Summary Plan Description

Terex Corporation
Health and Welfare Benefits Plan

Effective Date of Amended Plan: January 1, 2019

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INTRODUCTION

Your Benefits Plan

Terex is pleased to present its health and welfare benefit plan, a comprehensive plan to help you meet the needs of your *family* and to protect you and your *family* from the high cost of health care services. The amended *Plan* became effective January 1, 2019, and provides:

- medical,
- prescription drug,
- dental,
- vision,
- life insurance,
- accidental death and dismemberment,
- short-term *disability*,
- long-term *disability*,
- flexible spending accounts,
- an employee assistance program,
- health advocacy services and,
- a group legal service**.**

The *Plan*, as described in this Summary Plan Description (SPD), represents Terex's continuing interest in helping you meet your financial responsibilities for your *family*'s health care.

This SPD outlines eligibility requirements, services covered, and *Plan* limitations, as well as how to file a claim and how to find an answer when you have a question. We recommend that you read all of this SPD because many of the topics are interrelated; reading just one or two parts may result in a misunderstanding. As you review the material, please note that the words and phrases that you find in *italics* are further explained in the Plan Definitions section. If you have any questions that do not appear to be covered in this SPD, please contact the appropriate *claims administrator* listed on the inside front and back covers of this book. The *claims administrators* keep the records of individual *Plan participants* and perform claims processing services for the *Plan.*

Cafeteria Plan Benefits

The Terex Corporation Health and Welfare Benefits Plan includes a Cafeteria Plan. A Cafeteria Plan is a plan that allows you to choose between different benefit options that are offered. The choice of your health benefit options allows you to tailor your benefits package to your needs and/or the needs of your *family*. The Cafeteria Benefits Plan is governed by Section 125 of the Internal Revenue Code ("Code") and allows your payroll deductions to be made on a pre-tax basis for some of these benefits. This is a tax-saving advantage which allows you to take home more spendable income.

Your Social Security taxes (FICA) may be slightly reduced because of the *Plan*'s pre-tax arrangement under Section 125. This in turn could reduce the amount you receive as Social Security benefits at retirement or in case of *disability*.

Because premiums that are paid on a pre-tax basis have already been deducted from your taxable income, you are not able to claim them as a tax-deductible expense when you file your income tax return. If you have any questions, you should contact a tax advisor or tax preparer.

Certain benefits, such as voluntary Team Member Life insurance and Short-Term and Long-Term *Disability* coverage, allow the *team member* to choose whether their payroll deductions for these selected benefits will be deducted from their pay check either pre-tax or post-tax. Generally, when you elect a benefit to be paid for with pre-tax dollars, you will be required to pay tax on the actual benefit received if and when you have a claim. Alternatively, if a benefit is elected as a post-tax benefit, the premium cost is deducted from your pay check after your payroll taxes have been calculated and the actual benefit received if and when a claim is made would be paid to you free of personal income taxes. Terex cannot advise you as to which tax treatment may be best for you, so if you are in doubt, it is recommended that you speak with a personal tax advisor.

The Cafeteria Plan offers you flexibility in the following benefit options:

- medical coverage, including a Health Savings Account (HSA) option that allows you to choose to set aside pre-tax dollars to pay for qualified out of pocket expenses (as defined by the IRS).
- dental coverage,
- vision coverage,
- A health care flexible spending account that allows you to choose to set aside a portion of your pre-tax dollars to cover health care expenses that are not covered by this *Plan's* medical, dental, and/or vision benefits or by any other plan or policy you may have,
- a dependent care flexible spending account that allows you to choose to pay for work-related dependent day care expenses with pre-tax dollars,
- life insurance coverage,
  accidental death and dismemberment coverage,
- short-term *disability* coverage, and
- long-term *disability* coverage.

You may change your per pay period HSA contributions at any time during the year. Your local Human Resources representative can help you make this change.

Flexible spending accounts, or FSAs, are outlined in further detail in the Flexible Spending Account section of this Summary Plan Description.

Tobacco Free Discount for Team Member Medical Paycheck Contributions is provided to a team member's medical contribution when the team member attests to be tobacco free for more than 6 months. Alternatively, participation and completion of a Wellness program's smoking cessation coaching program will offer the discount rate for the remainder of the plan year soon after completion of the 6 week program.

The following sections of this SPD describe the benefits provided according to the benefit options you elect. If you have any questions regarding this material or how the Cafeteria Plan benefits you, please contact your Human Resources Representative.

Each of these benefits has its own terms and conditions which, in all respects, control the benefits provided. The *Company* reserves the right to amend, change, or terminate the benefits described in this booklet at any time. No other oral or written statements can change the terms of a benefit in this *Plan*.

Reasonable effort has been made to keep information in this SPD accurate and up-to-date. Should there be any conflict between their provisions and this SPD, the provisions of the insurance policies, administrative contracts, and other official *Plan* documents will always prevail.

Save all Benefits Communications, including benefit descriptions, summaries of benefits, policy statements, *company* newsletters, and benefit correspondence. These documents include important information. It is your responsibility to use all this information in managing your benefits.

[This booklet constitutes the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 for the medical, prescription drug, dental, vision, life insurance, accidental death and dismemberment insurance, short term and long-term *disability*, health care flexible spending account benefits, an employee assistance program, health advocacy services and a group legal service. Certificates of coverage are available from your Human Resources Representative for the life insurance, accidental death and dismemberment, and long-term *disability* benefits.]

Preferred Provider Organization (PPO)

A preferred *provider* organization, commonly known as a PPO, is a network of *hospitals, physicians* and other non-*hospital* services rendered by a *provider,* who provide health care services at a reduced rate.

The PPO allows you to exercise control over the cost of your health care by choosing an in-network *provider*. For example:

- Benefits for *hospital* services, *physician* services, and other non-hospital services rendered by a member of the PPO are provided at a negotiated, discounted rate. These discounts translate into savings for you because your coinsurance is based on a lower dollar amount.
- Benefits for *hospital* services, *physician* services, and other non-hospital services rendered by a *provider* that is NOT a member of the PPO network are based on the *usual, customary*, *and reasonable charges*. You may receive services from an out-of-network *provider;* however, your claims will be reimbursed at a lower rate. You will be held responsible for your coinsurance **and** for any amounts over the *usual, customary, and reasonable charges*. Refer to the Medical Benefits section of this SPD for specific details.

When you receive services from a PPO service *provider,* the *provider* will submit the claim to the *claims administrator* on your behalf. Additional information about this option, as well as access to a list of participating *providers,* is available at our *claims administrator*'s websites or can be provided to covered *team members* by contacting their local Human Resources department.

Anthem Blue Cross and Blue Shield has established nationwide Preferred Provider Organization (PPO) networks of *Physician*s, *hospital*s, and other healthcare *provider*s. As a PPO member, you have access to these networks through the BlueCard PPO Program. The suitcase logo on your Anthem ID card indicates that you are a member of the BlueCard PPO Program. Visit www.anthem.com/terex, search the National BlueCard Directory and select the "PPO" network; or call the Customer Service number on your Anthem ID card to locate participating *provider*s.

Notification Requirements

Generally, in-network *providers* are responsible for notifying the *claims administrator* before they provide certain services to you. There are some benefits, however, which you are responsible for notifying the *claims administrator*.

The notification requirements are designed to ensure that you receive the most appropriate and cost-effective treatment. These requirements are described in detail in the Health Management Services and the Dental Management Services sections of this SPD.

Notification does not mean benefits will be payable in all cases. Coverage depends upon the *covered health services* that are actually given, your eligibility status, and any benefit limitations this *Plan* has.

Rights and Limits

This SPD provides a general description of the *Plan* and your benefits. It is important to remember that:

- The description of benefits in this SPD replaces and supersedes any other SPD previously issued by Terex Corporation or any of its subsidiaries for this *Plan*.
- All benefits are subject to the terms, conditions, and limitations of the Terex Corporation Health and Welfare Benefits Plan as set forth in the *Plan Document.*
- No *Plan* provision is intended to provide *team members*, former *team members*, or *covered dependents* with a vested right to any benefits under the *Plan* or any rights for continued employment.
- Your rights, if any, to a benefit of the *Plan* depend upon whether you satisfy the eligibility requirements of the *Plan* for the applicable benefit and whether your submitted claims are *covered charges* under the *Plan*.
- Your rights as a participant in this *Plan* are outlined in the ERISA Information section.

Presumption of Exclusion

This *Plan* provides for those expenses expressly described within, and any omission is presumed to be an exclusion. This *Plan* covers only those procedures, services, and supplies that are determined to be *covered health services*.

ELIGIBILITY AND ENROLLMENT

Eligible Team Members

Except as otherwise provided in this SPD, all active, regular, full-time *team members* on the U.S. payroll who are regularly scheduled to work an average of 30 hours per week or more are eligible on the first of the month coinciding with or following 30 days of continuous employment from the date of hire. *Team members* who are already eligible and (i) who are scheduled to work at least 20 hours per week and who participate in a state shared work program, or (ii) who return to work from a *Company*-approved leave of absence on a return-to-work agreement for 20 hours or more per week are also eligible to participate in the *Plan*. Temporary *team members* are not eligible except as indicated above. If the *team member's* status changes from temporary employment to regular employment, time served as a Terex temporary *team member* in the preceding 12-month period may count towards the waiting period.

A *team member* who is absent due to a health factor is considered to be *actively at work* for eligibility purposes of the *Plan.* However, you must have actually reported for your first day of employment in order to be eligible for any benefits, even if all other eligibility requirements have been met.

In no event will leased *team members* or independent contractors be eligible to participate in this *Plan*.

Eligibility for Married Team Members **(includes opposite gender and same gender spouses)**

A *team member* may enroll in the *Plan* either as a *team member* or as a *covered dependent* of his or her *spouse* who is enrolled in the *Plan*, but not as both.

If both parents are *team members* and are enrolled separately in this *Plan*, then each eligible *dependent child* may be the *covered dependent* of only one parent.

Eligibility for Dependents who become Team Members

A covered *dependent* hired by Terex in a position that provides eligibility for this plan as a *team member*, can no longer be covered as a *dependent* on their parent's benefits. The *dependent* must enroll according to the new hire rules for eligible *team members* and the parent is required to make a special enrollment to remove that *dependent* from their own coverage effective with the date the *dependent* became benefits eligible with Terex. The newly hired dependent will be provided with the Terex default benefits package should they fail to enroll in their own benefits within the allowed new hire enrollment timeframe.

Reinstatement of Coverage for Rehires

If you terminate your employment with Terex and are subsequently rehired within one year of your termination date, you may re-enroll in this *Plan* effective on the first day of the month coinciding with or following your return to work without completing the waiting period, if it had already been met. If you had accumulated any amount toward that calendar year's annual deductible or annual or lifetime benefit maximums, those amounts count toward your new deductible for that year and any applicable annual or lifetime benefit maximums once you re-enroll.

If you return to *actively at work* status more than one year from the last date worked, your conditions of enrollment in the *Plan* are as a newly hired *team member.*

Effect of Eligibility on Employment

This *Plan* or your eligibility for benefits under it shall not be deemed to constitute a contract of employment between Terex and you or a consideration or inducement for your employment. Nothing in this *Plan* shall be deemed to give you a right to be retained in the service of Terex or to interfere with the *Company's* right to discharge you at any time regardless of the effect such discharge will have upon you as a *team member* in this *Plan*.

Eligible Family Members and Effective Dates

Eligible *family* members may participate in certain benefits of this *Plan* if you, the *team member,* elect a level of dependent coverage as provided by this *Plan.*

Eligible *family* members are a *team member*'s legally married *spouse (opposite gender or same gender)*, and a *dependent child.* However, any *dependent child* who is a "child" (as that term is defined by Code Section 152(f)) will be eligible only through the end of the month in which the child's 26th birthday occurs.

Notwithstanding this paragraph to the contrary, former *spouses*, common law *spouses* and domestic partners are NOT eligible *family* members for purposes of benefits in this *Plan*.

Benefits for a *covered dependent* begin on the same date as the *team member's benefits* if the *covered dependent* is enrolled at the same time as the *team member.* See the Plan Enrollment section for further information.

Spousal Surcharge for Spouse with Other Employer Coverage Available

A spousal surcharge (additional fee) will be added to the team member's cost for any medical option selected when electing to cover a spouse in a Terex medical benefits when his or her employer offers coverage to that spouse.

It is your responsibility to notify your local Human Resources Department when you divorce, or your child no longer meets the definition of a *covered dependent*. Enrolling and/or submitting claims for a person not meeting the definition of a *covered dependent* is a fraudulent act. Any *team member* who enrolls or submits a claim for an ineligible person may be subject to disciplinary action, up to and including termination of employment. You will also be required to reimburse Terex for any claims paid by the *Plan* or expenses, penalties, or taxes *incurred* by Terex.

Eligibility for Dependent Children

All of the *team member*'s natural children, eligible foster children, stepchildren, legally adopted children from the date the *team member* assumes legal responsibility, and children for whom the *team member* assumes legal sole or co-guardianship are eligible for benefits in this *Plan*. Also included are the *team member*'s children or children of the *team member*'s Spouse for whom the *team member* has legal responsibility resulting from a valid court decree.

In any instance above, the eligibility of a *dependent child* will terminate at the end of the month in which he or she turns age 26, unless he or she is *disabled* as described below.

Eligibility for Disabled Children

In order for a *disabled dependent child* to be eligible for coverage under the *Plan* after the end of the month in which his or her 26th birthday occurs, he or she:

- must be incapable of self-support because of mental retardation or a permanent, chronic, and *total disability* that commenced prior to age 26,
- must be principally supported by the *team member*, and
- must be continuously *totally disabled* and covered thereafter.

If you believe a *covered dependent* of yours meets the *total disability* criteria above, obtain a statement from the attending *physician* indicating the complete diagnosis and prognosis of the *covered dependent*. This information must be submitted to a Human Resources Representative within 31 days of the end of the month in which the *covered dependent*'s 26th birthday occurs. This information will be reviewed by the *Plan* to determine eligibility for continued benefits under the *Plan*. You may be required to submit additional information in connection with the eligibility determination.

You will be notified if the *covered dependent* is eligible for benefits under the *Plan* as a *disabled dependent child*. If such eligibility is approved, you may be further required, usually not more frequently than once a year, to furnish satisfactory evidence to substantiate the continued eligibility of such a *covered dependent* for benefits under the *Plan*.

Qualified Medical Child Support Orders

This *Plan* complies with all *Qualified Medical Child Support Orders (QMCSOs)*.

The *QMCSO* will require that the *Plan* cover the children even if the *team member* does not want to enroll the children in the *Plan* or wishes to drop the children's medical coverage. The *team member* is required to pay for the cost of this coverage.

Plan participants and beneficiaries may obtain, without charge, a description of the procedures governing *QMCSO* determinations from the *Plan Administrator.*

When Coverage Starts for Medical Child Support Orders

For qualified orders other than those received from a state or national agency, coverage for an otherwise eligible *dependent child* will become effective on the date specified in the order, if it is received by your local Human Resources Department within 31 days after the date of the order.

For state agency orders, coverage for an otherwise eligible *dependent child* will become effective on the date the order is received by Terex.

A change in contributions, if required, will begin from the effective date of coverage for the child.

Please contact your local Human Resources representative or Benefits Department for additional information.

Plan Enrollment and Effective Date

A Human Resources Representative will provide you with information about your coverage and enrollment instructions prior to the date, or as soon as administratively possible after you become eligible for coverage.

Carefully review the material and complete the enrollment process as soon as possible, but no later than 31 days after your eligibility date.

- If you do not enroll for benefits within 31 days from the date of eligibility**,** you will only receive benefits that are paid by Terex, such as basic *team member* Life and Accidental Death and Dismemberment, Short Term *Disability* and basic *team member* Long-term *disability* coverage. To make any changes to this default coverage, you must wait until the next annual enrollment period or until you *incur* a change in status. See the Changes in Plan Elections on a Pre-Tax Basis and the Special Enrollment Periods sections.

- If you or your *spouse* has a newborn, the child's coverage begins the day of birth provided you enroll the child within 60 days of their birth. Failure to enroll the new dependent within the required period forfeits all *Plan* coverage for the new dependent. You will not have another opportunity to enroll the dependent until the next open enrollment period or if you experience a special enrollment right through a life event change. See the Changes in Plan Elections on a Pre-Tax Basis and the Special Enrollment Periods sections.

- If you or any of your *covered dependents* become covered by *Medicare* or other group coverage, notify Anthem and your local Human Resources Representative.

Special Enrollment Periods

This *Plan* provides two special enrollment periods that allow you to enroll in the *Plan* before the next annual enrollment period, even if you declined enrollment during your initial enrollment period.

Loss of Other Coverage

If you declined enrollment for yourself or your dependents (including your *spouse*) because you are enrolled in other health coverage, you may in the future be able to enroll yourself or your dependents in this *Plan* during a special enrollment period if your other coverage is lost. You must enroll no later than 31 days after the loss of your other health coverage. For example, if you lose your other health coverage on September 15, you must make your enrollment election no later than midnight eastern time on October 16.

If your dependent requests special enrollment in this *Plan* due to the loss of coverage under another plan, you and your dependent may enroll in a benefit option other than your current option if other benefit options are available under this *Plan*.

This special enrollment period is available only to the following individuals:

- **A *team member*** who is eligible for coverage under the terms of the *Plan*, is not enrolled, and, when enrollment was previously offered to the *team member* under the *Plan*, declined because he or she was covered under another group or individual health plan or had other health insurance coverage.

- **A dependent** of a *team member* (i.e., an eligible *team member* actually enrolled in the *Plan*) who is eligible for coverage under the terms of the *Plan*, is not enrolled, and, when enrollment was previously offered to the dependent under the *Plan*, declined because he or she was covered under another group or individual health plan or had other health insurance coverage.

- **A *team member* and dependent** of an eligible *team member*, in the case where they are eligible for coverage under the terms of the *Plan*, are not enrolled, and, when enrollment was previously offered to the *team member* or dependent under the *Plan*, declined because the *team member* or dependent was covered under another group or individual health plan or had other health insurance coverage.

In order for you to qualify for this special enrollment period, the following conditions apply:

- You or your dependent had COBRA continuation coverage under another plan and such COBRA has since been exhausted.
    - NOTE: Your COBRA is considered exhausted when your COBRA continuation coverage ceases for any reason other than either your failure to pay premiums on a timely basis or for improper or illegal acts (such as making a fraudulent claim or an intentional misrepresentation to the *Plan*). You are also considered to have exhausted COBRA continuation coverage if such coverage ceases (a) due to the failure of the *employer* or other responsible entity to remit premiums on a timely basis, or (b) when you no longer reside, live, or work in a service area of an HMO or similar program (whether or not within your choice) and there is no other COBRA continuation coverage available to you.
- If the "other" health coverage you or your dependent lost was not COBRA continuation coverage or COBRA coverage was not elected, the coverage was terminated either due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, an individual no longer living or working in the service area of an HMO, a child ceasing to be a dependent, or because the plan no longer offers any benefits to a class of similarly situated individuals), or because employer contributions for the coverage were terminated.
    - You will **NOT** be considered to have a loss of eligibility (see above) if you lose the coverage:
        - as a result of a spouse's or dependent child's employer's open enrollment period, where coverage is dropped voluntarily, or
        - as a result of your failure to pay premiums on a timely basis, or
        - for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).
- To have special enrollment rights for loss of coverage, you must completely exhaust your COBRA or other health coverage, i.e., you must continue the coverage for as long as it is available to you. Therefore, if you prematurely stop your COBRA or other coverage (for example, by ceasing to pay premiums), you will not be entitled to a special enrollment period for loss of coverage.

If you meet the preceding conditions and have made an enrollment election within 31 days of loss of coverage, the enrollment of you or your dependent will be effective the date of the event.

