. The predetermination process lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment.

**ORTHODONTIC MAXIMUM**

Not more than $1,500 per lifetime will be payable for covered orthodontic services for a Covered Person age 21 and younger. 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 Traditional Dental Coverage section beginning on page 57 does not apply to Orthodontic Services.

**Dental Coverage – General Exclusions**

Except as may be specifically provided in the Covered Dental Services section beginning on page 57 or through an amendment to this SPD, the following are not Covered Dental Services. However, the Claims Administrator may, in its sole discretion amend this list of general exclusions.

- Dental services that are not Necessary.
- Hospitalization or other facility charges. (Refer to the Traditional Medical Benefits section beginning on page 18 of this SPD for possible coverage.)
- Any dental procedure performed solely for cosmetic/aesthetic reasons (i.e., procedures that improve physical appearance.)
- Reconstructive Surgery regardless of whether or not the surgery is incidental to a dental disease, Injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. Appropriate payment will be made toward the cost of procedures necessary to eliminate oral diseases and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension to restore occlusion will be considered optional and their cost will not be payable under the Program.
- Any dental procedure not directly associated with dental disease.
- Any procedure not performed in a dental setting.
- Procedures that are considered to be Experimental or Investigational Services or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental or Investigational Service or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be an Experimental or Investigational Service or Unproven Service in the treatment of that particular condition.
- Drugs or medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit. (Refer to the Prescription Drug Benefits section beginning on page 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 bony 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 21 in the subsection, Benefit Information, of the section of this SPD entitled What’s Covered – Benefits for possible coverage under the oral surgery benefit.)

• Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision. (Refer to Item 16 (Oral Surgery) of the Benefits Information Grid beginning on page 21 in the subsection, Benefit Information, of the section of this SPD entitled What’s Covered – Benefits for possible coverage under the oral surgery benefit.)

• Replacement of complete or partial dentures, fixed bridgework, or crowns previously submitted for payment under the Program within 60 consecutive months of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

• Replacement of complete or partial dentures, crowns, or fixed bridgework if damage or breakage was directly related to Provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient noncompliance, the patient is liable for the cost of replacement. The patient is liable for the cost of replacement of lost, missing or stolen appliances and prosthetic devices.

• Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint. (Refer to Item 16 (Oral Surgery) of the Benefits Information Grid beginning on page 21 in the subsection, Benefit Information, of the section of this SPD entitled What’s Covered – Benefits for possible coverage under the oral surgery benefit.)

• Charges for failure to keep a scheduled appointment without giving the dental office 24 hours’ notice.

• Expenses for dental procedures begun prior to the Covered Person’s eligibility with the Program.

• Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

• Procedures related to the reconstruction of a patient’s correct vertical dimension of occlusion (VDO). Appropriate payment will be made toward the cost of procedures Necessary to eliminate oral diseases and to replace missing teeth. Appliances or restorations Necessary to increase vertical dimension to restore occlusion will be considered optional and their cost will not be payable under the Program.

• Full-mouth radiograph series in excess of once every 60 consecutive months. Panoramic radiographs in excess of once every 60 consecutive months, except when taken for diagnosis of third molars, cysts or neoplasms.

• Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

• Occlusal guards (except if prescribed to control habitual grinding), including those specifically used as safety items or to affect performance primarily in sports-related activities.

• Dental services otherwise covered under the Program, but rendered after the date individual coverage under the applicable plan terminates, including dental services for dental conditions arising prior to the date individual coverage terminates, except those conditions covered under the Extended Coverage section beginning on page 57. If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination.

• Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.

• Orthodontic Services for patients age 22 and older unless due to accidental Injury or as an alternative to Orthogenetic surgery.

• Diagnostic casts, bacteriologic studies and caries susceptibility tests.
• Interim partial dentures only covered for persons under the age of 19.
• Charges for plaque control, fissure sealants, dietary instruction, and any other dental health care instructions.
• Charges by the Dentist for completing and filing claim forms on the patient’s behalf.
• Replacement or repair of a broken orthodontic appliance.
• General Analgesia, except if required for patients under six years of age or patients with behavioral problems or physical disabilities.
• Charges set forth as exclusions in any other sections of the Program.
HEALTH REIMBURSEMENT ARRANGEMENT (HRA) BENEFITS

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

HRA Eligibility

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

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

Your Spouse is eligible to enroll in the HRA Benefits of the Program if he/she meets the following requirements:

- your Spouse is an eligible Spouse; and
- your Spouse is no longer eligible for Traditional Healthcare Benefits under the Program because your Spouse Reaches Age 65.

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

HRA Participation

HOW TO ENROLL

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

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

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

If you divorce your Spouse, coverage under the HRA Benefits of the Program ends for your Spouse and your Spouse is eligible to elect COBRA continuation coverage. If your Spouse fails to elect COBRA continuation coverage, no additional amounts will be credited to your Spouse’s HRA Account following the divorce.

The Value Of Your HRA Account

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

If you retired prior to January 1, 2011, the amount credited to your HRA Account and the amount credited to your Spouse’s HRA Account will be the maximum amount, regardless of your age and credited service at the time of retirement, subject to Caterpillar’s discretionary right to make changes to the Program.

If you retire on or after January 1, 2011, the amount credited to your HRA Account and the amount credited to your Spouse’s HRA Account will be the maximum amount only if you are age 65 and have completed 30 or more years of Healthcare Benefit Service at the time of your retirement.

If you are not age 65 and have not completed 30 or more years of Healthcare Benefit Service at the time of your retirement, the amount allocated to your HRA Account and the amount allocated to your Spouse’s HRA Account will be the sum of:

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

For example, you retire in 2011 at the age of 62 with 22 years of Healthcare Benefit Service. Your maximum HRA Account contribution when you Reach Age 65, lose Traditional Healthcare Benefits under the Program and elect to participate in the HRA Benefits of the Program, will be $1,440 (4% x 12 full years of age between 50 and 65 x $3,000) plus $240 (4% x 2 years of Healthcare Benefit Service between 20 and 30 years of credited service x $3,000), or $1,680.

If you are the Spouse of another eligible retiree, the maximum benefit available to both you and your Spouse as retirees is determined based on your respective retirement dates, ages and years of Healthcare Benefit Service.

The applicable amount will be allocated to your HRA Account and your Spouse’s HRA Account at the beginning of each year. If you enroll in HRA Benefits after the beginning of the year, a pro-rata portion of the applicable maximum amount will be allocated to your HRA Account and your Spouse’s HRA Account based on the number of full calendar months remaining in the year. The amount in your HRA Account is the amount that is available for reimbursement of medical care expenses.
Using Your HRA Account To Pay Healthcare Expenses

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

ELIGIBLE HEALTHCARE EXPENSES

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

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

Medical Expenses

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

Vision Expenses

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

Hearing Expenses

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

This SPD issued May 2011
YEBB3303a 68
Dental Expenses

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

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

Expenses may be reimbursed from your HRA Account only if you are not reimbursed for the expenses through insurance or any other health plan. If only a portion of the expense has been reimbursed through insurance, your HRA Account may reimburse the remaining portion of the expense. For example, if another health plan pays for a medical procedure, but you are responsible for payment of a co-pay and deductible, you may be reimbursed from your HRA Account for the amount of the applicable co-pay and deductible.

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

INELIGIBLE EXPENSES

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

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

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

Reimbursement Procedure

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

Forfeiture Of HRA Account

If your (or your covered Spouse’s) HRA Account is not depleted sooner, the HRA Account will be forfeited upon the occurrence of any of the following events:

- Upon your death, your HRA Account will be forfeited after payment of claims filed within 6 months of death.
• Upon the death of your covered Spouse, your Spouse’s HRA Account will be forfeited after payment of claims filed within 6 months of death.

• Upon your re-employment with the Company, as described in the section titled Reemployment below.

• Upon divorce, the HRA Account of your Spouse will be forfeited unless your Spouse elects COBRA continuation coverage. If your Spouse elects COBRA continuation, the HRA Account of your Spouse will be forfeited when COBRA continuation coverage ends and after payment of claims filed within 6 months following the end of COBRA coverage.

**Reemployment**

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

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

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

Eligibility For Life Benefits

You are eligible for life benefits under the Program if you satisfy the eligibility criteria described in the section of this SPD entitled Eligibility beginning on page 3 and any additional requirements described in this section.

BASIC LIFE INSURANCE AT RETIREMENT

If you retire and are covered by the Program, the Company will provide reduced basic life insurance benefits for a period following your retirement, as described below.

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

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

- If you were a non-management employee and your retirement date occurred on or after January 1, 1991 but prior to July 1, 1996, and

  - you retire on or before your 65th birthday, your basic life insurance coverage will continue until the first day of the month following your 65th birthday. At that time, your basic life insurance coverage amount will be reduced by 2% per month until the amount of coverage equals one and a half percent (1½%) of the amount of your basic life insurance coverage in effect on the day before your retirement date, multiplied by the number of years of credited service you earned under a pension plan sponsored by the Company in which you participate as of your date of retirement; or

  - you retire after your 65th birthday, your basic life insurance coverage will continue but it will be reduced by 2% per month until the amount of coverage equals one and a half percent (1½%) of the amount of your basic life insurance coverage in effect on the day before your retirement date, multiplied by the number of years of credited service you earned under a pension plan sponsored by the Company in which you participate as of your date of retirement.

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

If you retire after January 1, 2003 (after January 1, 2004 for retirees from Caterpillar Paving Products Inc.), your basic life insurance coverage will continue in the amount in effect on the day before your retirement date until the first anniversary of your retirement (up to a maximum of $500,000). On the first anniversary of your retirement, your basic life insurance coverage will be reduced to 50% of the amount in effect during the first year of your retirement. Your basic life insurance coverage will terminate on the third anniversary of your retirement.
OPTIONAL LIFE INSURANCE AT RETIREMENT

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

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

EXTENDED RETIREE COVERAGE

If you retire after January 1, 2003, on your retirement date, you will have the option of purchasing group life insurance that will extend your basic life insurance coverage beyond the third anniversary of your retirement date. If you elect to continue your coverage, your benefits will continue at the amount in effect on the day preceding the termination of your coverage. You will be required to pay the full group rate for the life insurance coverage, as determined by the Insurance Carrier. To extend your basic life insurance coverage, you must contact the MetLife National Benefit Center for Caterpillar at the telephone number listed in the section entitled Contact Information beginning on page 96 within 31 days of the date of your retirement or, if later, within 31 days of notice from the MetLife National Benefit Center for Caterpillar. You may extend your basic life insurance coverage without providing Evidence of Insurability if you were eligible to retire as of January 1, 2003 or if you carry optional life insurance coverage at the time you actually retire. In all other cases, you will be required to provide satisfactory Evidence of Insurability to extend your basic life insurance coverage.