New Dependent

If you obtain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents during a special enrollment period. You must request enrollment no later than 31 days after you obtain the new dependent by marriage, or no later than 60 days after you obtain the new dependent by birth or placement for adoption. For example, if you are married on September 15, you must enroll no later than midnight eastern time on October 16.

This special enrollment period is available only to the following individuals:

- **A *team member*** who is eligible, who is not enrolled in the *Plan*, who would be a participant except for a prior election not to enroll in the *Plan* during a previous enrollment period, and who obtains a dependent through marriage, birth, adoption, or placement for adoption.
- **The new *spouse* of a *team member*** (i.e., an eligible *team member* actually enrolled under the *Plan*).
- **The current *spouse* of a *team member*** in the case where a child becomes a dependent of the *team member* through birth, adoption, or placement for adoption.
- **A *team member* who is eligible, and the *spouse* of the *team member*,** if the *team member* is not enrolled in the *Plan,* would be a participant except for a prior election by the *team member* not to enroll in the *Plan* during a previous enrollment period, and either (a) the *team member* and the *spouse* have

just become married, or (b) the *team member* and the *spouse* have been married and a child becomes a dependent of the *team member* through birth, adoption, or placement for adoption.

- **A dependent of a *team member*** (i.e., an eligible *team member* actually enrolled under the *Plan*) who becomes a dependent of the *team member* through birth, adoption, or placement for adoption.

- **A *team member* who is eligible and a dependent of such *team member*,** if the *team member* is not enrolled in the *Plan,* would be a participant but for a prior election by the *team member* not to enroll in the *Plan* during a previous enrollment period, and the dependent becomes a dependent of the *team member* through birth, adoption, or placement for adoption.

The enrollment of you or your dependent will be effective on the following date:

- For a marriage, the date of the marriage.
- For a birth, the date of birth.
- For an adoption or placement for adoption, the date of the adoption or placement for adoption.

Retroactive *team member* contributions may not be taken on a pre-tax basis per IRS Section 125 rules. Any retroactive contributions for coverage that is retroactively provided prior to the actual date of enrollment will be deducted on an after-tax basis.

Changes in Plan Elections

Generally, you may make a change in the *Plan* options you elected at your initial enrollment **only** at the next annual enrollment period. The annual enrollment period takes place prior to the beginning of each *Plan Year*.

However, you may change your level of coverage before the next annual enrollment period if you experience a change in status. The change in coverage must be on account of and consistent with a change in status event that affects coverage eligibility of the *team member*, their legally married *spouse*, or the *team member's* child (as defined by Code Section 152(f)) who will not have attained age 27 by the end of the applicable tax year.

Note that this age 27 referenced here and those in the bullet points below, pertain to IRS tax law and not the eligibility of dependent children in this Plan.

A change in status may include:

- legal marriage

- divorce, legal separation, or annulment

- birth, adoption, or placement for adoption of a child.

- death of a *spouse*, tax dependent, or child who will not reach age 27 by the end of the tax year.

- termination or commencement of employment by you, your *spouse*, your tax dependent, or your child who will not reach age 27 by the end of the tax year.

- reduction or increase in hours of employment by you, your *spouse*, your tax dependent, or your child who will not reach age 27 by the end of the tax year (including a switch from part-time to full-time employment status or vice versa, a strike, or a lockout).

- place of residence change by you, your *spouse*, your tax dependent, or your child who will not reach age 27 by the end of the tax year that results in a change in eligibility.

- your child who will not reach age 27 by the end of the tax year satisfies or ceases to satisfy the requirements for coverage due to attainment of age or any similar circumstance as provided in the *Plan*.

- commencement or return from a leave of absence by you, your *spouse*, your tax dependent, or your child who will not reach age 27 by the end of the tax year.

- a change in worksite of you, your *spouse*, your tax dependent, or your child who will not reach age 27 by the end of the tax year.

If you experience such a change in status and wish to change your level of coverage, you must make the change within 31 days of your change in status (or within 60 days of your change in status for a birth or placement for adoption). The *Plan Administrator* reserves the right to require the applicant to submit proof of any change in status at the applicant's expense. The change in coverage generally becomes effective the date of the event. However, when applicable, retroactive *team member* contributions will be taken on a pre-tax basis only as permitted under Section 125 of the Internal Revenue Code.

If you declined coverage when first hired, you may enroll in this *Plan* during any open enrollment period.

Enrollment or Removal Periods and Status Change Coverage Start/End Date		
***Family* member**	**Must be enrolled or removed within 31 days from:**	**Coverage starts/ends**
Spouse and children added through marriage	Your date of marriage	Your date of marriage
Legal custody or sole or co-guardianship	The date of the court order	The date of the court order
Newly eligible child (other than newborn or child placed for adoption)	The date the child meets the definition of a *dependent child*	The date the child meets the definition of a *dependent child*
Loss of other group or COBRA coverage	The date the loss occurs	The next day following the date the loss occurs.
Spouse loses other group or COBRA coverage	The date the loss occurs	The next day following the date the loss occurs.
Divorce	The date of the divorce	Date of divorce for healthcare or dependent care FSA or dependent life and *Family* AD&D End of the month following date of divorce for all other benefits
Child is no longer an eligible dependent	Child is no longer an eligible dependent	End of the month in which eligibility ends
***Family* member**	**Must be enrolled within 60 days from:**	**Coverage starts**
Your newborn child	Date of birth	Date of birth
A child placed with you for adoption	Placement Date	Placement Date

TERMINATION OF COVERAGE

You and your *covered dependents* are no longer eligible for coverage effective the end of the month in which any one of the following events occurs:

- Your status as an eligible *team member* changes.
- The *Plan* is amended to make your employment classification ineligible.
- Your employment terminates* or you retire.
- The *Plan* terminates.
- You cease making the required contributions for the *team member* and/or *covered dependent* and the last period for which you made a required contribution has expired.
- You join any *military service* covered by USERRA and you choose not to continue coverage under this *Plan*.
- You elect to terminate coverage for yourself and/or *covered dependents* during the open enrollment period. In this situation, coverage will end for the affected individuals on the December 31 following the election change. In addition, you and your dependents will not be eligible for COBRA continuation coverage. Certain exceptions apply to a *spouse* in the event of a divorce.

In addition, *covered dependents* are no longer eligible for coverage effective the end of the month in which any one of the following events occurs:

- Your *covered dependent* other than your *spouse* becomes eligible for benefits as an eligible *team member* of Terex.
- Your benefits discontinue.
- Your *covered dependent* no longer meets conditions for eligibility (e.g., reaches the age limit, no longer qualifies as a “child” under Code Section 152(f), etc.). See Eligibility and Enrollment.
- You get divorced or legally separated such that your covered *spouse* is no longer eligible for coverage.
- The *Plan* is amended to make the dependent classification ineligible.
- You cease making the required contributions for the *team member* and/or *covered dependent* and the last period for which you made a required contribution has expired.
- Your *covered dependent* joins the military.

In most cases, continuation of benefits may be available. See Continuation of Coverage for more information.

*Beginning the first of the month following the month of termination and while you are receiving severance pay or supplemental unemployment benefits, your cost to continue your elected benefits will be the same as the Terex active team member monthly contribution costs. See the COBRA section of this booklet for more information on continuation of coverage.

CONTINUATION OF COVERAGE

Following is information regarding benefits continuation in certain circumstances. Please note that any collective bargaining agreement terms supersede the following language, unless required by law.

Under FMLA

This *Plan* allows for the continuation of coverage for a leave of absence, subject to the Family and Medical Leave Act of 1993 as Amended by Section 585 of the National Defense Authorization Act for FY 2008, Public Law [110-181], for up to 12 weeks in a 12-month period (or for up to 26 weeks in a 12-month period for Service Member Family Caregiver Leave).

If you are no longer *actively at work* due to an approved personal leave of absence and/or an approved medical leave of absence that commenced on or after August 5, 1993, and

- you have worked at least 1,250 hours in the past 12-month period, and
- you and your *employer* meet the criteria of the Family and Medical Leave Act of 1993 (PL 103-3) as Amended by Section 585 of the National Defense Authorization Act for FY 2008, Public Law [110-181],

then you (and your *covered dependents*) are eligible for continuation of coverage under the *Plan* for up to 12 weeks (or 26 weeks for Service Member Family Caregiver Leave), provided you continue to make the same monthly contribution as an active *team member.*

If you do not return from leave and your leave is exhausted or your employment is terminated, whichever comes first, you (and your *covered dependents*) may be eligible for continuation of coverage as described in the Continuation of Coverage Under section.

For Leave of Absence (Other Than FMLA)

If you are a full-time *team member* and obtain an approved leave of absence, you (and your *covered dependents*) are eligible for continuation of medical, dental, and vision coverage under this *Plan* for a period of up to 2 months from the first day of your leave of absence, provided that you contribute the **full cost** of coverage and you continue to be a *team member* of the *Company*. This means that you are responsible to pay both the *employer*'s and the *team member*'s portion of the contributions for group health coverage.

If you do not return from leave and your leave coverage is exhausted or your employment is terminated, you may be eligible for continuation of coverage as described in the Continuation of Coverage Under COBRA section.

For Layoff or Plant Shutdowns

Layoff: If you are a full-time *team member* and are laid off, you (and your *covered dependents*) are eligible for continuation of coverage under this *Plan* until the end of the month in which the layoff occurs provided you continue to make the same monthly contribution you were making while *actively at work.*

At the end of coverage for layoff, you may be eligible for continuation of coverage as described in the Continuation of Coverage Under COBRA section.

Shutdown: If you are a full-time *team member* and your facility experiences a **temporary shutdown,** you and your *covered dependents* are eligible for continuation of coverage under this plan for 60 consecutive days of shutdown provided you continue to make the same monthly contribution as an active *team member.*

If the shutdown is to extend beyond 60 consecutive days or you are not recalled or do not return to work after the shutdown ends, you may be eligible for continuation of coverage as described in the Continuation of Coverage Under COBRA section.

Leave for a Team Member's Own Disability

If you are an eligible *team member* and become *disabled* as determined by the Short Term Disability administrator or through Workers Compensation and obtain an approved medical leave of absence, you and your *covered dependents* are eligible for continuation of benefits under the *Plan* for up to six months from the date of *disability*, provided you continue to pay your portion of the coverage costs and remain a Terex *team member*. This means that the *Company* continues to pay its portion of the cost of coverage for you and any enrolled dependents and you must continue to pay your active *team member* contributions to Terex during your leave.

This six month period of coverage runs concurrent (at the same time as) with periods of time you qualify for benefit continuation under FMLA leave for your own medical condition.

If, at the end of six months of coverage for *disability,* you continue to be *disabled*, you may be eligible for continuation of coverage as described in the Continuation of Coverage under the COBRA section.

Continuation of Coverage for Military Leave

If you are called to active military duty, you and your *covered dependents* may be eligible for coverage under TRICARE, the *military service*'s health plan. You and your *covered dependents* may also elect to continue benefits under this *Plan* if you were covered by the *Plan* at the time you were called to military duty.

This *Plan* allows for the continuation of coverage for a military leave of absence, covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), provided you continue to pay your portion of the cost of coverage and you are a *team member* of Terex. Coverage may be continued until the earlier of:

- 24 months after your absence from work begins, or
- the day after the date on which you fail to timely apply for or return to employment as required under USERRA.

If you elect to continue coverage, you are required to pay your active *team member* contributions to Terex during your leave. Your payment is due on the first day of the month for that month's coverage. For example, for coverage in October, your share is due October 1. If your share is not paid by the last day of the applicable month, your coverage will be terminated retroactive to the last day of the previous month (September 30, in the previous example).

If you choose not to continue coverage under this *Plan* during your *military service*, you and your *covered dependents* are eligible for reinstatement of coverage on the date you return with reemployment rights guaranteed under USERRA. However, the reinstatement of coverage will be subject to any waiting periods that would have otherwise applied had you not left for *military service*. In addition, as permitted by USERRA, your coverage will not include any *illness* or *injury* determined by the Secretary of Veteran Affairs to have been *incurred* in, or aggravated during, performance of *military service*. Any other such *illness* or *injury* will be covered by the *Plan*, subject to all otherwise applicable conditions and limitations of the *Plan*.

Note: After your USERRA continuation coverage expires, you will not thereafter receive 18 months of COBRA continuation coverage. However, if your USERRA coverage expires prior to 18 months (e.g., because you do not return to employment), you may be eligible for COBRA continuation coverage for the remainder of the original 18-month continuation coverage period.

Effect of Leave of Absence on Plan Participation

If you go on leave of absence during the *Plan Year*, you have the option to continue your participation in the *Plan* and make payments according to the following options:

- For leaves in which your absence is paid, and Terex is the payor, your contributions will continue to be withheld from your leave payments.

- For leaves that are not paid by Terex or is an unpaid leave, you have two options to continue your contributions:

    - **Prepayment**: You may prepay the contributions (including those for a flexible spending account election) that will become due during your leave of absence.

    - **Pay-As-You-Go**: You may pay the contributions (including those for a flexible spending account election) that become due during your leave of absence on the same schedule as they would otherwise be taken from your pay, under the *employer*'s existing rules for payment. You may also request to pay your premiums monthly. Payments made later that 30 days after the due date will result in a termination of benefits for non-payment.

The *Plan Administrator*, at its sole discretion, may make the determination of which of the above payment options will apply. Speak with your Human Resources department for more information regarding your specific leave.

When returning from any qualified Leave of Absence where your coverage was terminated during your leave (for non-payment or any other reason), your return will be considered a change in status, allowing you to reenroll in benefits. These benefits will become effective on the date you return from leave and you will have 31 days from your return date to make your elections.

Uniformed Services Under USERRA – Flexible Spending Account (FSA)

If you are absent from employment because you are in "uniformed services" as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA), you may elect to continue your coverage under this *Plan* for the period of *Company*-approved leave, up to 24 months from the date the absence begins. To continue your coverage, you must comply with the terms of the *Plan* and pay your contributions in accordance with the procedures outlined above for a *team member* who goes on FMLA leave.

Upon Retirement

If you are a full-time *team member,* and retire while you are covered by the benefits of the *Plan*, you (and your *covered dependents*) may be eligible for continuation of coverage as described in the Continuation of Coverage Under COBRA section.

COBRA

Continuation of Coverage Under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). COBRA continuation coverage may become available to you when you otherwise would lose your group health, dental, vision, prescription drug, and/or health care FSA coverage. It may also become available to other members of your *family* who are covered under the *Plan* when they otherwise would lose their group health, dental, vision, prescription drug, and/or health care FSA coverage.

Qualifying Events for Covered Team Members and Family Members

COBRA provides a continuation of coverage when coverage otherwise would end because of a qualifying event. Specific qualifying events are listed below. When you experience a qualifying event, the *Plan* generally must offer COBRA continuation coverage to each person who is a *qualified beneficiary*. You, your *spouse*, and your *dependent children* may become *qualified beneficiaries* if coverage under the *Plan* is lost because of a qualifying event.

If you are a covered *team member* (meaning you are a *team member* and are enrolled and covered under the *Plan*), you will become a *qualified beneficiary* if you lose your coverage under the *Plan* due to either of the following qualifying events:

- Your hours of employment are reduced, making you ineligible for the Plan.
- Your employment ends (including retirement) for any reason other than your gross misconduct.

Your *spouse* will become a *qualified beneficiary* if your *spouse* loses coverage under the *Plan* due to any of the following qualifying events:

- You die*
- Your hours of employment are reduced, making you ineligible for the Plan.
- Your employment ends for any reason other than your gross misconduct.
- You become entitled to *Medicare* benefits. (*Medicare* entitlement is rarely considered a qualifying event, since it will typically not cause a loss of coverage under the terms of the *Plan*.)
- You become divorced or legally separated from your *spouse*.

Your *dependent children* will become *qualified beneficiaries* if they lose coverage under the *Plan* due to any of the following qualifying events:

- You die*
- Your hours of employment are reduced, making you ineligible for the Plan.
- Your employment ends (including retirement) for any reason other than your gross misconduct.
- You become entitled to *Medicare* benefits. (*Medicare* entitlement is rarely considered a qualifying event, since it will typically not cause a loss of coverage under the terms of the *Plan*.)
- You and your *spouse* become divorced or legally separated.
- A child ceases to be eligible for coverage under the *Plan* as a *dependent child*.

COBRA continuation coverage procedures include specific notice requirements for the *employer*, for the *qualified beneficiary*, and for the *Plan Administrator*. The *employer* will notify the *Plan Administrator* within 30 days of the date of certain qualifying events. Complete instructions on how to elect COBRA continuation coverage will then be provided by the *Plan Administrator* to you within 14 days of its receipt from the *employer* of the notice of your qualifying event. You will then have 60 days in which to elect COBRA continuation coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If you do not elect COBRA continuation coverage within that 60-day period, then your right to elect COBRA continuation coverage will cease. Refer to the Providing Notification and Election Notices section of this SPD for the specific name and address of where to send or hand-deliver the notices.

Each *qualified beneficiary* generally will have an independent right to elect COBRA continuation coverage. Covered *team members* may elect COBRA continuation coverage on behalf of their *spouses* and *dependent children*.

Upon your death while employed by Terex, the cost of COBRA coverage for your spouse and dependents already covered for medical, dental, and/or vision in this Plan, will be at no charge to them and paid by Terex for the first 6 months after the team member's death. The full cost of COBRA coverage will be required beginning with the seventh month and all subsequent months thereafter.

Notice from a Qualified Beneficiary

The *Plan* will offer COBRA continuation coverage to *qualified beneficiaries* only after the *Plan Administrator* has been notified that a qualifying event has occurred.

The *qualified beneficiary* must notify the *Plan Administrator* when any of these qualifying events occurs:

- Divorce.
- Legal separation.
- Child's loss of dependent status.
- A second qualifying event after an individual has become entitled to COBRA continuation coverage with a maximum duration of 18 (or 29) months. (This requirement does not apply to health care FSAs.)

The *qualified beneficiary* must notify the *Plan Administrator* in writing by the date that is 60 days after the latest of:

- The date of the qualifying event.
- The date coverage would be lost under the *Plan*.

The following actions must then be taken:

◊ The *Plan Administrator* must notify the *qualified beneficiary* within 14 days after such preceding notice of his or her election rights for COBRA continuation coverage. In certain cases, the preceding notice requirement may be extended up to 44 days.

◊ The *qualified beneficiary* must then notify the *Plan* in writing within 60 days after such preceding notice if he or she wants COBRA continuation coverage. Waiver of coverage is automatic if no election is received within 60 days.

Each *qualified beneficiary* making notice to the *Plan* may obtain a qualifying event notice from the *Plan Administrator*, free of charge. The qualifying event notice will highlight what information the *qualified beneficiary* must provide. Alternatively, the *qualified beneficiary* can provide his or her own notice that contains all of the required information as outlined under the Required Contents of the Notice section of this SPD.

If you have already begun receiving COBRA continuation coverage due to the *team member*'s termination of employment or reduction in hours and one of these events occurs:

- Death of *team member*.
- Divorce.
- Legal separation.
- Child's loss of dependent status.

COBRA continuation coverage may be extended up to 36 months from the date of the original qualifying event. (This extension is not available for health care FSAs.)

The following action must be taken:

◊ The *qualified beneficiary* must notify the *Plan* in writing within 60 days that the event has occurred and whether or not he or she wants the additional COBRA continuation coverage.

If you have already begun receiving COBRA continuation coverage and one of these events occurs:

- Former *team member* or his/her spouse gives birth.

- Former *team member* adopts a child.

The former *team member* is entitled to add the newborn or newly adopted child to the *Plan* as a *qualified beneficiary*.