NAMING A BENEFICIARY

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

When you enroll, you must name a Beneficiary. To designate a Beneficiary, go to the website at www.metlife.com/mybenefits and complete the form online. Alternatively, you may obtain a Beneficiary designation form by calling the MetLife National Benefit Center for Caterpillar at the telephone number listed in the section entitled Contact Information beginning on page 96. You may complete and submit your Beneficiary designation form to the MetLife National Benefit Center for Caterpillar at the address listed in the section entitled Contact Information beginning on page 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. Please note that you need to make separate beneficiary designations for your basic and optional life insurance benefits.

CHANGING A BENEFICIARY

Because family situations may change, you should review your Beneficiary designations from time to time. You may change your Beneficiary at any time by submitting a new Beneficiary designation form. You do not need the Beneficiary’s consent to make this change. If your form is accepted by the MetLife National Benefit Center for Caterpillar, in its sole discretion, your new designation takes effect on the date you sign the form, even if you are not alive on the date your form is received. A beneficiary change form can be obtained by calling the MetLife National Benefit Center for Caterpillar at the telephone number listed in the section entitled Contact Information beginning on page 96 or by completing the form on-line at metlife.com/mybenefits.
IF YOU DO NOT NAME A BENEFICIARY

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

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

GVUL COVERAGE

If your life insurance is provided through a group variable universal life policy, you will be provided with additional information regarding your life benefits upon request.
# GENERAL ADMINISTRATION

## Filing A Claim For Benefits

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### FILING A CLAIM FOR BENEFITS

<table>
<thead>
<tr>
<th>Plan/Benefit</th>
<th>Information Needed</th>
<th>Where to Send Your Claim</th>
<th>Deadline* and Initial Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Medical Coverage</td>
<td>• Retiree’s name and address</td>
<td>United Healthcare Insurance Company</td>
<td>Deadline: One year following calendar year in which expenses were incurred</td>
</tr>
<tr>
<td></td>
<td>• The patient’s name, age and relationship to the retiree</td>
<td>P.O. Box 740800 Atlanta, GA 30374-0800</td>
<td>Initial Decision:</td>
</tr>
<tr>
<td></td>
<td>• The member and group numbers stated on your ID card</td>
<td>Customer Service &amp; Care Coordination Notification:</td>
<td>• Urgent care claim: Within 72 hours after claim is filed</td>
</tr>
<tr>
<td></td>
<td>• An itemized bill from your Provider that includes:</td>
<td>(866) 228-4215  <a href="http://www.myuhc.com">www.myuhc.com</a></td>
<td>• Pre-service claim (not urgent): Within 15 days after claim is filed**</td>
</tr>
<tr>
<td></td>
<td>- Patient diagnosis code</td>
<td></td>
<td>• Post-service claim: Within 30 days after claim is filed**</td>
</tr>
<tr>
<td></td>
<td>- Date(s) of service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Procedure code(s) and descriptions of service(s) rendered</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Charge for each service rendered</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Provider of service name, address and tax identification number</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The date the Injury or Sickness began</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 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).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan/Benefit</td>
<td>Information Needed</td>
<td>Where to Send Your Claim</td>
<td>Deadline* and Initial Decision</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
</tbody>
</table>
| Traditional Prescription Drug Coverage | A receipt that provides:                                                            | RESTAT 11900 West Lake Park Drive        | Deadline: One year following calendar year in which expenses were incurred  
|                                      | • Date Filled                                                                       | Milwaukee, WI 53224                      | Initial Decision: Within 30 days after claim is filed **                   |
|                                      | • Days Supply                                                                        |                                           |                                         |
|                                      | • Drug Name                                                                          |                                           |                                         |
|                                      | • N.D.C. Code and Price                                                              |                                           |                                         |
|                                      | • Patient Name                                                                       |                                           |                                         |
|                                      | • Rx No.                                                                             |                                           |                                         |
|                                      | • Quantity                                                                           |                                           |                                         |
| Traditional Dental Coverage          | A claim form with the following information:                                         | CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037 | Deadline: One year following calendar year in which expenses were incurred  
|                                      | • Retiree name and address                                                           |                                           | Initial Decision: Within 30 days after claim is filed **                   |
|                                      | • 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) |                                           |                                         |
|                                      | • Itemized bill which includes the ADA codes or description of each charge           |                                           |                                         |
|                                      | • A statement indicating whether you are enrolled for coverage under any other health |                                           |                                         |
|                                      | or dental insurance plan or program. If you are enrolled for other coverage you      |                                           |                                         |
|                                      | must include the name of the other carrier(s) and the effective date of the coverage. |                                           |                                         |
|                                      | Claim forms are available on the internet at www.CatHealthBenefits.com or can be     |                                           |                                         |
|                                      | obtained by calling the Claims Administrator.                                        |                                           |                                         |
**TRADITIONAL MEDICAL COVERAGE CLAIMS**

If a Provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you don’t provide this information to the Claims Administrator within one year following the calendar year in which the expenses were incurred, benefits for that health service will be denied or reduced, in the Claims Administrator’s sole discretion. The time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

If you provide written authorization to allow direct payment to a Provider, all or a portion of any Eligible Expenses due to a Provider may be paid directly to the Provider instead of being paid to you. The Program will not reimburse third parties who have purchased or been assigned benefits by Physicians or other Providers.
If You Receive Covered Health Services from a Network Provider

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

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

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

Payment of Benefits

The Claims Administrator will make a benefit determination as set forth below. Benefits will be paid to you unless 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.

TRADITIONAL PRESCRIPTION DRUG COVERAGE 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-pay for each prescription or refill; and
• The participating pharmacy will bill the Company for all prescriptions covered under the Program.

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 74;
• Complete the Caterpillar Prescription Drug Expense Claim Form available under the Drug Benefits tab at cathealthbenefits.cat.com or by calling RESTAT at 1-877-228-7909;
• Submit claim form and receipt to RESTAT (via the fax number or address on the claim form); and
• A check will be mailed to you at the address listed in the RESTAT system for benefits payable.

For up-to-date information regarding the Company’s prescription drug benefit, visit the website at www.cathealthbenefits.com.
TRADITIONAL DENTAL COVERAGE CLAIMS

Payment of 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.

The Claims Administrator will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following are true:

- The Provider notifies the Claims Administrator that your signature is on file assigning benefits directly to that Provider; or
- You make a written request assigning benefits to the Provider at the time the claim is submitted.

HRA BENEFIT CLAIMS

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

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

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

LIFE BENEFIT CLAIMS

The Claims Administrator has the initial authority to decide whether an individual is eligible for life insurance benefits under the Program.

Benefit Determination

INITIAL DECISION

The Filing A Claim for Benefits chart beginning on page 74 above describes the deadlines for the Claims Administrator’s initial decision.

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

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

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

Pre-Service Claims (Pre-Determination)

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

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

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

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

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

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

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

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

If an ongoing 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 ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

**CLAIMS ADMINISTRATOR’S DECISION**

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

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

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

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

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

- Were relied upon in making the benefit determination;
- Were submitted, considered, or generated in the course of making the benefit determination;
- Demonstrate compliance with the Plan’s administrative processes or safeguards; or
- In the case of Disability and 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 Program consults with a health care professional with appropriate training, who will be identified upon request. Such health care professional will be someone who was...
neither consulted in connection with the initial denial of a claim that is the subject of the appeal, nor the subordinate of any such individual.

**Note:** If a claim for benefits is denied, there is a process for having your claim further reviewed. This review and appeals process is outlined in this *Further Review and Appeals* section beginning on page 81. You must follow this process in order to pursue a claim in court.

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**Further Review And Appeals**

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

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

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**REQUESTS FOR REVIEW**

<table>
<thead>
<tr>
<th>Type of Benefit</th>
<th>Send requests for review to the Claims Administrator at:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Eligibility</td>
<td>Request a Claim Initiation Form by contacting the Caterpillar Benefits Center at 877-228-4010</td>
</tr>
</tbody>
</table>
| Traditional Medical Coverage          | UnitedHealthcare Insurance Company  
  Attn: Caterpillar Appeals  
  P.O. Box 30432  
  Salt Lake City, UT  84130-0432  
  (866) 228-4215                      |
| Traditional Prescription Drug Coverage| RESTAT  
  11900 West Lake Park Drive  
  Milwaukee, WI  53224  
  (877) 228-7909                      |
| Traditional Dental Coverage           | CIGNA Dental  
  P.O. Box 188037  
  Chattanooga, TN 37422-8037  
  (800) 244-6224                      |
| HRA Benefits                          | Your Spending Account  
  P.O. Box 785040  
  Orlando, FL  32878-5040  
  (866) 766-6087                      |
| Life Benefits                         | MetLife  
  P.O. Box 14406  
  Lexington, KY  40511  
  metlife.com/mybenefits  
  (888) 228-1811                      |
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 74 you may appeal it as described below without first contacting the Claims Administrator. If you first contact the Claims Administrator and later wish to send your appeal in writing, the Claims Administrator can provide you with the appropriate address.

If you are appealing an urgent care claim denial, please refer to the Urgent Claim Appeals that Require Immediate Action section beginning on page 79 and contact the Claims Administrator immediately.

How to Appeal a Claim Decision

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

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

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

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

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

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:
For appeals of pre-service claims (as defined in the section entitled Benefit Determination beginning on page 78), 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 78), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see Urgent Claim Appeals That Require Immediate Action beginning on page 79.

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.

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

Urgent Claim Appeals That Require Immediate Action

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

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

**HRA BENEFIT CLAIMS**

**How to Appeal a HRA Claim Decision**

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

• You may contact the Claims Administrator in an attempt to resolve the complaint in an informal manner.

• If you are not satisfied with any attempts at informal resolution, you must submit a written request for review of a denied claim or a written notice of the complaint or dispute to the Claims Administrator’s address in accordance with the time frames set out above. You may submit supporting documentation or information to be considered. You must submit any requested additional information or documents.

• A written notice of the final decision will usually be sent to you within 60 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute.

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

• The specific reason(s) for the adverse determination;

• The specific plan provisions on which the determination was based;

• A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and make copies of, all records, documents and other information relevant to the claim;

• A statement that you have the right to obtain, upon request and free of charge, a copy of the internal rules or guidelines relied upon in making the determination;

• A statement describing any voluntary appeal procedures offered under the plan and your right to bring a civil action under Section 502(a) of ERISA following the denial of your appeal;

• A statement that if your claim was denied based on a medical necessity or experimental treatment exclusion, you have a right to obtain, free of charge, an explanation of the scientific or clinical judgment for the determination, applying the terms of the 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

Important Legal Provisions

PLAN DOCUMENT

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

CLERICAL ERROR

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

PLAN ADMINISTRATION

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

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

The Plan Administrator has delegated to the Claims Administrators listed in the Plan Information chart beginning on page 96 the authority described in this Plan Administration section, including the authority to determine eligibility and entitlement to benefits and to construe the terms of the Program. The Plan Administrator may adopt uniform rules for the administration of the plans from time to time, as it deems necessary or appropriate.