The following action must be taken:

◊ The *qualified beneficiary* must notify the *Plan Administrator* of the birth or adoption within 30 days of the event.

Notice from an Employer

The *Plan* will offer COBRA continuation coverage to *qualified beneficiaries* only after the *Plan Administrator* has been notified that a qualifying event has occurred.

The *employer* must notify the *Plan Administrator* when any of these qualifying events occurs:

- Death of *team member*.
- Termination of employment.
- Reduction in hours, making you ineligible for the Plan .
- Covered *team member*'s entitlement to *Medicare*. (*Medicare* entitlement is rarely considered a qualifying event, since it will typically not cause a loss of coverage under the terms of the *Plan*.)
- Commencement of *employer*'s bankruptcy proceedings.

The following actions must then be taken:

◊ The *Plan Administrator* must notify the *qualified beneficiary* within 14 days of his or her election rights for COBRA continuation coverage. In certain cases, the preceding notice requirement may be extended up to 44 days.

◊ The *qualified beneficiary* must respond in writing within 60 days of the later of the date of the *Plan Administrator's* notice or the loss of coverage, notifying the *Plan* if he or she wants COBRA continuation coverage. Waiver of coverage is automatic if no election is received within this 60-day period.

COBRA Continuation Coverage for a Disabled Qualified Beneficiary

The following provisions apply to a *qualified beneficiary* who is eligible for COBRA continuation coverage as a result of the covered *team member*'s *termination* of employment or reduction in hours and is determined by the Social Security Administration to be *disabled*:

The *disabled qualified beneficiary* may elect to extend COBRA continuation coverage for the applicable benefits (except health care FSAs) from 18 months to 29 months. This extension to 29 months of coverage applies to all *qualified beneficiaries* who have lost coverage under the *Plan* due to the covered *team member*'s termination of employment or reduction in hours, and who have elected COBRA continuation coverage. The *qualified beneficiary*'s *disability* must occur or be determined to be in existence within the first 60 days of COBRA continuation coverage. The *disability* must be recognized by the Social Security Administration. The *qualified beneficiary* must submit proof of this *disability* in writing to the *Plan Administrator* prior to the end of his or her 18th month of COBRA continuation coverage AND by the date that is 60 days after the latest of:

- The date of the *disability* determination by the Social Security Administration.
- The date on which the qualifying event occurs.
- The date on which the *qualified beneficiary* loses or would lose coverage under the *Plan*.

The *Plan Administrator* may charge the *disabled qualified beneficiary* with COBRA continuation coverage up to 150% of the applicable contributions for the COBRA continuation coverage for the 19th through 29th months of COBRA continuation coverage.

A *qualified beneficiary* who experiences a change in *disability* status in which the Social Security Administration determines the *qualified beneficiary* is no longer *disabled* must notify the *Plan Administrator* in writing by the date that is 30 days after the date of the final determination by the Social Security Administration that the *qualified beneficiary* is no longer *disabled*.

The *Plan Administrator* may terminate the extended coverage as of the first day of the month that begins more than 30 days after a determination that the *qualified beneficiary* is no longer *disabled*.

Providing Notification and Election Notices

The *qualified beneficiary* is responsible for providing the *Plan Administrator* with the qualifying event notice and election notice, in writing, by U.S. First Class mail. The notice must be postmarked by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage will be lost.

Notice Procedures

Any notice that you provide **must be in writing**. An oral or verbal notice, including by telephone, is not valid. If mailed, your notice must be postmarked no later than the last day of the required notice period and must be sent to:

Terex Corporation
Attn: Plan Administrator
200 Nyala Farm Road
Westport, CT 06880

If delivered by hand, it must be physically handed to a Human Resources representative at your place of work.

Any individual who is a *qualified beneficiary* with respect to the qualifying event, or any representative acting on behalf of the *qualified beneficiary*, may provide the notice, and the provision of notice by one individual will satisfy any responsibility to provide notice on behalf of all related *qualified beneficiaries* with respect to the qualifying event.

Required Contents of the Notice

The notice must contain the following information:

- The name of the *Plan* (Terex Corporation Health and Welfare Benefits Plan).
- The applicable benefits (e.g., medical coverage).
- Name and address of the covered *team member* and each *qualified beneficiary*.
- The reason for and date of the qualifying event.
- If you are already receiving COBRA continuation coverage and wish to extend the maximum coverage period, identification of the initial qualifying event and its date of occurrence.
- A description of the qualifying event (for example, divorce, legal separation, or a *dependent child*'s loss of dependent status).
- In the case of divorce or legal separation, the name(s) and address(es) of the *spouse* and *dependent child(ren)* covered under the *Plan*, the date of divorce or legal separation, and a copy of the decree of divorce or legal separation.

- In the case of a covered *team member*'s entitlement to *Medicare*, the name of the covered *team member*, the date of entitlement, and the name(s) and address(es) of the *spouse* and *dependent child(ren)* covered under the *Plan*.

- In the case of a *dependent child*'s cessation of dependent status under the *Plan*, the name and address of the child and the reason the child ceased to be an eligible dependent (for example, attainment of limiting age).

- In the case of the death of a covered *team member*, the date of death and the name(s) and address(es) of the *spouse* and *dependent child(ren)* covered under the *Plan*.

- In the case of a *disability* of a *qualified beneficiary*, the name and address of the *disabled qualified beneficiary*, the name(s) and address(es) of other *family* members covered under the *Plan*, the date the *disability* began, the date of the Social Security Administration's determination, and a copy of the determination.

- In the case of a loss of *disability* status, the name and address of the *qualified beneficiary* who is no longer *disabled*, the name(s) and address(es) of other *family* members covered under the *Plan*, the date the *disability* ended, and the date of the Social Security Administration's determination.

- A certification that the information is true and correct, a signature, and the date of the signature.

If you cannot provide a copy of the decree of divorce or legal separation or the Social Security Administration's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the Social Security Administration's determination within 30 days after the deadline. The notice will be considered timely if you do so. However, no COBRA continuation coverage, or extension of such coverage, will be available until you provide the copy of the decree of divorce or legal separation or the Social Security Administration's *disability* determination.

If the notice does not contain all of the required information, the *Plan Administrator* may request additional information. The *Plan Administrator* may reject the notice if the individual fails to provide such information within the time period specified by the *Plan Administrator* in the request, or if it does not contain enough information for the *Plan Administrator* to identify the *Plan*, the covered *team member*, the *qualified beneficiaries*, the qualifying event or *disability*, the applicable benefits, and the date on which the qualifying event occurred.

COBRA Continuation Coverage and Cost

COBRA continuation coverage is identical to the coverage provided to similarly situated beneficiaries who are covered under the *Plan*. However, the *Plan* requires the *qualified beneficiary* to pay the full cost of COBRA continuation coverage (employer plus team member shares) and a 2 percent administrative fee. An extra charge may apply during the *disability* COBRA extension period. The monthly payments are due the first day of each month that COBRA continuation coverage is available and requested.

The mailing address for election forms and monthly payments will be included in your COBRA package of materials mailed to your home address.

COBRA Continuation Coverage and Timely Payment

Once you elect COBRA continuation coverage, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month in order to continue coverage for that month. If a payment is not made within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. Payment is considered made on the date it is sent to the *Plan*.

COBRA Continuation Coverage Period

COBRA continuation coverage will be available up to the maximum time period shown in the following table. See below for special rules that apply to health care FSAs.

Qualifying Event	Continuation Coverage Period
Termination of employment (other than for gross misconduct) Reduction in hours	up to 18 months, for the covered *team member*, *spouse*, and *dependent child(ren)*
Covered *team member*'s death Covered *team member*'s *Medicare* entitlement Divorce Legal Separation	up to 36 months, for the *spouse* and *dependent child(ren)*
Child's loss of dependent status	up to 36 months, for the *dependent child*
For *Disabled Plan Participants* Termination of employment (other than for gross misconduct) Reduction in hours	up to 29 months, if determined by the Social Security Administration to be *disabled* at the time of the qualifying event or during the first 60 days of COBRA coverage
Special note: In the event of multiple qualifying events, in some cases continuation coverage may be extended up to 36 months measured from the date of the first qualifying event.	

Special Medicare Rule

If the covered *team member* experiences a termination of employment or reduction in hours (a qualifying event) less than 18 months after the date the covered *team member* became entitled to *Medicare* benefits (the first qualifying event), the maximum coverage period will be 36 months beginning on the date the covered *team member* became entitled to *Medicare*. This 36-month coverage period applies only to covered *spouses* and *dependent children*.

COBRA Continuation Coverage Period for Health Care FSAs

If you have experienced a qualifying event and have a positive balance in your health care flexible spending account at the time of the event (taking into account all claims submitted before the date of the event), you may be eligible to continue participation in that account under COBRA continuation coverage. Your COBRA continuation coverage period ends on the last day of the *Plan Year* in which the qualifying event occurs.

For example: This year you elected to contribute $1200 to your health care FSA. In May, you terminated your employment. As of the date of your termination, you had submitted $200 in claims. If you had not terminated employment, you would have had $1000 remaining in your health care FSA.

The total COBRA continuation coverage premium for the remainder of the *Plan Year* is $714 calculated as follows: Your total contribution for the year ($1200) is divided by 12, equaling $100 per month, which is multiplied by the 7 months remaining, equaling $700. This $700 plus the 2% COBRA continuation coverage surcharge equals $714.

Since the maximum COBRA continuation coverage premium ($714) is less than the remaining benefit ($1000) you would have had if you had not terminated employment, you will be offered COBRA continuation coverage for the remainder of the current *Plan Year.*

Termination of Continuation Coverage Under COBRA

The *Plan* generally is not required to provide continuation coverage if:

- The *Plan Sponsor* ceases to provide any group health plan to its *team members,*
- The *qualified beneficiary* with COBRA continuation coverage fails to make timely payment of any contributions due,
- The *qualified beneficiary* with COBRA continuation coverage reaches the maximum time period for his or her qualifying event,
- The *qualified beneficiary* with COBRA continuation coverage becomes covered under another group health plan after the date of the team member's COBRA election, or,
- a covered *team member* becomes entitled to *Medicare* benefits after the date of the *team member*'s COBRA election.

If a *disabled qualified beneficiary* recovers from his or her *disability* before the end of the 29-month period, COBRA that has been extended due to the special *disability* extension may be terminated. COBRA coverage may be terminated as of the first day of the month that begins more than 30 days after a final determination by the Social Security Administration that the individual is no longer *disabled.* This will terminate not only the *disabled* individual's COBRA continuation coverage, but also that of all non-*disabled qualified beneficiaries* who are entitled to a *disability* extension due to that *disabled* individual's status. The *Plan Participant* must notify the *Plan Administrator* of the end of his or her *disability*.

Termination of COBRA Continuation Coverage for Health Care FSAs

COBRA continuation coverage in your health care FSA may also end before the end of the maximum period on the date your *employer* ceases to provide a qualified health care spending account to any *team member.*

Trade Act of 2002

Two provisions under the Trade Act of 2002 may affect benefits under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA continuation coverage premiums. Second, eligible individuals under the Trade Act who do not elect COBRA continuation coverage within the election period will be allowed an additional 60-day period to elect COBRA continuation coverage. If a *qualified beneficiary* elects COBRA continuation coverage during this second election period, the coverage period will run from the beginning date of the second election period. Consult the *Plan Administrator* if you believe the Trade Act applies to you.

Current Addresses

In order to protect your *family*'s rights, keep your local Human Resources Representative informed of any changes to the addresses of *family* members.

Effect of Participation on Employment

This *Plan* shall not be deemed to constitute a contract of employment between Terex and you, or a consideration or an inducement for your employment. Nothing in this *Plan* shall be deemed to give you the right to be retained in the service of Terex or to interfere with the *Company*'s right to discharge you at any time regardless of the effect such discharge will have upon you as a *team member* in this *Plan*.

COORDINATION OF BENEFITS AND SUBROGATION

Coordination of benefits (COB) is a feature of this *Plan* that prevents duplicate payment of *covered charges* if a *Plan participant* is covered under more than one benefits program. In order to ensure that you receive the maximum benefits if you have duplicate coverage, always present both ID cards and take the claim forms (if required) from both benefits programs when you receive a service.

COB determines which benefit plan is the primary payer (which plan pays first), and specifies how much is paid.

Determining the Primary Payer

Several rules are used to determine which benefit plan is the primary payer (or primary carrier) if a person is covered by more than one plan. The rules for primary payer are applied in the following order:

- A group benefits plan that does not have a COB feature is always the primary payer.
- In the event of a motor vehicle accident, this *Plan* is not primary. The other plan may include, but may not be limited to, auto medical insurance coverage, no-fault coverage, casualty coverage, or liability insurance.
- A benefits plan that covers the patient as an employee is the primary payer and pays before a plan that covers the patient as a dependent.
- A benefits plan that covers the patient as an active employee is the primary payer and pays before a plan that covers the patient as an inactive *team member.*
- If a child is covered under both parents' plans, the plan covering the parent whose **birthday** occurs earlier in the year pays before the plan covering the other parent.
- If the child's parents are divorced, separated, or not married, the primary payer is determined in the following order:
    - The plan of the parent who by court order or agency ruling is responsible for the child's health care expenses is the primary payer.
    - If there is no decree, the plan that covers the child as a dependent of the custodial parent is the primary payer. The plan of the non-custodial parent is secondary.
    - If there is no decree, the custodial parent's plan is the primary payer, and if the custodial parent remarries, the plan of the custodial parent's *spouse* is secondary. The plan of the non-custodial parent is tertiary.
    - If the parents have joint custody of the child, the plan covering the parent whose **birthday** occurs earlier in the year pays before the plan covering the other parent.
    - For purposes of this COB provision, if there is no decree, "custody" will be determined based upon which parent may claim the child as an IRS dependent or, in the case of a biological child, which parent provides the child's principal support.
    - If none of the above rules apply, the plan covering the plan participant for the longer period of time pays before the plan covering the plan participant for the shorter period of time.

If this *Plan* is secondary and you receive duplicate payment from the *Plan* and another health benefits plan, this *Plan* will collect that duplicate payment from you.

When This Plan Is Secondary

The following may help you understand how COB works.

- As secondary payer, this *Plan* pays benefits after your primary plan has paid.
- This *Plan* will never pay more as the secondary plan than it would have paid if it had been the primary plan.

COB for Medical Benefits

With COB, this *Plan*'s medical benefits are paid up to **this *Plan*'s benefit level.** When you submit a claim for a charge that this *Plan* covers at 80% and this *Plan* is determined to be the secondary carrier, this *Plan* pays 80% of the covered benefit less any amount the primary plan or carrier paid.

In the following example, this *Plan* pays up to the **benefit level** of this *Plan* (80% of the allowable charges or $800), less any amount paid by your primary carrier ($300). You are responsible for the unpaid balance of $200 (20% of $1000 of allowable expenses).

Example 1 *(assumes deductibles have been met)*	
Amount Billed by *Hospital*	$1,200
Less PPO Discount	-200
Allowable *Plan* Charges	$1,000
This *Plan*'s Benefit Level (80% of $1,000)	**$ 800**
Amount Paid by Primary Plan	-300
This *Plan* Pays The difference between this *Plan*'s benefit and the amount paid by the primary plan.	**$ 500**

In the following example, this *Plan* pays nothing since this *Plan*'s benefit level of $800, less the $800 paid by your primary plan, is $0. You are responsible for the unpaid balance of $200 (20% of $1000 of allowable expenses).

Example 2 *(assumes deductibles have been met)*	
Amount Billed by *Hospital*	$1,200
Less PPO Discount	-200
Allowable *Plan* Charges	$1,000
This *Plan*'s Benefit Level (80% of $1,000)	**$ 800**
Amount Paid by Primary Plan	-800
This *Plan* Pays The difference between this *Plan*'s benefit and the amount paid by the primary plan.	**$ 0**

COB for Dental Benefits

With COB, this *Plan*'s dental benefits are paid up to the **allowable level of this *Plan***. This means that when you submit a claim for a charge for which this *Plan* is determined to be the secondary payer, this *Plan* pays the lesser of either the *Plan*'s allowable benefit or the *Plan*'s allowable charges less any amount the primary plan or carrier paid.

COB for All Other Benefits

This Plan does not have a coordination of benefits feature for Vision or Prescription drug benefits.

COB with Other Plans

The COB provision applies to other benefit plans, even if they do not have their own coordination provisions. These plans include:

- group, blanket, or franchise insurance coverage;
- BlueCross, BlueShield, or other prepayment coverage;
- coverage under a labor-management trusteed plan;
- any union welfare plan;
- an employer organization plan or employee benefit organization plan;
- group student coverage which is sponsored by a school or other educational institution, and which includes medical benefits for disease or *illness*;
- coverage under any law, including any federal, state, or other governmental plan or law, toward the cost of which any employer has made payroll deductions; and
- coverage under any plan solely or largely tax-supported or otherwise provided for, by, or through action of any government.

The *Plan* provides benefits relating to health care services *incurred* as a result of an automobile accident on a secondary basis only. Benefits payable under the *Plan* will be coordinated with and secondary to benefits provided or required by any automobile insurance statute (whether or not a no-fault policy is in effect) and/or other automobile insurance.

COB and Medicare

Active Team Members Age 65 or Over

Medicare coverage is secondary to the *Plan* for an active *team member*, age 65 or over, and a *spouse*, age 65 or over, of such active *team member*. *Medicare* is also secondary for any *disabled covered dependents*. *Medicare* coverage, even on a secondary basis, can provide valuable benefits. If you apply when eligible for *Medicare* Part A, there is no premium charge.

In any situation where this *Plan* would have been secondary to *Medicare* Part A coverage had the *Plan participant* enrolled, this *Plan* will not pay for any expenses that otherwise would have been paid under *Medicare* Part A regardless of whether or not the *Plan participant* actually enrolled.

Because of this *Medicare* secondary provision, it is important that you have certain information concerning the *Plan* and *Medicare*:

- If you and/or your *spouse* are not presently enrolled in the *Plan*, you and/or your *spouse* may request coverage at any time. However, requested coverage is subject to the *Plan*'s normal eligibility and effective date provisions.

- If you and your *spouse* are presently covered under the *Plan*, you may remain covered while you continue active employment unless you request that coverage be terminated.

- A person becomes eligible for *Medicare* upon attainment of age 65 if he or she is then qualified for Social Security retirement benefits.

- *Medicare* coverage is divided into two parts. *Medicare* Part A (*Hospital*) coverage generally is provided at no cost. *Medicare* Part B (Surgical and Medical) coverage requires payment of a monthly premium.

- To enroll for *Medicare*, contact your local Social Security office prior to attainment of age 65. Also, a booklet entitled "Your Medicare Handbook" is available from any Social Security office. This booklet is free and provides a detailed description of *Medicare* benefits.

NOTE: For active *team members,* age 65 or over, and for *spouses,* age 65 or over, federal law requires that *Medicare* be a secondary payer and pay after an employer-sponsored medical plan, under which these active *team members* and *spouses* are covered. However, an active *team member,* age 65 or over, has the option of rejecting the employer-sponsored medical plan with the result that *Medicare* becomes the primary payer. Rejection of this employer-sponsored medical plan should be submitted to a Human Resources Representative.

Carefully review your options when you become eligible for *Medicare* Part B. Persons who do not elect *Medicare* Part B when first eligible, and who later wish to obtain *Medicare* Part B coverage, must usually serve a waiting period and are charged an increased monthly premium. The waiting period and the increased premium, however, generally are waived for persons during the period their *Medicare* coverage is secondary to this *Plan*.

If *Medicare* coverage for you or your *spouse* will be (or is now) secondary to the *Plan*, and if you wish to reject or delay *Medicare* Part B, contact the Social Security Administration as early as possible.