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

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

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

COMPANY AUDIT

The Company and the Plan Administrator reserve the right to audit any aspect of the Program, including but not limited to eligibility, enrollment and claims. In connection with any such audit, the Plan Administrator may request from you, your Spouse 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 Program.

REPRESENTATIONS CONTRARY TO THE PLAN

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

NO ASSIGNMENT

To the extent permitted by law, and except as specified under the terms of the Program, no benefits will be subject to alienation, sale, transfer, assignment, garnishment execution or encumbrance of any kind, and any attempt to do so will be void. However, benefits under the Program may be subject to a Qualified Medical Child Support Order (“QMCSO”).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (“QMCSOS”)

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

NO CONTRACT OF EMPLOYMENT

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

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

IMPLIED PROMISES

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

CHANGE OF ADDRESS

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

SEVERABILITY

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

RECOVERY OF PAYMENTS MADE BY MISTAKE

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

FORFEITURE OF UNCLAIMED OR ABANDONED BENEFIT PAYMENTS

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

REFUND OF OVERPAYMENTS

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

• All or some of the expenses were not paid by the participant or did not legally have to be paid by the participant.
• All or some of the payment the Program made exceeded the benefits under the plans.
The refund equals the amount the Program paid in excess of the amount the plan should have paid under the Program. If the refund is due from another person or organization, the participant agrees to help the plan get the refund when requested.

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

**SUBROGATION**

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

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

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation coverage, other insurance carriers or third party administrators (these third parties and persons or entities are collectively referred to as “Third Parties”).
- This right of subrogation does not apply against insurers of policies of insurance issued to, and in the name of, the Employee or covered Dependent.

You agree as follows:

- To assign to the Program all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits it provided, plus reasonable costs of collection.
- To cooperate with the Program in a timely manner protecting its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Providing any relevant information requested by the Program.
  - Signing and delivering such documents as the Program or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or Injuries.
  - Appearing at dispositions and in court.
  - Obtaining the consent of the Program or its agents before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and the institution of legal action against a Covered Person.
• That the Program has the authority and sole discretion to resolve all disputes regarding the interpretation of the language stated herein.

• That the Program’s rights will be considered as the first priority claim against Third Parties, to be paid before any other of your claims are paid.

• That you will do nothing to prejudice the Program’s rights under this provision, either before or after the need for services or benefits under the Program.

• That the Program may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name.

• That regardless of whether or not you have been fully compensated or made whole, the Program may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the Program.

• To hold in trust for our benefit under these subrogation provisions any proceeds of settlement or judgment.

• That the Program shall be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you.

• That you will not accept any settlement that does not fully compensate or reimburse the Program without written approval.

• To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as the Program may reasonably request from you.

• That the Program may set off from any future benefits otherwise allowed by the Program the value of benefits paid or advanced under this section to the extent not recovered by the Program.

• That the Program’s rights will not be reduced due to the Covered Person’s own negligence.

• That the Program shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.

• That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.

• That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Program Beneficiary, this section applies to the personal representative of the deceased Program Beneficiary.

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

**REIMBURSEMENT TO THE PLAN**

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

**The Program**

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

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

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Self-Insured</th>
<th>Fully Insured</th>
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<tbody>
<tr>
<td>Medical</td>
<td></td>
<td>Life insurance benefits</td>
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<tr>
<td>Prescription Drug</td>
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<tr>
<td>Dental</td>
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<tr>
<td>Vision Care</td>
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</table>

**Definition**

As claims are made, covered benefits are paid from the Company’s general assets. In addition, the Company has administrative services contracts with third-party administrators to decide and to process claims.

An Insurance Carrier is a legal reserve life insurance company selected by the Company that provides administrative services. The Insurance Carrier insures coverages and makes benefit payments. The Company pays premiums to the Insurance Carrier for coverages from its own funds as well as Employee payroll deductions.

**APPLICABLE LAW**

The plans are governed and construed in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), and in the event that any reference shall be made to state law, the laws of the state of Illinois shall apply.

**LEGAL ACTION LIMITATIONS**

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

**HIPAA PRIVACY AND SECURITY**

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

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

This SPD issued May 2011

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This is only a brief summary of HIPAA. As a participant in the plans listed in this section, you have received a “privacy notice” that more fully describes the important uses and disclosures of protected health information and your rights under the HIPAA privacy provisions. If you need a free copy of this notice, you should contact the Manager of Compliance and Controls of the Company’s Compensation and Benefits Department at (309) 675-1000.

RELATIONSHIP WITH PROVIDERS

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

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

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

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

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

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

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

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

INCENTIVES TO PROVIDERS

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

Examples of financial incentives for Network Providers are:

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

The methods used to pay specific Network Providers may vary. From time to time, the payment method may change. If you have questions about whether your Network Provider’s contract includes any financial incentives, the Company encourages you to discuss those questions with your Provider. You may also contact the Claims Administrator at the telephone number on your ID card or in the section entitled Contact Information beginning on page 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 Program. If you do not provide this information upon request, the Company or the Claims Administrator may delay or deny payment of your benefits.

By accepting benefits under the Program, you authorize and direct any person or institution that has provided services to you to furnish the Company or the Claims Administrator with all information or copies of records relating to the services provided to you. The Company or the Claims Administrator 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 Employee’s enrollment form. The Company and the Claims Administrator agree that such information and records will be considered confidential.

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

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

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

**EXAMINATION OF COVERED PERSONS**

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

**CERTIFICATES OF CREDITABLE COVERAGE**

When your or your Dependent’s coverage for medical or dental benefits ends, the Program automatically provides you or your Dependents with a certificate of creditable coverage. If you or your Dependents elect COBRA continuation coverage, another certificate of creditable coverage is provided when COBRA continuation coverage ends. These certificates are important because they may enable you to reduce any Pre-existing Condition exclusion period under the plan of your next employer. You should keep the certificate with your other important papers. If you do not receive a certificate, or if you lose the certificate, you may request another one by contacting the Plan Administrator within 24 months after your coverage ends.

**WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998**

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

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

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

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

**STATEMENT OF RIGHTS UNDER THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT**

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

**STATEMENT OF ERISA RIGHTS**

As a participant in the employee benefit plans described in this SPD, you are entitled to certain rights and protections under 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, all documents governing the plans, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plans, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plans’ annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

**Continue Group Health Plan Coverage**

Continue health care coverage for yourself, Spouse 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.

Reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a Pre-existing Condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Prudent Actions by Plan Fiduciaries**

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

**Enforce Your Rights**

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

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

Assistance with Your Questions

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

General Information

<table>
<thead>
<tr>
<th>General Contact Information</th>
<th>United Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination Notification</td>
<td>(866) 228-4215</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.myuhc.com">www.myuhc.com</a></td>
</tr>
<tr>
<td>Caterpillar Benefits Center</td>
<td>(877) 228-4010 [Outside the U.S. 718-354-1345]</td>
</tr>
<tr>
<td></td>
<td><a href="http://resources.hewitt.com/cat">http://resources.hewitt.com/cat</a></td>
</tr>
<tr>
<td>COBRA Administrator</td>
<td>Caterpillar Benefits Center</td>
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<tr>
<td></td>
<td>(877) 228-4010 [Outside the U.S. 718-354-1345]</td>
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<td><a href="http://resources.hewitt.com/cat">http://resources.hewitt.com/cat</a></td>
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<td>For HRA Benefits only:</td>
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<td>Extend Health</td>
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<tr>
<td></td>
<td>(866) 766-6087</td>
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<tr>
<td>Caterpillar HR Service Center – Americas</td>
<td>(800) 447-6434</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:HR_Service_Center@cat.com">HR_Service_Center@cat.com</a></td>
</tr>
<tr>
<td>General Health and Welfare Benefit Information</td>
<td><a href="http://www.cathealthbenefits.com">www.cathealthbenefits.com</a></td>
</tr>
<tr>
<td>MetLife National Benefit Center for Caterpillar</td>
<td>(888) 228-1811</td>
</tr>
<tr>
<td></td>
<td>metlife.com/mybenefits</td>
</tr>
</tbody>
</table>

Plan Sponsor: Caterpillar Inc.
100 NE Adams Street
Peoria, IL 61629-4190
(309) 675-1000

Employer Identification Number: 37-0602744

Agent for Legal Service: Caterpillar Inc.
Attn: Legal Services Division
100 NE Adams Street
Peoria, IL 61629-7310
(309) 675-1000

Plan Information

<table>
<thead>
<tr>
<th>Plan Name/Type</th>
<th>Plan Number</th>
<th>Funding/Claims Administrator</th>
<th>Plan Administrator</th>
<th>Plan Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caterpillar Inc. Retiree Benefit Program</td>
<td>501</td>
<td>Medical benefit Claims are administered by: United Healthcare Insurance Company P.O. Box 150450 450 Columbus Blvd. Hartford, CT 06115-0450 (866) 228-4215 <a href="http://www.cathealthbenefits.com">www.cathealthbenefits.com</a> Prescription drug benefit claims are administered by: RESTAT 11900 West Lake Park Drive Milwaukee, WI 53224 (877) 228-7909</td>
<td>Caterpillar Inc. Attn: Plan Administrator – Retiree Benefit Program 100 NE Adams Street Peoria, IL 61629 (309) 675-1000</td>
<td>The 12-month period ending December 31</td>
</tr>
</tbody>
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This SPD issued May 2011
YEBB3303a
<table>
<thead>
<tr>
<th>Plan Name/Type</th>
<th>Plan Number</th>
<th>Funding/Claims Administrator</th>
<th>Plan Administrator</th>
<th>Plan Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.cathealthbenefits.com">www.cathealthbenefits.com</a></td>
<td>Dental benefit claims are administered by: CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037 (800) 244-6224 <a href="http://www.cathealthbenefits.com">www.cathealthbenefits.com</a></td>
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<td>HRA Benefits are administered by: Your Spending Account P.O. Box 785040 Orlando, FL 32878-5040 (866) 766-6087</td>
<td></td>
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<tr>
<td></td>
<td>Life insurance claims are administered by: MetLife P.O. Box 14406 Lexington, KY 40511 metlife.com/mybenefits (888) 228-1811</td>
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This SPD issued May 2011
YEBB3303a 97
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 Program 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. The Annual Deductible amounts shall be established from time to time by the Plan Administrator in its sole discretion and as such Annual Deductible amounts may be different for different categories of Participants or services.

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

Annual Maximum Benefit – The maximum amount paid for Covered Dental Services during a calendar year for a Covered Person under the Program. The Annual Maximum Benefit is stated in the Schedule of Dental Benefits beginning on page 58.

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

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

Care CoordinationSM – A program provided by the Program Claims Administrator designed to encourage an efficient system of care for Covered Persons by identifying and addressing possible unmet covered health care needs.