Plan Participants with Permanent Kidney Failure

Medicare is a secondary payer to an employer's group health plan for up to 30 months for beneficiaries who have *Medicare* solely because of permanent kidney failure. At the end of the 30-month period, *Medicare* becomes the primary payer until your *Medicare* coverage for permanent kidney failure ends. For further information, check with your local Social Security office.

Plan Participants Under Age 65 with Disabilities

Medicare may be secondary payer for participants (except COBRA recipients and their dependents) under age 65 who are entitled to *Medicare* based on *disability* and who have large group health plan coverage. For further information, check with your local Social Security office.

Medicare and Limiting Charges

When *Medicare* is the primary or secondary payer for a *Plan participant,* the *Plan* specifically limits coverage of *Medicare* balance bills to the limiting charge amounts. Generally, a *provider* who has not accepted assignment may not charge more than 115% of the *Medicare*-approved amount. This is considered the limiting charge.

Subrogation

Recovery of Overpayments

Occasionally, health care benefits are paid more than once, are paid based on improper billing, or are not paid according to the *Plan*'s terms, conditions, limitations, or exclusions. Whenever the *Plan* pays health care benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the *Plan participant* on whose behalf such payment was made.

A *Plan participant*, a health care service *provider*, another health benefit plan, an insurer, or any other person or entity who receives a payment for health care expenses exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, must return the amount of such erroneous payment to the *Plan* within 30 days of discovery or demand. The *Plan Administrator* will have no obligation to secure payment for the health care expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another health care expense. The *Plan Administrator* will have the sole discretion to choose who will repay the *Plan* for an erroneous payment and such payment will be reimbursed in a lump sum or deducted from future claims presented for processing.

Health care service *providers* and any other person or entity accepting payment from the *Plan*, in consideration of such payments, agree to be bound by the terms of this *Plan* and agree to submit claims for reimbursement in strict accordance with their states' health care practice acts, ICD-9 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions must be repaid to the *Plan* within 30 days of discovery or demand or *incur* prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the *Plan* will be entitled to recover its litigation costs and actual attorneys' fees *incurred.*

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of, and implementing the terms of, this coordination of benefits (COB) provision or any provision of similar purpose of any other plan, this *Plan* may, without the consent of or notice to any person, release to or obtain from any insurance *company*, or other organization or individual, any information with respect to any person that the *Plan* deems to be necessary for such purposes. Any person claiming benefits under this *Plan* must furnish to the *Plan* such information as may be necessary to implement this provision.

Reimbursement and Subrogation

This *Plan* reserves all rights of reimbursement and subrogation. Reimbursement means that the *Plan* has the right to recover its previously paid benefit payments from any award, settlement, or damages that you or your *covered dependents* may receive or to which you may become entitled. Subrogation means that the *Plan* has the right to assert your rights (take action on your behalf) to obtain an award, settlement, or damages. The most common situations involving reimbursement and subrogation are auto accidents, but others include medical malpractice, *accidental injuries,* negligence, defective products, etc.

NOTE: You must immediately notify the *Plan Administrator* whenever an *injury* or *illness* arises as a result of an accident, a person's negligence, or any other circumstance that may entitle you or your *covered dependent* to an award, settlement, or damages.

Right to Recover Benefit Payments

The *Plan* will have the first lien upon all awards, settlements, or damages subject to its subrogation or reimbursement rights listed below. This lien will be in the amount of benefits provided or the amount of benefits that will be provided under the *Plan,* plus the reasonable expenses, including attorneys' fees, to enforce the *Plan*'s rights.

- The *Plan* has the right to recover all payments it has made for benefits.
- The *Plan* has the right to recover payments it has made for benefits paid by the *Plan* to or on behalf of you or your *covered dependents* from any award, settlement, or damages to which you or your *covered dependents* may become entitled or that you may receive as a result of an accident, a person's fault or negligence, or any other circumstance under which you or your *covered dependent* has the right to recover from any other party.
- The *Plan* may recover its benefit payments for any type of benefit that may be paid by the *Plan*, such as medical, dental, vision, mental, *disability,* supplemental accident, or accidental death or dismemberment benefits.
- An "award, settlement, or damages" includes any award, settlement, damages (whether equitable, legal, compensatory, etc.), compensation, benefits, or any other payment of any kind. The amount may be paid by formal court award, informal compromise, redemption agreement, application for benefits, or otherwise. The amount also may be paid in a lump sum, installment, or annuity payments (such as income replacement). The *Plan* has the right to recover from all of these amounts.
- An "award, settlement, or damages" includes amounts of any type, kind, nature, or character, regardless of whether the amount identifies or covers the *Plan*'s benefit payments, otherwise relates to medical benefits, or is specifically limited to certain kinds of damages or payments. For example, if you receive an award, settlement, or damages solely for pain and suffering, the *Plan* is still entitled to recover its benefit payments from such amount. In addition, attorneys' fees or any other costs associated with the amount will not reduce the amount of the *Plan*'s reimbursement. **This *Plan* has the first priority to recover from your award, settlement, or damages**. The *Plan*'s first priority lien also will apply regardless of whether you or your *covered dependent* is or was made whole from the award, settlement, or damages, whether before or after the *Plan*'s subrogation recovery. This *Plan* precludes the operation of the "made-whole" and "common fund" doctrines.
- Your "right to recover" from any other party means that you or your *covered dependent* has the right to recover damages or expenses from another party, such as an individual, partnership, corporation, government, or other entity, as well as against that party's respective insurance carriers or governmental fund, for causing an *injury* or *illness* to you or your *covered dependent* or otherwise with respect to any *injury* or *illness incurred* by you or your *covered dependents*. This right to recover from any other party also includes your own insurance carrier, such as your automobile insurance, automobile no-fault coverage, homeowners insurance, personal accident coverage, general liability insurance, or life insurance carrier. It also includes a second medical insurance or other non-insured medical or other coverage. It also includes uninsured and underinsured motorist coverage or programs. The *Plan* has the right to recover from any of these parties, or any other parties, in connection with your *illness* or *injury*.

In the event you or your *covered dependent* is entitled to or receives an award, settlement, or damages from any party (including the other party's or your own insurance carrier or coverage), the *Plan* has the first lien upon the award, settlement, or damages and must be reimbursed for its benefit payments made to you or your *covered dependent,* or on your behalf. The *Plan*'s first lien supersedes any right that the *Plan participant* may have to be "made whole." In other words, the *Plan* is entitled to the right of first reimbursement out of any award, settlement, or damages the *Plan participant* procures or may be entitled to procure regardless of whether the *Plan participant* has received compensation for any of his or her damages or expenses, including any of his or her attorneys' fees or costs. The *Plan* has a right to any full or partial recovery of any and all amounts paid by it on the *Plan participant*'s behalf. The *Plan* will be accorded priority over the *Plan participant* as to any funds recovered. Additionally, the *Plan*'s right of first reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the *Plan,* the *Plan participant* agrees that acceptance of benefits is constructive notice of this provision.

Reimbursement to the *Plan* must be made immediately upon entitlement or receipt of any award, settlement, or damages. The *Plan* will charge interest at a reasonable rate for any delay in reimbursement.

Right to Assert Claims on Your Behalf

The *Plan* has the right, if it so chooses, to assert rights on your behalf to obtain an award, settlement, or damages. Specifically, through subrogation, the *Plan* is entitled to all claims, demands, actions, and rights of recovery that you or your *covered dependent* may have against or from any party (including the other party's or your own insurance carriers) to the extent of the *Plan*'s benefit payments. In addition, this *Plan* is entitled to attorneys' fees *incurred* in asserting rights on your behalf.

The *Plan* does not require you or your *covered dependents* to pursue a claim against another party. However, as stated above, the *Plan* reserves the right to directly pursue recovery against another party on your behalf, should you or your *covered dependent* elect not to pursue an award, settlement, or damages against or from a party.

The *Plan* also has the right to assert its subrogation rights through intervention into any court action you may file against another party.

Miscellaneous Subrogation

This *Plan* is a self-insured plan governed by the Employee Retirement Income Security Act (ERISA), a federal statute that preempts all state law limitations concerning subrogation. Accordingly, state laws pertaining to subrogation do not apply under this *Plan*.

You, your *covered dependents,* your attorneys, or anyone acting on your behalf legally cannot do anything to prejudice the rights of the *Plan* in the exercise of its subrogation rights to recover from, or assert your rights to obtain, an award, settlement, or damages.

The *Plan*'s subrogation rights also extend to the guardian or estate of you and your *covered dependents*. The *Plan*'s subrogation provisions will apply without limitation by the *Plan*'s coordination of benefits (COB) provisions, unless the COB provisions would result in a greater recovery for the *Plan.*

Participant Agreement Obligation

As a condition to participating in the *Plan* and receiving benefits under the *Plan,* you and your *covered dependents* agree to be bound by all of the *Plan*'s provisions, including, but not limited to, the *Plan*'s reimbursement and subrogation provisions. The *Plan* will make benefit payments on a claim on the condition that you or your *covered dependent,* upon entitlement or receipt of any award, settlement, or damages, will fully reimburse the *Plan* for the *Plan*'s benefit payments and for expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) *incurred* by the *Plan* in collecting this amount.

As a precondition to receiving benefits under the *Plan,* you and your *covered dependents* must enter into agreement with the *Plan* to reimburse the *Plan* for its benefit payments from any award, settlement, or damages pursuant to the *Plan*'s reimbursement provisions. In this agreement, you also must agree to assign direct payment to the *Plan* from any award, settlement, or damages to the extent of the *Plan*'s benefit payments. You and your *covered dependents* also otherwise must sign and deliver any and all instruments, papers, and reimbursement agreements required by the *Plan* necessary for the *Plan*'s reimbursement right. You and your *covered dependents* also are required to do whatever is requested or necessary in order to fully execute and to fully protect all the *Plan*'s rights and to do nothing that would interfere with or diminish those rights. Further, you and your *covered dependents* must notify the *Plan* in writing of any proposed settlement and obtain the *Plan*'s written consent before signing any release or agreeing to any settlement. In any event, the *Plan*'s benefit payments for any current or historical claims under the *Plan* on your behalf will be deemed to be the equivalent of you or your *covered dependent* entering into an agreement to reimburse the *Plan* and otherwise signing and delivering any instruments and papers as required by the *Plan.*

In the event that you or your *covered dependents* fail to enter into the foregoing agreement, or otherwise to comply with such requests, the *Plan* is entitled to withhold or deny benefits otherwise due under the *Plan* until you do so. The *Plan*'s reimbursement and subrogation rights are valid and enforceable even if the foregoing agreement is not signed.

When a Plan Participant Retains an Attorney

A *Plan participant* or his or her attorney who receives any recovery (whether by award, settlement, damages, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the *Plan* under the terms of this provision. A *Plan participant* or his or her attorney who receives any such recovery and does not immediately tender the recovery to the *Plan* will be deemed to hold the recovery in constructive trust for the *Plan*, because the *Plan participant* or his or her attorney is not the rightful owner of the recovery and should not be in possession of the recovery until the *Plan* has been fully reimbursed.

When a Plan Participant Does Not Comply

When a *Plan participant* does not comply with the provisions of this section, the *Plan Administrator* will have the authority, at its sole discretion, to deny payment of any claims for benefits by the *Plan participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, at its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement. If the *Plan* must bring an action against a *Plan participant* to enforce this provision, then that *Plan participant* agrees to pay the *Plan*'s attorneys' fees and costs, regardless of the action's outcome.

MEDICAL AND PRESCRIPTION DRUG BENEFIT LIMITATIONS AND PROVISIONS

Medical Benefit Deductibles (Per Calendar Year)						
	Medical 500*		**Medical 1000***		**Medical HSA****	
	PPO	**Non-PPO**	**PPO**	**Non-PPO**	**PPO**	**Non-PPO**
Per Individual	$500	$1,000	$1,000	$2,000	$1,500	$3,000
Family Maximum	$1,500	$3,000	$3,000	$6,000	$3,000	$6,000
*For Medical 500 and Medical 1000, any one person cannot contribute more than the individual amount toward the *family* maximum. **For Medical HSA, when electing t*eam member* and dependent coverage, the *family* maximum deductible must be met before the *Plan* pays benefits for any eligible *family* member (except preventive care).						

Prescription Drug Benefit Deductibles (Per Calendar Year)			
	Medical 500	**Medical 1000**	**Medical HSA**
Per Individual	$50	$75	Combined with medical deductible above. When electing *team member* and dependent coverage, the *family* maximum deductible must be met before the *Plan* pays benefits for any eligible *family* member (except preventive care).
Family Maximum	$150	$225	
Prescription deductible does not apply to generic drugs			
Any one person cannot contribute more than the individual amount toward the *family* maximum			

Medical Benefit Out-of-Pocket Maximums (Per Calendar Year)						
	Medical 500*		**Medical 1000***		**Medical HSA****	
	PPO	**Non-PPO**	**PPO**	**Non-PPO**		
Per Individual	$2,500	$3,900	$4,400	$7,000	$5,500	$9,000
Family Maximum	$6,400	$10,150	$9,800	$18,400	$11,000	$18,000
*For Medical 500 and Medical 1000, any one person cannot contribute more than the individual amount toward the *family* maximum. **For Medical HSA, when electing *Team member* and dependent coverage, the *family* out-of-pocket maximum must be met before the *Plan* will pay benefits at 100% for any eligible *family* member.						
Medical Out of Pocket Maximums Excludes: • Team member contributions for coverage • Amounts over the *usual, customary, and reasonable charges (UCR*) • Prescription deductible and co-payments for Medical 500 and Medical 1000. See below for separate prescription out of pocket maximum information. • Exclusions and Limitations - Medical						

Prescription Drug Benefit Out-of-Pocket Maximums (Per Calendar Year)			
	Medical 500	**Medical 1000**	**Medical HSA**
Per Individual	$1,550	$2,075	Combined with medical Deductible above
Family Maximum	$3,150	$3,725	
Includes Prescription Deductible. Any one person cannot contribute more than the individual amount toward the *family* maximum.			

Remember, to obtain specific benefits you must comply with the notification requirements as outlined in the Health Management Services and Special Provisions section.

Lifetime Maximums	
Per Individual	$3,000 for Non-Surgical Treatment of Obesity
	$400 for Non-Prescription Smoking Cessation Services

Annual Maximums (Per Calendar Year)	
Per Individual	20 Visits for Spinal Manipulation and Related Services (Chiropractic Care)
	10 Visits for Acupuncture
	120 days in-patient at an *Extended Skilled Nursing Facility* Care
	130 Visits for *Home Health Care* Nursing

Other Maximums	
Per Individual	$1,000 per ear for one Hearing Aid per ear every 3 years

Pre-Existing Conditions

This *Plan* does not limit medical benefits relative to a *Plan participant*'s pre-existing condition.

Detailed Description of Plan Limits and Provisions – Medical 500 and Medical 1000

Deductibles

The medical deductibles are the amounts you must pay each calendar year before this *Plan* pays benefits for most other services. The deductibles apply to each *Plan participant* and are listed at the beginning of this section.

Office visits are not subject to the deductible under this *Plan;* however, they are subject to a co-payment as described in the Schedule of Benefits.

The deductible applies to each covered member of a *family*. However, when *family* members *incur* any combination of *covered charges* totaling the *family* deductible in any calendar year (as long as no one person contributes more than his or her individual amount), then the deductible amount is considered satisfied for your entire *family*.

Any payments for *covered charges* that are used to help satisfy the deductible under the PPO portion of the *Plan* are also used to satisfy the deductible under the non-PPO portion of the *Plan,* and vice versa.

Co-Payments

A co-payment is a flat dollar amount you must pay for certain services before the *Plan* pays benefits. For example, for some services, you must first make a $25 or $40 (for specialty providers) co-payment, and the *Plan* then covers the remainder of your eligible expenses for those services at 100% of the PPO rate. You must make a $25 or $40 co-payment each time you receive those services.

Coinsurance

After you have satisfied the annual deductible, coinsurance is the amount you must pay for each service before the *Plan* pays benefits. This is a percentage of the eligible benefit that is not covered by the *Plan*. For example, for those benefits for which the *Plan* pays 75% or 80%, you are responsible for the remaining 25% or 20% coinsurance.

Out-of-Pocket Maximum

This *Plan* has an out-of-pocket maximum feature that helps limit the amount of money you must pay for *covered charges* in any one calendar year. This means that once you have reached the out-of-pocket maximum, this *Plan* covers subsequent eligible charges at 100% of the PPO negotiated rate or the *UCR* for the remainder of the calendar year. This feature helps ensure that the amount you must pay out-of-pocket for eligible benefits remains a manageable amount. The out-of-pocket maximums apply to each *Plan participant* and are listed at the beginning of this section.

Any payments for *covered charges* that are used to help satisfy the out-of-pocket maximum under the PPO portion of the *Plan* are also used to help satisfy the out-of-pocket maximum under the non-PPO portion of the *Plan,* and vice versa.

The out-of-pocket maximum excludes certain items which are listed in the Out-of-Pocket Maximums table at the beginning of this section.

Detailed Description of Plan Limits and Provisions – Medical HSA

Tax Advantage Health Savings Account

The Medical HSA options offer a new approach for managing health care expenses, using a tax-advantaged personal health savings account. This account can help you save for out-of-pocket medical expenses, in the current year or any time in the future including retirement. You can contribute to the HSA with pre-tax dollars, which lowers your taxable income. Also, you pay no taxes on any money you withdraw, now or in the future, as long as the funds are used to pay for qualified medical expenses. Unlike a Flexible Spending Account, you can change the amount of your pre-tax contribution at any time during the year. For more detailed information on this savings account, see your local Human Resources department.

HSA Deductibles

As a qualified, high deductible health plan option, as defined by the IRS, the Medical HSA requires higher individual and *family* deductibles. This option also differs from Medical 500 and Medical 1000 in that when covering dependents under Medical HSA, the entire *Team member* and Dependent deductible must be met before the *Plan* pays benefits for any eligible *family* member (except for preventive care).

HSA Co-Payments

There are no fixed copayments in the Medical HSA option. Instead Medical HSA has an annual deductible which you will need to meet before the *Plan* begins to pay a share of eligible expenses. This means you pay the full cost of most *medical services* and prescription drugs until you have satisfied the annual deductible.

HSA Coinsurance

After you have satisfied the annual deductible, coinsurance is the amount you will pay for each service. This is a percentage of the eligible benefit that is not covered by the *Plan*. For example, for those benefits for which the *Plan* pays 80%, you are responsible for the 20% coinsurance.

HSA Out-of-Pocket Maximum

This *Plan* has an out-of-pocket maximum feature that helps limit the amount of money you must pay for *covered charges* in any one calendar year. This means that once you have reached the individual out-of-pocket maximum (or family out-of-pocket maximum when more than the team member is covered by this medical HSA option), this *Plan* covers subsequent eligible charges at 100% of the PPO negotiated rate or the *UCR* for the remainder of the calendar year. This feature helps ensure that the amount you must pay out-of-pocket for eligible benefits remains a manageable amount.

Any payments for *covered charges* that are used to help satisfy the out-of-pocket maximum under the PPO portion of the *Plan* are also used to help satisfy the out-of-pocket maximum under the non-PPO portion of the *Plan,* and vice versa.

The out-of-pocket maximum does **not** include items listed in the Out-of-Pocket Maximums table at the beginning of this section.

Annual Maximums – Medical 500, Medical 1000 and Medical HSA

Annual day or visit limit maximums are on a calendar year basis as listed at the beginning of this section. Once the annual maximum for a listed service has been reached, no additional benefits will be paid during the remainder of the calendar year for that service for that *Plan participant*.

Conditions for Providing Benefits

Medical benefits are provided at the PPO negotiated rate when you use a PPO *provider*, or on the basis of *usual, customary, and reasonable (UCR) charges* when you use a non-PPO *provider*, based on what is usually and customarily accepted as payment for the same service within a geographic area, as determined by the *Plan*.