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

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

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

COBRA Administrator – The Company or its designee that provides COBRA services for the plans.
Co-insurance – The charge you are required to pay for certain Covered Health Services or Covered Dental Services, after satisfaction of the Annual Deductible. The Co-insurance amounts shall be established from time to time by the Plan Administrator, in its sole discretion, and such Co-insurance amounts may be different for different categories of Participants or services. Co-insurance is typically a percentage of Eligible Expenses.

Company – Caterpillar Inc.

Compounded Drug - A product not commercially available that is the result of the combining, mixing, or altering of two or more ingredients (one of which is a prescription drug) in order to create a customized medication for an individual patient in response to a written order of a Physician, or his or her legally licensed agent who is acting within the scope of his or her license.

Continuous Creditable Coverage – Health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the Uniformed Services, and for their dependents.
- A Medical Care program of the Indian Health Services Program or a tribal organization.
- A state health benefits risk pool.
- The Federal Employees Health Benefits Program.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the Peace Corps Act.
- State children’s health insurance program.
- Health plans established or maintained by foreign governments or political subdivisions and by the U.S. government.
- Any health coverage provided by a governmental entity.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

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

Cosmetic Procedures – Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Care CoordinationSM (which is the Claims Administrator).

Covered Dental Service(s) – Dental care or treatment provided by a Dentist to a Covered Person, provided such care or treatment is recognized, in the sole discretion of the Claims Administrator, as a generally accepted form of care or treatment according to prevailing standards of dental practice. A Covered Dental Service is a dental service or supply described in Covered Dental Services beginning on page 57 under the Dental Benefits section of this SPD as a Covered Dental Service, which is not excluded as set forth herein. Covered Dental Services must be provided:
• When the Program is in effect; and
• Prior to the effective date of any applicable individual termination conditions set forth in this SPD; and
• When the person who receives services is a Covered Person and meets all eligibility requirements specified in the Program.

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

Covered Health Service(s) – Those health services provided for the purpose of diagnosing or treating a Sickness, Injury, Mental Illness, Substance Abuse or their symptoms. A Covered Health Service is a health care service or supply described in What’s Covered – Benefits subsection beginning on page 18 under the Medical Benefits section of this SPD as a Covered Health Service, which is not excluded as set forth herein. Covered Health Services must be provided:

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

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

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

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

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

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

Custodial Care – Services that:

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

Dentist – Any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental services, perform dental surgery or administer anesthetics for dental surgery.
**Dependent** – The retiree’s legal Spouse or Dependent child of the retiree or the retiree’s Spouse who is not an individual eligible in their own right. For purposes of this definition of Dependent, Dependent child includes Dependent children identified in the Eligibility section of this SPD.

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

**Designated United Resource Network ("URN") Facility** – A Hospital that the Claims Administrator, in its sole discretion, names as a Designated United Resource Network Facility. A Designated United Resource Network Facility has entered into an agreement with the Claims Administrator to render Covered Health Services for the treatment of specified diseases or conditions. A Designated United Resource Network Facility 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 United Resource Network Facility.

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

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

**Eligible Expenses** –

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

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

Eligible Expenses are based on either of 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 sole discretion by either (i) calculating Eligible Expenses based on available data resources of competitive fees in that geographic area (Reasonable 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 sole discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

• 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 source or determination that the Claims Administrator accepts.

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

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

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

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

**Eligible Person** – An individual who satisfies the eligibility requirements explained in the Eligibility section beginning on page 3.

**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.

**Employee Program** – The Caterpillar Inc. Employee Health, Life and Disability Benefit Program, as it may be amended from time to time. The Employee Program provides health, life and disability benefits to eligible employees of Caterpillar and certain subsidiaries.

**Enrolled Dependent** – A Dependent who is properly enrolled under the applicable plan.

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

**Experimental or Investigational Services** – Medical, surgical, diagnostic, psychiatric, substance abuse or other health care or dental services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time a determination by the Claims Administrator, in its sole discretion, is made regarding coverage in a particular case, are determined to be any of the following:
• Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
• Subject to review and approval by any institutional review board for the proposed use; or
• The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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

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

Healthcare Benefit Service – The service used for purposes of determining the amount allocated to a retiree’s (and the retiree’s spouse, if applicable) HRA Account and is equal to the sum of the following:

• For periods of service prior to January 1, 2011, the years of “credited benefit service” (rounded down to the nearest whole year) determined under the Caterpillar Inc. Retirement Income Plan.
• For periods of service on or after January 1, 2011, the years (rounded down to the nearest whole year) of service determined under Caterpillar’s 401(k) plans for purposes of determining “points” thereunder.

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

Hearing Aid – An electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mold, if necessary.

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

Hospice Agency – A Hospital, Home Health Care Agency or other agency or organization approved by the Plan Administrator, in its sole discretion, which meets each of the following requirements:

• Has Hospice Care available twenty-four (24) hours a day;
• Meets licensing or certification standards set forth by the jurisdiction in which it performs services;
• Provides or arranges for the following services as appropriate: (1) services of a Physician; (2) physical or occupational therapy; (3) part-time home health aide services which mainly consist of caring for terminally ill persons; and (4) Inpatient care in a facility when needed for pain control and acute and chronic symptom management;
• Establishes policies governing the provision of Hospice Care; and
• Keeps clinical records on each patient.
Hospice Care – Care given to a terminally ill person by or under arrangements with a Hospice Agency. A person is terminally ill if the medical prognosis is that the patient’s life expectancy is six months or less if the illness runs its normal course. Generally, Hospice Care is continuous care designed to give supportive care to people in the final phase of a terminal illness focusing on comfort, pain control, and quality if life. Services provided may include drugs to control pain and manage other symptoms, medical supplies and equipment, medical social services, dietary and other counseling, and home care. Hospice Care may also apply to a professional facility that provides care to dying patients who can no longer be cared for at home and as an alternative to hospitalization.

Hospital – An institution, operated as required by law, which:

• Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals, with care provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
• Has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

HRA Account - The notional accounts established by the Company in your name and the name of your Spouse to track health reimbursement amounts. The HRA Account is not a funded account and does not hold segregated assets.

HRA Benefits - The Health Reimbursement Arrangement under the Program established to reimburse eligible retirees and their Spouses for eligible healthcare expenses.

Initial Enrollment Period – The initial period of time, as determined by the Plan Administrator, during which Eligible Persons may enroll themselves and their Dependents under the plan.

Injury – Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient – A patient stay that is an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

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

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

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

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

Maximum Out-of-Pocket – The maximum amount you pay out-of-pocket every calendar year after the Annual Deductible is met. 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;
• Charges that exceed Eligible Expenses including any amounts over Reasonable and Customary; and
• Any Co-payments and Co-insurance for services received from a non-Network Provider 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.

**Maximum Plan Benefit** – The maximum amount the Company will pay for any benefits during the entire period of time that you are enrolled under the Program, or any other plan of the Plan Sponsor.

**Medical Care** – Services or products furnished by a Provider acting within the scope of his or her professional license and training for the prevention, diagnosis, examination, care or treatment of a Participant’s Injury or Sickness, that are (a) prescribed, administered, or recommended by a Physician acting within the scope of his or her professional license; and (b) within the definition of “medical care” under Section 213(d) of the Internal Revenue Code.

**Medicare** – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

**Mental Health Provider** – A state-licensed mental health professional who meets the required education of master’s level, psychologist, or doctorate level degree.

**Mental Health Services** – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

**Mental Illness** – Those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Program.

**Necessary** – Covered Health Services and Covered Dental Services and supplies which are determined by the Claims Administrator, in its sole 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 in its sole discretion;
• 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 Plan Sponsor or a designee (directly or through one or more other organizations) of the Plan Sponsor to provide Covered Health Services to Covered Persons.

A Provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services. In this case, the Provider will be a Network Provider for the Covered Health Services included in the participation agreement, and a non-Network Provider for other Covered Health Services. The participation status of Providers may change from time to time.

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

Network Pharmacy - Any Physician, pharmacy or other organization licensed to dispense drugs which has entered into an agreement to provide prescription drugs under the Program.

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

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

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 or as a result of accidental Injury and which require repositioning of teeth to establish normal occlusion.

Outpatient – A patient stay at a Hospital or other health care facility that is not Inpatient.

Participating Company – A subsidiary or Affiliate of Caterpillar Inc. that adopts the Program for the benefit of its eligible retirees with the approval of Caterpillar Inc.

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 (except with respect to disability claims and certification thereof), 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. The Plan Administrator for each of the plans included in this SPD is listed in the Plan Information chart beginning on page 96.

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

Preferred Network Pharmacy - a Network Pharmacy that is designated by the Company as a preferred provider.

Pregnancy – Includes all of the following:

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

**Primary Residence** – The location in which the Participant primarily resides and which is reported to the Plan Administrator.

**Provider** – A Hospital, Physician, or Mental Health Provider or other individual designated by the Company, in its sole discretion, as an eligible Provider, providing health care services or supplies within the scope of their license that may be subject to reimbursement under the Program.

**Reach Age 65** – For purposes of medical benefits under the Program, an individual reaches age 65 on: (1) the first day of the month immediately preceding the month during which the individual’s 65th birthday occurs if the birthday occurs on the first day of the month; or (2) the first day of the month during which the individual’s 65th birthday occurs if the birthday occurs on any day other than the first day of the month.

**Reasonable and Customary** – As determined in the sole discretion of the Claims Administrator, the usual charge made by the Physician, person or organization providing the service to persons or organizations within the area for services comparable in nature and complexity, or in excess of the charge that would have been made had no coverage been in effect. The term “area” means a county or such greater area as is necessary to obtain a representative cross-section of Physicians’, persons’ and organizations’ charges for such services.

**Semi-private Room** – A room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

**Service Area** – A geographic area, as determined by the Plan Administrator, in its sole discretion, in which a specific Network is designated to provide services or supplies in connection with a specific benefit or program of benefits under the Program.

**Sickness** – Physical illness, disease or maternity services.

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

**Spouse** – The person of the opposite sex who is legally married to you.

**Substance Abuse Services** – Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Program. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

**Traditional Healthcare Benefits** – The healthcare coverage described in the *Traditional Medical Coverage*, *Traditional Prescription Drug Coverage* and *Traditional Dental Coverage* sections of this SPD as well as the HMO benefits and the United Healthcare Choice Plan benefits provided under the Program. HRA Benefits are not Traditional Healthcare Benefits and individuals who are eligible for HRA Benefits are not eligible for Traditional Healthcare Benefits.

**Unproven Services** – Services that, in the sole discretion of the Claims Administrator, are not consistent with conclusions of prevailing medical or dental research which demonstrate that the health or dental service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

• Well-conducted, randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
• Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical or dental research, based on well-conducted, randomized trials or cohort studies, as described.

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

**Urgent Care 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.