Benefits are provided only for covered services recommended by a *physician* who is a member of the medical staff or acceptable to the *hospital* or *ambulatory care center* selected by the *Plan participant*. The *Plan participant* may select any *hospital* or *ambulatory care center* that meets the criteria described in the definition of that type of facility. All services furnished are subject to the rules and regulations of the facility.

Usually, benefits under this *Plan* are paid directly to the *provider* rendering the service, unless you provide itemized bills indicating that the charges have been paid in full. In that case, allowable benefits are paid to the *Plan participant*.

In making a decision on claims involving services, supplies, or days of care that are determined by the *Plan* to be unnecessary, unproven, *experimental*, or *investigational*, the *Plan* reserves the right to obtain advisory opinions from consultant(s) of its choice. On reconsideration of denied claims for this reason, the *Plan* further reserves the right to refer such cases to the appropriate peer review committee.

A Look at Your Options

The *Plan* offers three medical coverage options: Medical 500, Medical 1000 and Medical HSA. All three options cover the same *medical services*. The differences are related to your:

- ⇒ payroll contributions;
- ⇒ deductible amounts (individual and *family*);
- ⇒ availability of flat co-payments
- ⇒ out-of-pocket maximum and
- ⇒ Tax advantaged savings accounts (HSA option only)
- ⇒ Health Care Flexible Spending Account availability

	Medical 500	***Medical 1000***	***Medical HSA***
Contributions	Highest Team Member Contribution	Lower Team Member Contribution	Lowest Team Member Contribution
Deductibles	Lowest Deductible with individual limits	Higher Deductible with individual limits	Highest Deductible with combined limits when covering dependents
Flat Copayments	Yes	Yes	No
Out-of-Pocket Maximum	Lowest Out-of-Pocket Maximum	Higher Out-of-Pocket Maximum	Highest Out-of-Pocket Maximum
Tax Advantage Savings account	No	No	Yes, rolls over year to year and you can take it with you if you leave Terex.
Health Care Flexible Spending Account	Yes	Yes	No, instead make pre-tax contributions to an HSA account to pay for eligible out of pocket health care expenses.

MEDICAL BENEFITS

Overview of PPO vs. Non-PPO

If you use a *provider* who is a member of the PPO network, and depending on your plan option enrolled in, most benefits are paid at either 75% or 80% of the PPO negotiated rate, subject to the deductible. You are responsible for the deductible and for the remaining 25% or 20% coinsurance. In the case of some services provided by a PPO network *provider*, you will pay a $25 or $40 (for specialty providers) per office visit co-payment (not available to those enrolled in Medical HSA). Please note that other services provided at the time of an office visit may still be subject to the deductible and coinsurance.

If you use a *provider* who is **not** a member of the PPO network, and depending on your plan option enrolled in, most benefits are paid at either 55% or 60% of the *usual, customary, and reasonable (UCR)*, subject to the deductible. You are responsible for *the* deductible, for the 45% or 40% coinsurance, **and** for any amounts in excess of the *UCR* charges.

If you reside outside the PPO network area, and you utilize a *provider* outside the PPO network, benefits are covered at the in-network deductible, benefit percentage and out of pocket maximum, subject to the *usual, reasonable and customary* allowance. ("Reside outside the PPO network area" means that there is not one *hospital*, or there are not two primary care *physicians* or there are not two specialists within 30 miles of your home zip code).

Services which are covered by the *Plan* and are not available through a network *provider* are paid at the in-network deductible, benefit percentage and out of pocket maximum, subject to usual, reasonable and customary allowance. ("Not available" is defined as lacking access to a PPO *provider* in the specialty you are seeking within 30 miles your home zip code.)

Lab tests and x-rays ordered by an in-network provider but performed by an out-of-network laboratory or facility are paid at the in-network deductible, benefit percentage and out of pocket maximum, subject to usual, customary and reasonable allowance.

Services provided at a network *hospital*, by an out-of-network *provider,* are paid at the PPO benefit percentage of *UCR*.

Some PPO *hospitals* have arrangements through which the patient is billed more than the actual charges, e.g., per diem or diagnosis-related group (DRG) charges. When this occurs, the *Plan* pays 100% of these excess charges.

You may obtain information regarding participating PPO *providers,* without charge, through the *claims administrator*'s Website at http://www.anthem.com/terex. If you have any questions, contact a local Human Resources Representative.

Each *Plan participant* has a free choice of any *physician* or surgeon, and the *physician*-patient relationship will be maintained. The *Plan participant,* together with his or her *physician,* is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the *Plan* will pay for all or a portion of the cost of such care. The PPO *providers* are independent contractors; neither the *Plan* nor the *Plan Administrator* makes any warranty as to the quality of care that may be rendered by any PPO *provider.*

Note: In order to receive your maximum allowable benefits, you must comply with the notification requirements as outlined in the Health Management Services and Special Provisions section.

Important Note Regarding Preferred *Providers*:

It is your responsibility to confirm whether or not your *provider* is an in-network *provider* PRIOR to obtaining services. Occasionally, a particular medical *facility* may be listed as an in-network *facility*, or a particular *physician* at a medical *facility* may be listed as an in-network *physician*. This does not mean any *provider* at that *facility* is also an in-network *provider*. A medical *facility* may employ both in-network and out-of-network *physicians*.

In addition, *provider* status can change. Therefore, it is important not to rely solely upon in-network *provider* directories. The directories may be outdated. You should ask your *provider* if he or she is affiliated with your preferred *provider* organization or you can contact the PPO network directly to obtain the most current information.

Schedule of Benefits

The following tables outline your percentage of coverage as provided by this *Plan.* The tables are followed by a more detailed description of specific benefits.

Urgent Care or *Emergency* Services: It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the *Plan* for prior approval. The *Plan participant* should obtain such care without delay and follow the rules described in Health Management Services and Special Provisions.

UCR stands for *usual, reasonable, and customary charges*.

IMPORTANT NOTE: The services in the Medical Plan pages that follow indicate coinsurance percentages, such as 75%/80% and 55%/60%. These percentages are related to Medical 500 and Medical 1000, respectively. That means Medical 500 covers 75% and Medical 1000 covers 80% for in-network services and Medical 500 covers 60% and Medical 1000 covers 55% when using out-of-network providers.

Hospital Inpatient Services		
	PPO	***Non-PPO***
Standard Room and Board and Ancillary Charges	75%/80% of PPO rate for *Semi-Private Room*, subject to deductible	55%/60% of *UCR* for *Semi-Private Room*, subject to deductible
Extended Skilled Nursing Facility, Room & Board and Ancillary Charges	75%/80% of PPO rate, subject to deductible and day maximum	55%/60% of *UCR*, subject to deductible and day maximum
Intensive Care Room and Board	75%/80% of PPO Intensive Care Rate, subject to deductible	55%/60% of *UCR* of Intensive Care Rate, subject to deductible
Rehabilitation Room and Board	75%/80% of PPO rate for *Semi-Private Room*, subject to deductible	55%/60% of *UCR* for *Semi-Private Room*, subject to deductible
Personal Items	Not Covered	Not Covered

Hospital Newborn Care		
	PPO	***Non-PPO***
Newborn Nursery and Ancillary Charges	75%/80% of PPO rate, subject to the mother's deductible for first 3 days, then subject to the newborn's deductible if the newborn is enrolled in the medical benefits of this *Plan* within the required 60 days after birth.	55%/60% of *UCR*, subject to the mother's deductible for first 3 days, then subject to the newborn's deductible if the newborn is enrolled in the medical benefits of this Plan within the required 60 days after birth.
Neo-Natal Room and Board and Ancillary Charges	75%/80% of PPO rate, subject to the mother's deductible for first 3 days, then subject to the newborn's deductible if the newborn is enrolled in the medical benefits of this Plan within the required 60 days after birth.	55%/60% of *UCR*, subject to the mother's deductible for first 3 days, then subject to the newborn's deductible if the newborn is enrolled in the medical benefits of this Plan within the required 60 days after birth.

Mental Health and Substance Abuse Inpatient, Partial Hospitalization, and Intensive Outpatient Services		
	PPO	***Non-PPO***
Mental Health Care — Room and Board and Ancillary Charges	75%/80% of PPO rate for *Semi-Private Room*, subject to deductible	55%/60% of *UCR* for *Semi-Private Room*, subject to deductible
Substance Abuse Care — Room and Board and Ancillary Charges	75%/80% of PPO rate for *Semi-Private Room*, subject to deductible	55%/60% of *UCR* for *Semi-Private Room*, subject to deductible
Mental Health Care — Partial Hospitalization and /Intensive Outpatient Services	75%/80% of PPO rate for *Semi-Private Room*, subject to deductible	55%/60% of *UCR* for *Semi-Private Room*, subject to deductible
Substance Abuse Care —Partial Hospitalization and /Intensive Outpatient Services	75%/80% of PPO rate for *Semi-Private Room*, subject to deductible	55%/60% of *UCR* for *Semi-Private Room*, subject to deductible

Providers' In-Hospital Services		
	PPO	***Non-PPO***
Provider Hospital Visit	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Mental Health Hospital Visit	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Substance Abuse Hospital Visit	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Newborn Visit	75%/80% of PPO rate, subject to the mother's deductible for first 3 days, then subject to the newborn's deductible if the newborn is enrolled in the medical benefits of this Plan within the required 60 days after birth.	55%/60% of *UCR*, subject to the mother's deductible for first 3 days, then subject to the newborn's deductible if the newborn is enrolled in the medical benefits of this Plan within the required 60 days after birth.

Surgical Inpatient and Outpatient Services		
	PPO	***Non-PPO***
Primary Surgeon	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Pain Management	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Assistant Surgeon	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Anesthesia	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Obesity Treatment - Gastric Bypass and Gastric Sleeve ONLY	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
	Procedures **not** included are lap band, liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw as well as any other procedures not specifically mentioned. Gastric Bypass and Gastric Sleeve surgery is covered only when determined to be medically necessary by the Plan and requires precertification.	
TMJ Surgery	Not Covered – See Dental Benefits	Not Covered – See Dental Benefits
Dental Surgery - Non-Accident	Not Covered – See Dental Benefits	Not Covered – See Dental Benefits
Dental Surgery – Accident	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible

All inpatient services, including *extended skilled nursing facilities* and rehabilitation facilities, must be pre-certified by Anthem BlueCross BlueShield as outlined in the Health Management Services and Special Provisions section.

Professional Interpretation Services Inpatient and Outpatient		
	PPO	***Non-PPO***
Pathologist Fee	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Radiologist Fee	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Diagnostic Testing – Interpretation Fee	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible

Emergency Room Services		
	PPO	***Non-PPO***
Emergency Room — Accident — Facility	75%/80% of PPO rate after $150 co-payment, subject to deductible (co-payment waived if admitted for longer than 24 hours)	75%/80% of *UCR* after $150 co-payment, subject to PPO deductible and PPO out-of-pocket maximum (co-payment waived if admitted for longer than 24 hours)
Emergency Room — *Illness* — Facility	75%/80% of PPO rate after $150 co-payment, subject to deductible (co-payment waived if admitted for longer than 24 hours)	75%/80% of *UCR* after $150 co-payment, subject to PPO deductible and PPO out-of-pocket maximum (co-payment waived if admitted for longer than 24 hours)
Emergency Room — Accident — *Physician* or Other *Provider*	75%/80% of PPO rate, subject to deductible	75%/80% of PPO rate, subject to deductible
Emergency Room — *Illness* — *Physician* or Other *Provider*	75%/80% of PPO rate, subject to deductible	75%/80% of PPO rate, subject to deductible

Outpatient Facility Fees		
	PPO	***Non-PPO***
Outpatient Surgery / or *Surgery Center* - Facility Fee only	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Clinic Visit - Facility Fee only	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Outpatient *Hospital* Services / or *Ambulatory Care Center*	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Pre-Admission Testing – Medical 500 and Medical 1000	100% of PPO rate, if within 7 days of admission.	100% of *UCR*, if within 7 days of admission.
Pre-Admission Testing – Medical HSA	75%/80% of PPO rate, subject to deductible, if within 7 days of admission.	55%/60% of *UCR*, subject to deductible, if within 7 days of admission.

Outpatient Diagnostic Services		
	PPO	***Non-PPO***
Diagnostic Laboratory	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Diagnostic Testing	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Diagnostic X-ray	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Diagnostic PET Scan	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
CAT Scan	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Magnetic Resonance Imaging	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible

Outpatient Therapy Services		
	PPO	***Non-PPO***
Biofeedback - Medical	Not Covered	Not Covered
Cardiac Rehabilitation	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Chemotherapy	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Dialysis	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Intravenous Therapy	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Occupational Therapy	75%/80% of PPO rate, subject to deductible	55%/60% of UCR, subject to deductible
Osteopathic Manipulation Therapy	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Physical Therapy	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Radiation Therapy	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Speech Therapy	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Vision Therapy	Not Covered	Not Covered

Outpatient Mental Health and Substance Abuse Services		
	PPO	***Non-PPO***
Biofeedback — *Mental Health*	Not Covered	Not Covered
Mental Health Office Visit—Outpatient – Medical 500 and Medical 1000	100% of PPO rate after $40 co-payment	55%/60% of *UCR*, subject to deductible
	Includes marriage and *family* counseling.	
Mental Health Office Visit—Outpatient – Medical HSA	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
	Includes marriage and *family* counseling.	
Mental Health Testing and Evaluation	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Social Worker Visit	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Substance Abuse Office Visit Outpatient – Medical 500 and Medical 1000	100% of PPO rate after $40 co-payment	55%/60% of *UCR*, subject to deductible
Substance Abuse Office Visit Outpatient – Medical HSA	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible

Doctor's Office Services		
	PPO	***Non-PPO***
Allergy Care (extracts, serums, injections)	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Allergy Testing	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Diagnostic Laboratory	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Diagnostic X-ray	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Injections	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
	Does not include routine immunizations and flu shots which are covered as a Preventive service at 100%.	
Office Extras	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Office Visit – Medical 500 and Medical 1000	100% of PPO rate after $25* co-payment	55%/60% of *UCR*, subject to deductible
	Includes urgent care visits billed by a *physician*. ***** You pay a $40 copayment for each office visit to an in-network provider who is a specialist. Refer to the *2018 Primary Care and Specialist Provide List* available from your local human resources department	
Office Visit – Medical HSA	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Venipuncture – Medical 500 and Medical 1000	100% of PPO rate if billed with office visit; otherwise, 75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Venipuncture – Medical HSA	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible

Chiropractic Services		
	PPO	***Non-PPO***
Chiropractic Visit – Medical 500 and Medical 1000	100% of PPO rate after $40 co-payment, subject to annual visit maximum	55%/60% of *UCR*, subject to deductible and annual visit maximum
Chiropractic Visit – Medical HSA	75%/80% of *UCR*, subject to deductible and annual visit maximum	55%/60% of *UCR*, subject to deductible and annual visit maximum
Chiropractic X-ray	75%/80% of PPO rate, subject to deductible and chiropractic annual visit maximum	55%/60% of *UCR*, subject to deductible and chiropractic annual visit maximum

Preventive Care Services		
	PPO	***Non-PPO***
Immunizations and vaccinations – All Ages	100% of PPO rate. Immunizations and vaccinations solely for travel are not covered.	100% of *UCR.* Immunizations and vaccinations solely for travel are not covered.
Flu Shot Immunizations	100% of actual charge	100% of actual charge
Well Child Care	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Preventive Exam	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Prostate Exam	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Gynecological (GYN) Exam	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Mammogram	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Pap Test	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Contraceptive Devices	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
	Includes contraceptive management and birth control devices that require a prescription and are administered by a *physician*	
Colonoscopy	100% of PPO Rate	55%/60% of *UCR*, not subject to deductible
	Once every 5 years. Includes *surgical procedures*, associated facility fees, anesthesia fees and lab charges. No age limit. This coverage applies to any colonoscopies regardless of diagnosis.	
Sigmoidoscopy	100% of PPO Rate	55%/60% of *UCR*, not subject to deductible
	Once every 5 years. Includes *surgical procedures*, associated facility fees, anesthesia fees and lab charges. No age limit. This coverage applies to any sigmoidoscopies regardless of diagnosis.	
Routine Hearing Exam	100% of PPO	55%/60% of *UCR*, not subject to deductible
Routine PET Scan	Not Covered	Not Covered
Preventive Lab	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Lab - Lipid Profile	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Lab - Hemoccult	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Lab - PSA	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Preventive Lab - Pathologist Fee	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Lab - Lipid Profile Pathology	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Lab - Hemoccult Pathology	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Lab - PSA Pathology	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Lab - Pap Pathology	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Preventive X-ray	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Preventive X-ray - Radiologist Fee	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
X-ray - Mammogram Radiologist Fee	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Preventive Testing	100% of PPO rate	55%/60% of *UCR*, not subject to deductible
Preventive Testing - Interpretation Fee	100% of PPO rate	55%/60% of *UCR*, not subject to deductible

Second Surgical Opinion Services		
	PPO	***Non-PPO***
Office Visit For Second and Third Surgical Opinion - Confirmed or Non-Confirmed - Medical 500 and Medical 1000	100% of PPO rate	100% of *UCR*
Office Visit For Second and Third Surgical Opinion - Confirmed or Non-Confirmed - Medical HSA	75%/80% of PPO rate, subject to deductible	75%/80% of PPO rate, subject to deductible

Other Miscellaneous Services		
	PPO	***Non-PPO***
Acupuncture	75%/80% of *UCR*, subject to deductible and annual visit maximum	75%/80% of *UCR*, subject to in-network deductible and annual visit maximum
Ambulance - Air Transportation and Ground Transportation	75%/80% of PPO rate, subject to deductible	75%/80% of *UCR*, subject to in-network deductible and in-network out-of-pocket maximum
Dental Service - *Accidental Injury*	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Durable Medical Equipment	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Hearing Aids	75%/80% of PPO rate, subject to deductible and maximum	75%/80% of *UCR*, subject to deductible and out-of-pocket maximum
Gender Identity Services	75%/80% of PPO rate, subject to deductible	75%/80% of UCR, subject to deductible
Home Health Care Services	75%/80% of PPO rate, subject to deductible and day maximum	55%/60% of *UCR*, subject to deductible and day maximum
Hospice	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Medical Records Reimbursement	100% of charges	100% of charges
	Coverage is only for provider record fees requested by Anthem	
Miscellaneous Covered Expenses	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Naturopathy — Office Visits – Medical 500 and Medical 1000	100% of *UCR* after $40 co-payment	100% of *UCR* after $40 co-payment
	Includes visits, consultations, and diagnostic lab services; excludes naturopathic remedies and supplements.	
Naturopathy — Office Visits – Medical HSA	75%/80% of PPO rate, subject to deductible	75%/80% of *UCR*, subject to deductible
	Includes visits, consultations, and diagnostic lab services; excludes naturopathic remedies and supplements.	
Naturopathy — Other Expenses	75%/80% of *UCR*, subject to deductible	75%/80% of *UCR*, subject to PPO deductible and out-of-pocket maximum
Nutrition Counseling for diabetes, heart conditions and eating disorders	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
	If determined to be a *covered health service* and conducted by a registered dietician or licensed nutritionist.	
Obesity Treatment, surgical and non-surgical	75%/80% of PPO rate, subject to deductible and lifetime maximum	55%/60% of *UCR*, subject to deductible and lifetime maximum
	Requires pre-certification	
Orthotics	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Pain Management Programs	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Prosthetics	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
RN and LPN Services — Outpatient	75%/80% of PPO rate, subject to deductible and day maximum	55%/60% of *UCR*, subject to deductible and day maximum
Sleep Disorder Clinic	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Smoking or Tobacco Cessation, non-prescription* products and services – Medical 500 and Medical 1000	100% of charges, subject to lifetime dollar maximum	100% of charges, subject to lifetime dollar maximum
	* Prescription products are covered under the prescription drug benefit and are not subject to the lifetime maximum.	
Smoking or Tobacco Cessation, non-prescription* products and services – Medical HSA	75%/80% of *UCR*, subject to deductible and lifetime dollar maximum	75%/80% of *UCR*, subject to in-network deductible and lifetime dollar maximum
	* Prescription products are covered under the prescription drug benefit and are not subject to the lifetime maximum.	

Replacement of Organs/Tissues			
	Center of Excellence	***PPO***	***Non-PPO***
Transplant Procedure - Medical 500 and Medical 1000	100% of Pre-Negotiated *Center of Excellence* Facility Fee Schedule	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Transplant Procedure - Medical HSA	75%/80% of PPO rate, subject to deductible	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Organ procurement and acquisition - Medical 500 and Medical 1000	100% of Pre-Negotiated *Center of Excellence* Facility Fee Schedule	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Organ procurement and acquisition - Medical HSA	75%/80% of PPO rate, subject to deductible	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Transportation of recipient to *transplantation* - Medical 500 and Medical 1000	100% of PPO rate	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Transportation of recipient to *transplantation* - Medical HSA	75%/80% of PPO rate, subject to deductible	75%/80% of PPO rate, subject to deductible	55%/60% of *UCR*, subject to deductible
Transportation of one other adult (two parents if the recipient is a minor child) - Medical 500 and Medical 1000	Up to $10,000 per *transplant*	Up to $10,000 per *transplant*	Up to $10,000 per *transplant*
Transportation of one other adult (two parents if the recipient is a minor child) - Medical HSA	75%/80% of the actual expenses, subject to deductible, up to $10,000 per *transplant*	75%/80% of the actual expenses, subject to deductible, up to $10,000 per *transplant*	55%/60% of the actual expenses, subject to deductible, up to $10,000 per *transplant*

Prescription Drugs		
Medical 500 and 1000		***Medical HSA***
Prescription Drug Card — Generic (Retail)	100% after $10 co-payment; maximum 30-day supply	80% of the cost after the deductible is met. Preventive Drugs are covered at 100% with no deductible
Prescription Drug Card — Brand Name on the National Preferred Formulary List (Retail)	75% after your 25% coinsurance payment (up to $50 per prescription)*, subject first to prescription drug annual deductible; maximum 30-day supply	
Prescription Drug Card — Brand Name, not on the Preferred Formulary List (Retail)	55% after your 45% coinsurance payment (up to $75 per prescription), subject first to prescription drug annual deductible; maximum 30-day supply	
Prescription Drug Mail Service and Walgreen's Smart 90 program — Generic	100% after $20 co-payment; maximum 90-day supply	
Prescription Drug Mail Service and Walgreen's Smart 90 program — Brand Name, Preferred	75% after your 25% coinsurance-payment (up to $100 per prescription), subject first to prescription drug annual deductible; maximum 90-day supply	
Prescription Drug Mail Service and Walgreen's Smart 90 program — Brand Name, Non-Preferred	55% after your 45% coinsurance payment (up to $150), subject first to prescription drug annual deductible; maximum 90-day supply	
Prescription Drugs Note: Some specialty prescription drugs that are not covered under your prescription drug card program may be covered as medical benefits at 75% or 80% of *UCR*, subject to the medical deductible.		

All inpatient services, including extended skilled nursing facilities and rehabilitation facilities, must be pre-certified by Anthem BlueCross BlueShield as outlined in the Health Management Services and Special Provisions section.

Detailed Description of Medical Benefits

Hospital Inpatient Benefits

Inpatient Care: A *Plan participant* who is admitted to a *hospital* as an inpatient is entitled to benefits for *hospital* services. Benefits are paid according to the Schedule of Benefits, to include all types of room and board per *confinement*, unless otherwise excluded by the *Plan*.

In order for inpatient care (including partial hospitalization programs) to be covered as a benefit of this *Plan*, the service must be consistent with the diagnosis and treatment of the patient's condition. Also, **in order to receive the maximum benefits allowed,** you must comply with the notification requirements described in the Notification Requirements for Inpatient Services section**. Failure to notify** the *claims administrator* may result in reduced or denied benefits.

The following **inpatient care** charges are covered:

- Charges for *semi-private room* and board, including bed, meals, special diets, and general nursing services. If the *Plan participant* receives room and board known as "private accommodation," room and board charges are paid only at the *hospital*'s average *semi-private room* rate. However, a private room will be covered as any other covered service if a private room is ordered by the *physician* in charge of the patient for isolation purposes (this may include, but is not limited to, infectious disease or behavior management of a *Plan participant*), or if the facility in which the patient is confined contains only private rooms.

- Charges for the use of an operating room, delivery room, and recovery room.

- Charges for the use of an observation room in excess of 23 hours.

- Charges for *hospital* services in *intensive care units (ICU)* and *cardiac care units (CCU).*

- Charges for anesthetic materials.

- Charges for administration of anesthetics when administered by an employee of the *hospital* as a regular *hospital* service or through approved contractual arrangements.

- Charges for dressings, bandages, casts, and splints.

- Charges for X-rays, laboratory services, pathological services, and machine diagnostic tests.

- Charges for oxygen and other respiratory therapy, as provided by the *hospital.*

- Charges for physio-therapy, hydrotherapy, and other rehabilitative services, as provided by the *hospital.*

If a *Plan participant* seeks *emergency* services through a *hospital*'s *emergency* room and is admitted as a *hospital* inpatient at that time due to that *emergency*, coverage for that inpatient *confinement* will be provided as an inpatient *hospital* benefit, not as an *emergency* room benefit.

Extended Skilled Nursing Facility: In lieu of *hospital confinement*, benefits may be provided for services rendered by an *extended skilled nursing facility* according to the Schedule of Benefits and Medical and Prescription Drug Benefit Limitations and Provisions. The *medical services* and supplies of this benefit are provided under the terms of an Anthem BlueCross BlueShield approved *extended skilled nursing facility* treatment plan.

In order to receive the maximum benefits allowed, these above services must be determined to be *covered health services* by *Anthem BlueCross BlueShield*. Failure to follow the Notification Requirements may result in your claims being denied or paid at a reduced amount.

Hospital Maternity Care

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending *provider,* after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a *provider* obtain authorization from the *Plan* or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). You or your *covered dependents* are not required to give birth in a *hospital* or to stay in the *hospital* for a fixed period of time following birth.

If your *physician* feels that a longer stay is necessary, you must obtain approval from *Anthem BlueCross BlueShield*. See the Notification Requirements for Inpatient Services section.

Obstetrical Care – Hospital: Benefits are provided for obstetrical care and conditions of pregnancy to the *team member* and *covered dependents* during the period of *hospital confinement*. The payment of obstetrical benefits is determined as of the date the services are rendered. A child becomes a *covered dependent* at birth, **provided** the child is enrolled in the *Plan* within 60 days of the date of birth. *Hospital* benefits are paid according to the Schedule of Benefits.

Newborn Care: This provision is applicable to the team member and the team member's spouse only, provided the child is enrolled in the Plan within 60 days of the date of birth. Benefits provided include regular nursery care and neo-natal care for a newborn infant as long as the mother's hospital confinement is a covered benefit and the newborn infant is a covered dependent under the Plan. Routine newborn charges are subject to the mother's deductible for the first 3 days. Should the newborn require other than routine nursery care, the newborn will be admitted to the Hospital in their own name and charges for all covered non-routine services will be subject to the newborn's own deductible, coinsurance and individual out of pocket maximum. The Plan covers charges for circumcision provided the service is provided within 6 months following birth.

Newborn charges are subject to the mother's deductible for the first 3 days, provided the child is enrolled in the medical benefits of this Plan no later than 60 days after birth. This provision is applicable to the *team member* or the *team member's spouse* only. Newborns of this Plan's dependent children are not covered by this benefit nor are they eligible for any other benefits in this Plan.

Obstetrical Services: Benefits are provided for obstetrical services rendered by the *physician* in charge of the case or by another licensed *provider*, including services customarily rendered as prenatal and postnatal care. Benefits are also payable for prenatal care, delivery services, and postnatal care rendered by a Certified Nurse Midwife (CNM), Certified Licensed Midwife, Licensed Midwife, Registered Nurse Practitioner, home health agency, and/or registered nurse. Benefits for obstetrical services are provided to the *team member* and *covered dependents*.

It is the responsibility of the *team member* to add the baby to their coverage(s) through a *Plan* enrollment within 60 days of the child's birth.

Anthem Future Moms Program

Additional benefits and cash incentives are available to expectant team members and a team member's spouse who are 18 years of age or older and covered by one of the Terex medical plan options. These added benefits include:

- 24/7 telephonic access to a nurse who specializes in prenatal care
- A prenatal care book
- Educational materials to help with unexpected events
- Tools to help you throughout your pregnancy including how to identify possible risks
- Information on a variety of pregnancy-related topics

- 2 gift cards are available - during and after a pregnancy:
    - $75 for enrolling within the first trimester; and
    - $50 for completing the program and post assessment

More detailed information about the program is available from your local HR representative or if you prefer a confidential inquiry, you may call Anthem directly at 1-800-828-5891.

Mental Health and Substance Abuse Inpatient, Partial Hospitalization, and Intensive Outpatient Services

Benefits are provided for inpatient, partial hospitalization, and intensive outpatient *mental health* care only at a licensed *mental health* or *substance abuse treatment facility*.

Providers' In-Hospital Services

The *Plan* provides benefits according to the Schedule of Benefits for the following professional services performed by a licensed *provider*:

In-Hospital Concurrent Medical Care: Benefits are provided for services rendered concurrently by a *provider* other than the attending *physician* when warranted by the need for the skills of a specialist. A patient is eligible for concurrent medical care if he or she has a separate and complicated diagnosis that, if left untreated, would adversely affect his or her prognosis, and if management of the condition requires the skills of a specialist.

In-Hospital Medical Services: Benefits are provided for professional services rendered by the attending *provider* while the *Plan participant* is hospitalized. The *Plan* pays benefits for *Plan participants* who receive *medical services,* beginning on the first day of such hospitalization.

In order to receive the maximum benefits allowed, these above services must be determined to be *covered health services* by *Anthem BlueCross BlueShield*. Failure to follow the Notification Requirements may result in your claims being denied or paid at a reduced amount.

Surgical Inpatient and Outpatient Services

Anesthesia Services: Benefits are provided for the administration of spinal, rectal, or local anesthesia, or a drug or other anesthetic agent by injection or inhalation. Benefits are also payable for services rendered by a Certified Registered Nurse Anesthetist (CRNA).

Surgical Assistants: Benefits are provided for a licensed *provider* who actively assists the operating surgeon in the performance of surgical services when the condition of the patient and type of surgical services requires such assistance. Benefits are also provided for services rendered by a licensed surgical *physician*'s assistant.

Surgical Services: Benefits are provided for *surgical procedures*, including treatment for fractures and dislocations and routine preoperative and postoperative care.

When more than one *surgical procedure* is performed during the same operative session, the benefit is paid as follows:

- 100% of the applicable PPO or *UCR* rate is considered for calculating the correct benefit of the most complex procedure.

- 50% of the applicable PPO or *UCR* rate is considered for calculating the correct benefit of each subsequent procedure. To allow 100% for the second procedure, it must be independent of the first or major procedure and must be on a different organ system. Each procedure beyond the second procedure will be reviewed to determine if additional benefits are available.

Benefits are only provided for services of an assistant surgeon when determined to be a *covered health service*, and will not exceed 20% of the primary surgeon's allowable charge.

In order to receive the maximum benefits allowed, these services must be determined to be *covered health services* by *Anthem BlueCross BlueShield*. Failure to follow the Notification Requirements may result in your claims being denied or paid at a reduced amount.

Professional Interpretation Services Inpatient and Outpatient

Benefits are provided for the interpretation of diagnostic tests, including pathologist or radiologist interpretation fees.

Emergency Room Services

Benefits are provided for:

- *Emergency* room services due to an accident.
- *Emergency* room services due to an *illness*.

Benefits are also provided for the *provider*'s charges for surgical or medical care rendered in an *emergency* room. An additional copayment of $150 may be required for use of the emergency room

If you are admitted as an inpatient from the *emergency* room, in order to receive the maximum benefits allowed, inpatient services must be determined to be *covered health services* by *Anthem BlueCross BlueShield*. Failure to follow the Notification Requirements may result in your claims being denied or paid at a reduced amount.

Outpatient Services

For a *Plan participant* requiring outpatient care, the *Plan* pays the following benefits when provided in an outpatient department of a *hospital* or in an *ambulatory care center*. The following charges are covered according to the Schedule of Benefits.

Outpatient Diagnostic Examinations: Benefits are provided for services such as X-ray examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), positron emission tomography (PET scans), endoscopy, basal metabolism tests, and electroencephalograms (EEG), when the study is directed toward the diagnosis of a definite condition, disease, or *injury.*

Outpatient Surgery/Surgery Center: Benefits are provided for services administered at a *surgery center,* in an outpatient department of a *hospital,* or in a *physician*'s office, including the *physician* and anesthesiologist charges.

Pre-Admission Testing: Benefits are provided for *pre-admission testing* for expenses *incurred* within 7 days prior to the *hospital* admission for the scheduled procedure.

Outpatient Therapy Services

The following outpatient therapy services are paid according to the Schedule of Benefits.

Cardiac Rehabilitation: Benefits are provided for an outpatient cardiac rehabilitation program, provided the services are determined by *Anthem BlueCross BlueShield* to be *covered health services.*

Chemotherapy Services: Benefits are provided for expenses *incurred* for chemotherapy treatment when prescribed and billed for by a licensed *provider.*

Dialysis: Benefits are provided for kidney dialysis when not reimbursed by *Medicare.*

Intravenous Therapy: Benefits are provided for intravenous therapy.

Occupational Therapy: Benefits are provided for the use of work-related skills to treat or train the physically or emotionally ill, to prevent *disability,* to evaluate behavior, and to restore *disabled* persons to health or to social or economic independence. These services must be performed by a licensed occupational therapist, who evaluates the self-care, work, play, and leisure time task performance skills of well and *disabled* clients of all ages, and plans and implements programs, social activities, and interpersonal activities designed to restore, develop, and maintain the client's ability to accomplish satisfactorily those daily tasks required of his or her specific age and necessary to his or her particular role adjustment.

Osteopathic Manipulation Therapy: Benefits are provided for osteopathic manipulation therapy.

Physical Therapy: Benefits are provided for rehabilitation concerned with restoration of function and prevention of *disability* following disease, *injury,* or loss of a body part. The therapeutic properties of exercise, heat, cold, electricity, ultraviolet light, and massage may be used to improve circulation, strengthen muscles, encourage return of motion, and train or retrain an individual to perform the activities of daily living. These services must be performed by a licensed physical therapist, who is legally responsible for planning, conducting, and evaluating a physical therapy program for patients referred by a *physician.*

Radiation Therapy: Benefits are provided for treatment by X-ray, radium, external radiation, or radioactive isotopes (including the cost of materials unless supplied by a *hospital*), when performed and billed for by the licensed *provider* in charge of the case.

Speech Therapy: Benefits are provided for the evaluation and treatment of *Plan participants* who have voice, speech, language, swallowing, cognitive, or hearing disorders. These services must be performed by a licensed and certified speech therapist.

Vision Therapy: Benefits are provided for vision therapy when services are rendered as active treatment for improvement or correction of an organic medical condition.

Doctor's Office Services

Outpatient Diagnostic X-ray and Lab: Benefits are provided for diagnostic X-ray, laboratory, and pathological services given in a *physician*'s office that are required for the diagnosis of any condition, disease, or *injury,* and that are customarily billed by the *provider* who made such examination.

Chiropractic Services

Benefits are provided for spinal manipulation therapy and related charges, including X-rays. Chiropractic *maintenance care* is not covered. See Medical and Prescription Drug Benefit Limitations and Provisions for annual visit limitations on chiropractic services.

Outpatient Mental Health and Substance Abuse Services

Benefits are provided for outpatient *mental health* and *substance abuse* care by a licensed psychologist, psychiatrist, or *social worker*. Benefits are also provided for *family* and marital counseling.

Preventive Care Benefit

Each *Plan participant* is provided a preventive care benefit to cover the full cost of most preventive health care services. When billed as routine or preventive by the rendering *physician* or laboratory, the following services are usually paid at 100%. (*See note below regarding how to obtain information on current services considered to be preventive care.)

- Blood test to detect diabetes or high cholesterol
- Blood Pressure exam to detect high blood pressure
- Breastfeeding support, supplies (rental or purchase) and counseling
- Contraceptive Management and Counseling for approved birth control devices which require a prescription or are administered by a *physician,* sterilization procedures and patient education and counseling for all women with reproductive capacity.
- Flu Shots
- GYN Exam, including pap tests
- Hemoccult test
- HIV Counseling and screening for woman
- Human papillomavirus test
- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Those solely needed for travel are not covered by the *Plan*.
- Interpersonal and domestic violence screening and counseling for woman
- Mammogram test
- Preventive exam
- Preventive lab
- Preventive testing
- Preventive X-rays
- Preventive colonoscopy: once every 5 years
- Preventive sigmoidoscopy
- Prostate exam
- PSA (Prostate Specific Antigen) test
- Screenings related to adult and child obesity
- Screenings for gestational diabetes during pregnancy
- Well-woman visits, for age appropriate preventive services and screenings

Preventive Care services include outpatient clinic and doctor office services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered as a non-preventive service.

Preventive Care Services in this section shall meet requirements as determined by federal government agencies. Many preventive care services are covered by this *Plan* with no deductible, copayments or coinsurance from the patient when provided by a PPO Network Provider. That means the *Plan* pays 100% of the maximum allowed amount.

*You may call Customer Service using the number on your Anthem ID card for additional information about these services, or view the federal government's web sites:

- http://www.healthcare.gov/center/regulations/prevention.html
- http://www.ahrq.gov/clinic/uspstfix.htm
- http://www.cdc.gov/vaccines/acip/index.html

Other Services

The *Plan* covers charges that are reasonable for many services and supplies. The following are covered:

Abortion, elective

Accidental injury to sound natural teeth

- A sound *natural tooth* is defined as one that is a virgin, unrestored, or as one that, if it has a pre-existing restoration, has two or fewer surfaces restored and the restoration does not encompass more than 1/3 of the width of the occlusal surface or involve a cusp.
- An *injury* caused by chewing or biting is not considered an *accidental injury*.

Acupuncture Treatment: Benefits are provided for covered services rendered by a licensed acupuncturist, up to the annual maximum visits listed in Medical and Prescription Drug Benefit Limitations and Provisions.

Ambulance Service: Benefits are provided for local professional ambulance service to the nearest facility able to treat your condition when that condition warrants the level of skills and equipment typically provided by such ambulance service. This does not cover transfer to another facility unless the first facility is unable to treat your condition.

- This ambulance service may include an air ambulance or regularly scheduled airline, or railroad transportation to the nearest *hospital* qualified to provide the necessary treatment.

Blood transfusions and blood products to the extent the blood bank supply is not replaced.

Clinical Trials: Benefits are provided for in network services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated. Benefits are limited to the following trials:

- Federally funded trials approved or funded by one of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - Any of the following if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        - The Department of Veterans Affairs
        - The Department of Defense
        - The Department of Energy
- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
- Studies or investigations done for drug trials which are exempt from the investigational new drug application.

The Plan is not required to provide benefits for the following **excluded** Clinical Trial services:

- The Experimental/Investigative item, device, or service, itself; or
- Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Cochlear implants

Contraception: Benefits are provided for all FDA approved contraceptive devices as prescribed

Cosmetic services in connection with a congenital malformation, *accidental injury,* or functional disorder.

- **These services require pre-approval from *Anthem BlueCross BlueShield.***

Durable Medical Equipment: Benefits are provided for *durable medical equipment* approved for rental (or, at the *Plan*'s option, purchase). Benefits for *durable medical equipment* are not to exceed the purchase price. This benefit includes repair or replacement due to normal use or to the growth of a child. **These services require pre-notification and must be *covered medical services*.**

Enteral nutrition and non-oral food supplements: enteral nutrition consists of nutritional support given through any of a variety of tubes used in specific medical circumstances. This includes oral feeding, sip feeding, and tube feeding using nasogastric, gastrostomy, and jejunostomy or other tubes. Must meet medically necessary criteria.

Family counseling

Gender Identity Disorder Services and Gender Reassignment Surgery

Hearing aids, coverage is available per ear and is limited as listed in Medical and Prescription Drug Benefit Limitations and Provisions.

Home and office calls by *physicians* for diagnosis and treatment.

Home Health Care (Private Duty Nursing): *Home health care* is an outpatient service that is rendered to a patient in a home setting in lieu of *hospital confinement.* Benefits are provided for *home health care* when services are rendered by a licensed and/or accredited *home health care* agency. While *custodial care* may be rendered in the home and therefore is a form of *home health care,* it is excluded under the *Plan.*

Home health care services may include the skills and services of a nurse (RN or LPN), physical therapist, occupational therapist, speech therapist, and medical *social worker.*

These outpatient *medical services* are covered to the extent that such charges would have been considered *covered charges* had a person required *confinement* in a *hospital* as a registered bed patient, or *confinement* in a *skilled nursing facility.*

Home health care requires review from *Anthem BlueCross BlueShield.* A determination of whether or not a particular *home health care* service is a *covered health service* is based upon, but is not limited to, the level of skill required, the number of hours required, whether or not the treatment plan is appropriate (and whether or not it includes any related patient/*family* training goals), and the review of possible *custodial care*. Ongoing authorization is required and is based upon regular updates from the *home health care* agency or *provider.*

The nursing care may be provided by a registered nurse (RN) or licensed practical nurse (LPN) who does not ordinarily live in your home and who is not a member of your immediate *family*. The services provided by a nurse are divided into two categories: nursing visits and nursing care.

Nursing visits are defined as services rendered by an RN or LPN in the home care setting as ordered by a *physician.* These services are rendered on an intermittent basis for initial and ongoing assessment, treatment, and/or training. A nursing visit includes tasks and skills that a caregiver may be able to perform

after appropriate training. One visit is equal to two hours or less within the same 24-hour period. These benefits are limited as listed in Medical and Prescription Drug Benefit Limitations and Provisions.

Nursing care is defined as services rendered by an RN or LPN in the home care setting as ordered by a *physician.* The services are rendered on an hourly or per diem basis for patients who require ongoing assessment, treatment, evaluation, and training. Nursing care includes tasks and skills that a caregiver may be able to perform after appropriate training. Nursing care for the purpose of training one or more caregivers is covered under this *Plan* provision. Trainable services are identified as part of the initial assessment by the home health nurse and are to be included in the treatment plan. If the nursing care agency indicates that the caregiver has refused to participate or has elected not to provide the services to the patient in those areas identified as trainable, then this refusal is considered to be a matter of convenience for the caregiver. In this case, trainable nursing services would be excluded under the *Plan.* Only those services for which a caregiver cannot be trained and that meet the criteria of *covered health services* are covered under this provision. Nursing care includes hourly care that extends beyond two hours per day. These benefits are limited as listed in Medical and Prescription Drug Benefit Limitations and Provisions.

Medical social services, defined as the practice involving the disciplined application of social work values, principles, and methods, are also covered. These services are provided to a patient in a home environment if a patient and/or *family* is having difficulty adjusting to physical, psychological, financial, environmental, or familial limitations which inhibit recovery from an *illness* or *injury.* A Masters-prepared *social worker* (MSW) may provide advice and counsel, and instruct in the utilization of appropriate community resources. Social work services rendered in the home are subject to the overall home health visit maximum as defined in Medical and Prescription Drug Benefit Limitations and Provisions.

Hospice Care: *Hospice* care benefits for a terminally ill *Plan participant* are provided according to the Schedule of Benefits. **These services require pre-notification and must be *covered health services*.** The *medical services* and supplies of this benefit are provided under the terms of an approved *hospice* care plan and may include:

- Room and board for *confinement* in a *hospice*.
- Services and supplies, including prescription drugs and infusion therapy, furnished by the *hospice* while the patient is confined.
- Part-time nursing care by or under the supervision of a registered nurse.
- Nutrition services and/or special meals.
- *Respite services*.
- Counseling services by a licensed *social worker* or a licensed counselor.
- Bereavement counseling by a licensed *social worker* or a licensed counselor for the *team member* and/or *covered dependent(s)*.

Infertility: Only certain expenses for the diagnosis and treatment of *infertility* are covered:

- Diagnostic testing
- Procedures to restore fertility
- Ovulation management
- Sperm preparation
- Artificial insemination

The Medical Plan will not provide infertility benefits for:

- In vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection or other similar assisted reproductive technologies.
- Purchase of donor sperm or storage of sperm
- Care of donor egg retrievals or transfers
- Sonographic egg recovery
- Culture and fertilization
- Cryopreservation or storage of cryopreserved embryos
- Frozen embryo transfer
- Gestational carrier programs
- Home ovulation prediction kits
- Reversal of surgical sterilization

Additional non-covered services can be found in the Exclusions and Limitations – Medical Section

Infusion Therapy: Inpatient and outpatient service for infusion therapy are covered. Professional services, supplies, drugs, and solutions used in connection with infusion therapy will be provided only under this benefit.

Injectables: Benefits are provided for injectables administered under a *physician*'s care in a doctor or outpatient setting. Substances injected must be covered under the *Plan*. For self-administered injectables, see the Prescription Drug section.

Marital counseling

Mastectomy: mastectomy and all stages of reconstruction of a breast on which a mastectomy has been performed due to cancer or tumor fibrocysts, including the cost of prostheses and physical complications of all stages of mastectomy, including lymphedemas, as such services are recommended by the attending *physician* in consultation with the patient.

If you have received a mastectomy on or after January 1, 1999**,** and you are continuing to receive any benefits under this *Plan* directly related to that mastectomy, this provision includes coverage for any reconstructive surgery on the opposite breast necessary to produce a symmetrical appearance.

Naturopathic Treatment and Diagnosis: Benefits are provided for covered visits and consultations provided by a naturopathic doctor (N.D.) licensed by the state in which he or she operates. Diagnostic laboratory services are also covered. Naturopathic remedies or supplements are not covered.

Obesity treatment, non-surgical: The *Plan* covers outpatient, multi-disciplinary, *hospital*-based weight loss programs, including all costs associated with such programs, such as food and labs. The specific program must be submitted to and approved by the *Plan* prior to initiation of treatment and is subject to the non-surgical obesity treatment lifetime maximum as listed in Medical and Prescription Drug Benefit Limitations and Provisions. Obesity will be determined by the *Plan participant*'s Body Mass Index (BMI).

Obesity treatment, surgical: The Plan covers costs related to certain inpatient and outpatient surgical procedures for obesity. Only Gastric Bypass or Gastric Sleeve surgeries are covered. Liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw, as well as any other procedures not specifically mentioned or any procedure not pre-approved, are not covered. Prior to any surgery, a request for surgery must be submitted to and approved by Anthem prior to initiation of treatment. This will include a review of patient adherence to prior non-surgical therapy, as well as passing certain nutritional and mental health evaluations. Coverage for surgical procedures is limited to Plan participants age 18 and older. Both the procedure and post-surgical treatment must be provided at a COE. Obesity will be determined by the Plan participant's Body Mass Index (BMI of 40 or more).

Oral supplements or augmentation for treatment of the following inborn errors of metabolism: phenylketonuria (PKU), maple syrup urine disease (MSUD), homocystinuria, histidinemia, and tyrosinemia. This includes special medical foods or oral formulas specifically designed to restrict the intake of amino acids. This does not include any over-the-counter supplements or formulas that may be used in conjunction with the prescribed treatment.

Orthotics: Benefits are provided for supportive devices**,** rigid or semi-rigid, which limit or stop motion of a weak or diseased body part. **It is recommended you follow the pre-notification steps to ensure the device is covered by the Plan.**

Oxygen, only for medical purposes, and an oxygen concentrator, when deemed by the *Plan* to be a *covered health service*

Pain management services

Private Duty Nursing – See Home Health Care

Prosthetic Devices and Supplies: Benefits are provided for the purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body extremity (except teeth) and its adjoining tissues, or that replace all or part of the function of a permanently useless or malfunctioning body organ or extremity. **It is recommended you follow the pre-notification steps to ensure the device or supply is covered by the Plan.**

- The *Plan* covers charges for contact lenses following cataract surgery.
- The *Plan* covers charges for orthopedic inserts and their fitting as prescribed by a *physician* when determined to be a *covered health service.*
- The *Plan* covers penile implants if required due to an organic condition.

Self-inflicted *illness* or *injury*

Sleep Disorders: Benefits are provided for the diagnosis and treatment of sleep disorders, unless said treatment is a *Plan* exclusion.

Smoking or Tobacco Dependence Cessation: Non-prescription costs related to smoking or tobacco cessation are payable according to the Schedule of Benefits and are limited as listed in Medical and Prescription Drug Benefit Limitations and Provisions. Covered expenses under the Medical Plan are limited to nicotine replacement therapy; Nicorette gum; participation in individual or group smoking cessation programs, such as SmokEnders; acupuncture; and hypnotherapy. Prescription drugs for smoking cessation are covered by the Prescription Drug benefit without Plan limits.

Note: Tobacco Free Discount for Team Member Medical Paycheck Contributions is provided to a team member's medical contribution when the team member attests to be tobacco free for more than 6 months. Alternatively, participation and completion of a the Terex well-being programs' smoking cessation coaching program will offer the discount rate for completion of the 6 week program.

Sterilization procedures, elective (adult male and female), except for reversals, for the *team member* and covered *spouse* only.

Surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home.

Syringes, needles, and other similar items that serve only a medical purpose, excluding items usually stocked in the home.

Replacement of Organs/Tissues and Other Transplant Services

You must comply with the notification requirements if you require hospitalization for an organ *transplant*, hematopoietic blood or bone marrow *transplant*, or tissue replacement. Notification is also required for outpatient hematopoietic blood and marrow *transplant* procedures.

Inpatient services for *transplant*s are covered according to the Schedule of Benefits. Services and supplies that are considered to be *investigational* or *experimental* are not covered.

Blue Distinction®

The *Plan Administrator* recognizes certain facilities as designated *Blue Distinction Centers (BDC)* due to their history of successful outcomes and pre-negotiated rates. Not every *BDC* specializes in the same type of *transplant*. Thus, one *BDC* may specialize in kidney *transplant*s, while another Center may specialize in heart *transplant*s. The *transplant* needed must be performed at a *BDC* specifically designated for the type of *transplant* which you are seeking.

If you choose to utilize a *BDC* that is recognized by the *Plan Administrator*, the *Plan* will cover 100% of the cost of your *transplantation* procedure, not subject to the deductible for those enrolled in Medical 500 or Medical 1000. If you do not choose to utilize a *BDC* that is recognized by the *Plan Administrator*, or are enrolled in Medical HSA, your expenses will be reimbursed according to the Schedule of Benefits.

If you need help locating an appropriate *BDC* that specializes in the type of *transplantation* you need, *Anthem BlueCross BlueShield*'s *transplant* specialist is available to help you find a *transplant facility* that will meet your needs.

For the purposes of the *Plan*, the term *transplant* does not include cornea *transplantation*, skin grafts, or the *transplant* of blood or blood derivatives (except for hematopoietic stem cells.) Benefits for such services are provided under the *Plan*'s other benefits.

Solid Organs

This *Plan* provides benefits for the *transplantation* of solid human organs (with other human organs) and related services. This *Plan* excludes *transplantation* of non-human organs.

Blood and Bone Marrow Transplants

This *Plan* provides benefits for blood or bone marrow *transplant* procedures of hematopoietic stem cells that qualify as *covered health services,* including, but not limited to, synergic and allogeneic (homologous) blood or bone marrow *transplant*s, as well as autologous blood or bone marrow *transplant* procedures. These benefits are payable according to the Schedule of Medical Benefits. Services and supplies that are considered to be *investigational* or *experimental* are not covered.

Finding a donor who is an acceptable match for donation is important to the success of an allogeneic (homologous) blood or bone marrow *transplant*. Because an immediate *family* member has the greatest chance of being an acceptable match, benefits for donor testing are initially provided only for members of the immediate *family*. For purposes of this section, immediate *family* members include mother, father, biological children, and biological siblings. If a donor match cannot be identified in the immediate *family*, the *Plan* will cover a search for a matched unrelated donor through the National Marrow Donor Program (NMDP) national registry.

Tissue Replacement

This *Plan* also provides benefits for the replacement of human tissue (with human tissue or prosthetic devices), including porcine (pig) heart valve replacement procedures. These benefits are payable according to the Schedule of Medical Benefits. Services and supplies that are considered to be *investigational* or *experimental* are not covered.

Other Benefits Related to Transplantation

Benefits are also provided for:

- the preparation, acquisition, transportation, and storage of human organs, bone marrow, or human tissue.
- transportation of the *Plan participant*, of the organ recipient, and one member of the *Plan participant*'s immediate *family* or one significant other to and from the site of the *transplant* procedure.
- reasonable lodging expenses for the *Plan participant* and one member of the *Plan participant*'s immediate *family* or one significant other at the time of the *transplant* procedure.

Specific rules apply as to the payment of benefits for the donor and recipient of the transplanted organ, bone marrow, or tissue.

- When the *transplant* recipient and donor are **both** covered under this *Plan*, payment for covered services is provided for both, subject to each *Plan participant*'s respective benefit maximums.
- When the *transplant* recipient is covered under this *Plan* but the donor is not, payment for covered services is provided for both the recipient and the donor to the extent that charges for such services are not payable by any other source. Benefits payable on behalf of the donor are charged to the recipient's claim and applied to the recipient's maximums.
- When the *transplant* recipient is not covered under this *Plan* but the donor is covered, payment for covered services attributable to the donor is provided to the extent that charges for such services are not payable by any other source. Benefits are not provided for services attributable to the recipient.

Care Outside the United States

If you need *emergency* services when traveling outside the United States, the BlueCard Worldwide program provides coverage through an international network of *hospital*s, doctors and other healthcare *provider*s. With this program, you're assured of receiving care from licensed healthcare professionals. The program also assures that at least one staff member at the *hospital* will speak English, or the program will provide translation assistance. To find participating *provider*s, visit www.bcbs.com and click on "Healthcare Anywhere." In order to access the international directory of *provider*s, You will need to enter Your Anthem identification number that is located on the front of Your Identification Card.

Routine or preventive care is not covered. Any hospitalization requires the same notification requirement to be completed as is required for U.S. hospitalization. If a *Plan participant* is covered under another government's health plan, this *Plan* will not pay for the benefits while he or she is in that country.

Exclusions and Limitations Medical

The following services and supplies are NOT covered by this *Plan*:

∅ **Absence of coverage:** charges that would not have been made in the absence of coverage.

- This includes charges that are submitted to the *Plan* equal to any amount that the *provider* has discounted his or her fees or has "written off" amounts due.

∅ ***Accidental injury:*** *injuries* resulting from an accident for which you are reimbursed or entitled to be reimbursed by another party or insurer; however, the *Plan* may make payment on these claims with the understanding that the *Plan* will be reimbursed in accordance with the reimbursement provision contained in the Reimbursement and Subrogation section of this SPD.

- ∅ **Breast surgery or services:** altering the size or shape of the breast, male or female, whether elective or not.

    - This exclusion does not apply to reconstructive surgery performed as a result of a mastectomy due to cancer or tumor fibrocysts, either on the affected breast or, for mastectomy benefits received on or after **January 1, 1999**, on the opposite breast for the purpose of achieving a symmetrical appearance.

    - This exclusion does not apply to breast reduction surgery if a treatment plan is submitted in advance to *Anthem BlueCross BlueShield* and the *Plan participant* has multiple medical conditions that are worsened by the natural size of the breasts.

- ∅ **Charges in excess of the *semi-private room* rate,** except as otherwise noted.

- ∅ **Chiropractic *maintenance care***

- ∅ **Civil insurrection or riot:** treatment or services for *injuries incurred* or exacerbated while participating in a civil insurrection or riot.

- ∅ **Claims** received by *Anthem BlueCross BlueShield* later than one year from the date of service. Refer to How to File A Claim for more information.

- ∅ **Completion of claim forms**

- ∅ **Complications** due to, and services related to, non-covered services.

- ∅ **Corrective shoes,** except for the prescription to change part of the shoe. **It is recommended you follow the pre-notification steps to ensure the service is covered by the Plan.**

- ∅ ***Cosmetic services* or aesthetic services** (including complications).

    - This exclusion does not apply to services in connection with an *accidental injury* or *illness*, a congenital anomaly, or functional disorder. **Approval by *Anthem BlueCross BlueShield i*s required.**

- ∅ **Court-ordered services** that would not be otherwise covered under the *Plan.*

- ∅ ***Custodial care**,* except as specified.

- ∅ **Dental *hospital* services,** except for an accompanying condition that is determined to be a *covered health service*.

- ∅ **Dental prescriptions** (e.g., Peridex, fluoride).

- ∅ **Dental services,** unless otherwise specified.

- ∅ **Diagnostic studies:** room and board or general nursing care for *hospital* admissions solely for diagnostic studies.

- ∅ **Dietary supplements:** products taken by mouth that contain a “dietary ingredient” intended to supplement the diet. These are typically over-the-counter products used in conjunction with a regular diet. PKU formula is covered under the medical benefits of this *Plan*, but NOT through the prescription drug coverage.

- ∅ **DNA testing**

∅ **Drugs and medicines** that, as required by law, may be dispensed only by a registered pharmacist on the written prescription of a *physician* (excluded by the medical provisions of the *Plan*). Prescription drugs may be covered under your prescription drug card program and prescription drug mail service program.

- This exclusion does not apply to drugs and medicines dispensed by a registered pharmacist on the written prescription of a *physician* while the *Plan participant* is an inpatient in a *hospital* or *Plan* approved injectables administered under a *physician*'s care.

∅ **Eating disorders**, inpatient or outpatient treatment, unless a treatment plan has been submitted to and approved by *Anthem BlueCross BlueShield* prior to initiation of treatment.

∅ **Educational, vocational, or training purposes,** services or supplies, including vocational assistance and outreach or social, lifestyle, nutritional, and fitness counseling.

- This exclusion does not apply to educational services rendered for support services provided in the *substance abuse* care treatment benefit, counseling provided under the *mental health* benefit, diabetic counseling, peritoneal dialysis, or any other educational service deemed to be a *covered health service* by the *Plan.*

∅ **Environmental change,** hospitalization (such as hospitalization for children or adolescents due to *family* adjustment or relationship disorders).

∅ **Expenses relating to non-human organ or tissue *transplants*, gene therapies, xenographs or cloning,** except porcine (pig) heart valve procedures.

∅ ***Experimental* treatment**, procedures, facilities, equipment, drugs, devices, supplies, or services.

- In some cases, the applications of an established procedure, as a course of treatment for a specific condition, may be considered *experimental*, and hence, not covered by this *Plan.*

∅ **Felonious act or act of terrorism:** treatment or services for *injuries incurred* while committing a felonious act or act of terrorism for which the individual is convicted.

∅ **Fertility drugs,** neither through medical or prescription drug coverage.

∅ **Foot care services, routine**, including, but not limited to, cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive and *maintenance care*; performed in the absence of localized *illness, injury*, or symptoms involving the foot.

Formula (Infant): This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed Pharmacist.

∅ **Gamete intrafallopian transfer (GIFT)**

∅ **Genetic testing and/or counseling,** except during pregnancy.

∅ **Government services:** services furnished by a government (including governments of foreign countries) or division thereof, except a program for civilian employees of a government.

∅ **Growth hormone therapy.** These services may be covered under your prescription drug card program.

∅ ***Halfway house***

∅ **Immediate *family:*** treatment provided by a member of your immediate *family* (blood, marriage, or adoption) or yourself.

- ∅ **Impotence treatment including medications, except penile implants.** Certain medications to treat impotence may be covered under your prescription drug benefit.

- ∅ **In vitro fertilization**

- ∅ ***Infertility*** **treatment,** except as specifically covered.

- ∅ **Massage therapy,** unless applied in conjunction with other active physical therapy modalities for a specific *illness* or *injury.*

- ∅ ***Military service:*** treatment or services resulting from or prolonged as a result of performing a duty as a member of the *military service* of any state or country.

- ∅ **Missed appointments**

- ∅ **No charge:** services for which the *Plan participant incurs* no charge.

- ∅ **Not eligible:** charges *incurred* while not eligible for a benefit, such as prior to your effective date or subsequent to your coverage termination date.

- ∅ **Obesity treatment**, except as specifically covered. This Exclusion does not apply to gastric sleeve or gastric bypass when approved by the Plan. Excluded procedures include, but are not limited to, specific bariatric services and surgeries (e.g., lap band, liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw.

- ∅ covered for certain non-surgical services.

- ∅ **Oral contraceptives,** unless covered under your prescription drug card program.

- ∅ **Orthodontics.** See Dental Benefits.

- ∅ **Orthognathic surgery** (jaw realignment surgery): Services or supplies to correct retrognathia, apertognathia, prognathism, open bite malocclusion, transverse skeletal deformities, or other craniomandibular disorders and other conditions of the joint linking the jawbone and skull, and the muscles, nerves, and other tissues related to that joint, or for the diagnosis or treatment of Temporomandibular Joint Syndrome (TMJ). See Dental Benefits.

- ∅ **Other plan:** charges for services, in whole or in part, available to and covered for the *Plan participant* under any other group plan sponsored by the *employer*.

- ∅ **Patient convenience:** expenses *incurred* in the modification of homes, vehicles, or personal property to accommodate patient convenience items. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment, and cervical pillows.

- ∅ **Penalties** for non-compliance with the notification requirements for inpatient services.

- ∅ **Personal hygiene** or convenience items.

- ∅ **PET Scans, routine**

- ∅ **Premarital tests** not incidental to the treatment of a manifested *injury* or *illness.*

- ∅ **Prenatal vitamins.** These items may be covered under your prescription drug benefit.

- ∅ **Preoperative and postoperative visits** made by your surgeon or assistant surgeon on or after the date of your surgery, if billed as a separate line item.

- This exclusion does not apply to preoperative or postoperative visits that are appropriate to bill separately based on medical and procedural coding criteria.

∅ **Prescription Drugs** not included on the Express Scripts, Inc. (ESI) current National Preferred Formulary are excluded from plan coverage.

∅ **Prohibited by law:** charges for which the *Plan* is prohibited by law or regulation from providing benefits.

∅ **Radial keratotomy, keratomileusis, or other vision correction procedures.** These items may be covered under Vision Benefits.

∅ **Reimbursement:** *injuries* resulting from an accident for which you are reimbursed or entitled to be reimbursed by another party or insurer; however, the *Plan* may make payment on these claims with the understanding that the *Plan* will be reimbursed in accordance with the reimbursement provision contained in the Reimbursement and Subrogation section of this SPD.

∅ ***Residential care facility***

∅ **Reversal of sterilization**, male or female.

∅ **Sclerotherapy** for varicose veins, if not medically necessary.

∅ **Services furnished** or available to the *Plan participant*, in whole or in part, under the laws of the United States, or any state, or political subdivision thereof, or for which the *Plan participant* would have no legal obligation to pay in the absence of this or any similar coverage.

∅ **Sterilization of a *dependent child***

∅ **Surrogate parent agreement**, whether written or oral.

∅ **Tax and shipping** levied on items and services.

- This exclusion does not apply to surcharges required to be paid in applicable states.

∅ **Teeth or gum treatment,** or the fitting or wearing of dentures. See Dental Benefits.

- This exclusion does not apply to treatment of *accidental injury* to sound *natural teeth*.

∅ **Telephone and television** service while confined as an inpatient.

∅ **Telephone consultations.**

∅ **Temporomandibular Joint Syndrome – See Dental Benefits**

∅ **Travel**, even though prescribed by a *physician.*

- This exclusion may not apply to a *Plan participant* who is an organ *transplant* recipient, one adult accompanying the *transplant* recipient, and/or two parents when the *transplant* recipient is a minor child to travel to and from the site of the *transplant*.

∅ ***UCR,* over:** the portion of any charge that is in excess of the *UCR* charge for a particular service or supply.

∅ **Vitamins,** except in cases of deficiency, which may be covered under the prescription drug benefit.

∅ **Weekend *hospital* admissions, elective**

- ∅ **Without approval:** services furnished without the recommendation and approval of a *physician* acting within the scope of his or her license.

- ∅ **Work-related *illness* or *injury*:** treatment for an *illness* or *injury* for which the eligible *team member* or *covered dependent* is entitled to benefits under any Workers' Compensation or similar law.

- ∅ **Zygote intrafallopian transfer (ZIFT).**

Prescription Drug Benefits

This *Plan* provides benefits for prescription drugs (including certain over the counter medications) ordered by a *physician* for treatment *incurred* because of an *accidental injury* or *illness,* or as a result of pregnancy, childbirth, or a related medical condition. The prescription drug program *claims administrator* is Express-Scripts, Inc. (ESI).

Prescription Drug Benefit - Retail Pharmacy

When you purchase your prescription drugs through the retail drug program and use a *participating pharmacy* (a pharmacy that honors the ESI prescription drug benefit), simply present your Anthem ID card.

An annual deductible first applies to any preferred or non-preferred brand name drugs. After any applicable deductible, you then make the required co-payment amount as indicated in the Schedule of Benefits. Each retail pharmacy prescription has a 30-day supply limit, unless otherwise limited by state or federal law or other plan coverage restrictions. Co-payments for the prescription drug benefits apply to the prescription out-of-pocket maximum.

Prescription Drug Benefits — Mail Order and Walgreen's Smart 90

Benefits are also provided to *Plan participants* for maintenance prescription drugs through a mail order program or through local Walgreen's pharmacies as indicated in the Schedule of Benefits. Each prescription has a 90-day supply limit, unless otherwise limited by state or federal law.

For more information on the Walgreens' Smart 90 maintenance drug program, visit www.express-scripts.com

How to Use the Mail Order Service

To participate in the mail service:

- Obtain a mail order form from ESI or your local Human Resources Representative.
- Complete the patient profile questionnaire (for your first order only).
- Ask your *physician* to prescribe the needed medication for a 90-day supply, plus refills if applicable.
- If you are presently taking medication when you join the Terex Medical Plan, you will need a new prescription.
- If you need the medication immediately, **but will be taking it on an ongoing basis,** ask your *physician* for two prescriptions: one for a smaller supply that you can have filled at a local retail pharmacy, and one for the balance of the prescription, a 90-day supply or more, that you can submit to the mail service.
- Send the completed patient profile questionnaire to the address on the form along with your original prescription(s).

Once your order is processed, it will be sent to you via First Class Mail and will include instructions for the re-order of future prescriptions and/or refills.

Covered Prescriptions

Under the prescription drug benefit, covered benefits include federal legend drugs, state-restricted drugs, insulin, syringes and needles (used only to inject insulin) that are included in the Express Scripts, Inc. (ESI) current National Preferred Formulary.

Exclusions and Limitations Prescription Drugs

The following services and supplies are not covered:

- ∅ **Any claim or demand for *injury* or damage** arising in connection with manufacturing, compounding, dispensing, or use of any prescription drug.

- ∅ **Any prescription or refill that is in excess of the quantity specified by a *physician*, or that is dispensed after one year from the *physician*'s order.**

- ∅ **Baldness:** Medications for the treatment of baldness.

- ∅ **Biological sera, such as rabies serum.**

- ∅ **Birth control devices.** These items are covered under Medical Benefits.

- ∅ **Blood or blood plasma.**

- ∅ **Cosmetic use:** Drugs which are prescribed or dispensed for cosmetic use.

- ∅ **DHEA,** Dehydroeplaamdrosterone. (Human Growth Hormone)

- ∅ ***Experimental* or *investigational* drugs,** including compounded medications for non-FDA-approved use.

- ∅ **Glucowatch products.**

- ∅ **Immunization agents.**

- ∅ ***Infertility*:** Injectable or oral drugs for the treatment of *infertility*.

- ∅ **Injectables** in a doctor or outpatient setting which may be covered under the medical benefit of this *Plan*. Other prescriptions requiring parenteral administration or use (other than insulin) are excluded.

    - This exclusion does not pertain to **s**elf-administered injectables when the substance is covered by the prescription drug benefit of this *Plan*.

- ∅ **Intravenous therapy drugs or solutions.**

- ∅ **Legend medications with over the counter equivalents.**

- ∅ **Non-legend (over the counter) drugs,** other than insulin and ephedrine-containing products (e.g., *emergency* allergy treatment kits) or drugs which by law do not require a *physician*'s prescription.

- ∅ **Ostomy supplies.**

- ∅ **Parenteral administration:** Injectables or other prescriptions requiring parenteral administration or use (other than insulin).

- ∅ **Prescription barrier contraceptives,** such as diaphragms. These items are covered under Medical Benefits.

- ∅ **Prescription dental products,** including Peridex.

- ∅ **Services other than prescription drugs,** administration or injection of any drug, drugs delivered or administered by the *Plan participant*.

∅ **Smoking cessation products and services (over the counter).**

> **Note:** Non-prescription smoking cessation items or services are reimbursable by the participant filing a medical claim form to Anthem and are subject to a lifetime maximum.

∅ **Take-home drugs** dispensed and billed by a medical *facility*.

∅ **Therapeutic devices** or appliances, (including, but not limited to, hypodermic needles, syringes, except as stated, support garments, and other non-medical substances), regardless of their intended use.

∅ **Weight loss medications.**

∅ **Workers' Compensation:** prescriptions which an eligible person is entitled to receive, without charge, under any Workers' Compensation law, or under any municipal, state, or federal program.

HEALTH MANAGEMENT AND SERVICES SPECIAL PROVISIONS

To use any of the services listed in this section, contact Anthem BlueCross BlueShield at 1-800-889-4169, between the hours of 8 a.m. to 8 p.m. ET Monday through Friday.

It is important to remember that this *Plan* covers only those procedures, services, and supplies that qualify as *covered health services*.

Services that do not qualify as *covered health services* include, but are not limited to:

- Procedures of unproven value or of questionable current usefulness.
- Procedures that could be unnecessary when performed in combination with other procedures.
- Diagnostic procedures that are unlikely to provide a *physician* with additional information when used repeatedly.
- Procedures that are not ordered by a *physician* or that are not documented in a timely fashion in the patient's medical record, or that can be performed with equal effectiveness at a lower level of care facility (e.g., on an outpatient basis versus an inpatient basis).

For example, a *hospital* admission that would not qualify as a *covered health service* would be one that does not require acute *hospital* bed patient care and could have been provided in a *physician*'s office, *hospital* outpatient department, or lower level of care facility without reduction in the quality of care provided and without harm to the patient. Also, a *hospital* admission primarily for observation, evaluation, or diagnostic study that could be provided adequately and safely on an outpatient basis would not qualify as a *covered health service*.

Case Management

Case management is a service that your *employer* has included in your benefit *Plan* at no cost to you. *Anthem BlueCross BlueShield* case managers are registered nurses with extensive clinical experience.

When you are suffering from a serious *injury* or *illness* and require extensive treatment, you may be offered case management. You or your *family* may request this service at any time.

When you request this service, a case manager will contact you by phone or by mail to request your consent. Should you decide to give consent for case management, the case manager can:

- Help you make the best use of your health care benefits.
- Be an advocate in regards to benefits and helping you obtain needed services within the confines of your benefit *Plan*.
- Provide you with information about your particular *illness(es)* and treatment options.
- Help you access needed resources, medications, and/or medical equipment.
- Answer your questions about the plan of treatment, help you prepare for medical appointments, and help you get information about your medical claims.
- You may request a case manager at any time by calling *Anthem BlueCross BlueShield* at the toll-free number on your Anthem ID card and asking the operator to connect you with your claims team representative.

Case managers will maintain your confidentiality according to federal guidelines. Once assigned a case manager, you may call anytime at the toll-free number your case manager provides.

You may be eligible for benefits not specifically described in this Summary Plan Description if:

- charges result from a treatment plan identified through ongoing case management,
- the treatment plan results in charges which are less costly than those otherwise covered under this *Plan,* or
- the treatment plan is approved by the *Plan Administrator*.

The kinds of services covered by this *Plan* cannot be expanded except as approved by the *Plan Administrator* on a case-by-case basis meeting the requirements set forth above. In no event will approval of a treatment plan identified through case management increase the dollar limits of the *Plan's* liability otherwise set forth in this Summary Plan Description.

Each treatment plan is individually tailored to a specific patient. Any care or treatment provided will not be considered setting any precedent or creating any future liability, with respect to that patient or any other patient, even one with the same diagnosis.

Case Management is a voluntary service. There is no reduction of benefits or penalty if the patient and family chose not to participate.

Notification Requirements for Inpatient Services

A *hospital* stay can be a serious and expensive part of your course of treatment. This *Plan* has a feature to assist you in making sure that you are not hospitalized unnecessarily. If you are admitted to (or registered as a patient at) a *hospital* or a *rehabilitation facility*, whether for *emergency* treatment, elective non-emergency treatment, or maternity care in excess of 48 hours for normal delivery or 96 hours for cesarean delivery, you or a member of your *family* should call *Anthem BlueCross BlueShield* Compliance with the notification requirements is the sole responsibility of the *Plan participant.* Compliance with the notification requirements is also required for any extended *hospital* stay for an observation in excess of 23 hours. You must call *Anthem BlueCross BlueShield* within two business days following your admission or a non-compliance penalty will apply.

Urgent Care or Emergency Admissions

If a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to notify the *Plan* in advance. The *Plan participant* should obtain such care without delay. However, you must call *Anthem BlueCross BlueShield* within two business days following your admission or a non-compliance penalty will apply.

If you or a *covered dependent* must be admitted on an *emergency* basis, follow the *physician*'s instructions carefully and contact *Anthem BlueCross BlueShield* by telephone within two business days after the admission date.

The contact may be made by you, a *family* member, or your *provider*. The *Plan* does not require you or a *covered dependent* to obtain approval of a health care service prior to getting treatment for an urgent care or *emergency* situation, so there are no "pre-service urgent care claims" under the *Plan*. In an urgent care or *emergency* situation, simply follow the *Plan*'s procedures with respect to any notice that may be required after receipt of treatment, and file the claim as a post-service claim.

Non-Emergency Admissions

For inpatient services that are scheduled in advance, call *Anthem BlueCross BlueShield* as soon as possible before actual services are rendered.

Anthem BlueCross BlueShield's nurse and your admitting *hospital* review your inpatient treatment plan before and during your hospitalization. The objective is to help you obtain all the information you need to make informed decisions. The *Anthem BlueCross BlueShield* nurse:

- checks the *hospital* admission and length of stay against generally accepted medical standards, and
- suggests alternate treatment settings, if appropriate.

You will be notified by mail of the approved length of stay. Additional days may be assigned based on continuing review.

Non-Compliance Penalty

The final decision regarding treatment and hospitalization is yours. Maximum allowable *Plan* benefits are paid as long as you follow the above instructions and procedures for any inpatient hospitalization and treatment and/or hospitalization otherwise qualifies for coverage under the terms of the *Plan* contained herein.

However, if you fail to notify *Anthem BlueCross BlueShield* of any covered inpatient hospitalization as required above, allowed charges will be reduced as follows and you will be responsible for payment of the part of the charge that is not paid by the *Plan*.

If you fail to follow these steps, the *Plan* pays your claim at a reduced amount. After the benefits payable under this *Plan* are calculated, the benefits are further reduced by 20% or $500, whichever is less. The reduction of the claim, for which you are responsible, cannot be used to satisfy the annual deductible. You have the right to appeal any claim denial. See Appeal of Adverse Benefit Determinations in the How to File a Claim section.

Notification Requirements for Outpatient Services

The following services require notification and/or approval of a treatment plan in advance. Refer to this document for complete information on the notification requirement for each service listed:

- Durable medical equipment, rental or purchase
- Eating disorder treatment plans
- Hospice care
- Obesity, surgical and non-surgical treatment plans

Pre-Determination of Medical/Surgical Benefits

The Pre-Determination of Medical/Surgical Benefits Program is voluntary and allows you to make an informed decision before committing to a specific treatment. Participation in this program provides assurance in advance that the recommended service is an allowable expense under the *Plan*, and is a *UCR* charge.

It is suggested that this pre-determination program is used especially when you anticipating any of the following services:

- Breast reduction surgery.
- *Cosmetic services* even when preformed in conjunction with a congenital malformation, *accidental injury*, or functional disorder.
- *Home health care* services which include the services of a nurse (RN or LPN), physical therapist, occupational therapist, speech therapist, and medical *social worker.*
- Orthotics.
- Prosthetic devices and supplies.

When your *physician* recommends that you undergo a specific course of treatment, contact *Anthem BlueCross BlueShield* for Pre-Determination of Medical/Surgical Benefits. *Anthem BlueCross BlueShield* will:

- review the proposed treatment*,*
- check the treatment's eligibility for coverage and the extent of coverage relative to your *Plan,* and
- review the proposed charges and the reasonableness of planned treatment and fees.

Upon review of the information, *Anthem BlueCross BlueShield* returns to you and to your *physician* a determination outlining the proposed treatment's eligibility as a *covered charge,* and whether the surgeon's fees are within the *UCR* charges for that procedure. The decision regarding treatment remains with you and your *physician.*

Pre-determination of benefits does not guarantee payment. Exact benefits are determined based on the eligibility of the *Plan participant* at the time services are rendered.

This *Plan* does not provide benefits for certain services unless a pre-determination of benefits is obtained in advance. Refer to the Exclusions and Limitations Medical section.

It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the *Plan* or *Anthem BlueCross BlueShield* for pre-determination of benefits. The *Plan participant* should obtain such care without delay.

DENTAL BENEFIT LIMITATIONS AND PROVISIONS

Dental Benefit Limits

Eligibility	
Plan Participant	See Eligible Team Members and Effective Dates Section.

Deductibles		
	Premium Dental	***Basic Dental***
Per Individual	$50 per year for Type B Benefits	$50 per year for Type B Benefits
Per *Family*	$150 per year for Type B Benefits	$150 per year for Type B Benefits
The deductible applies to Type B dental benefits, and applies to each covered member of a *family*. However, when *family* members *incur* any combination of *covered charges* totaling the *family* deductible in any calendar year (as long as no one person contributes more than his or her individual amount), then the deductible amount is considered satisfied for your entire *family*.		

Limits for Certain Services		
	Premium Dental	***Basic Dental***
Lifetime Maximum	$2,000 for Orthodontic Services per eligible *Plan Participant*	Orthodontic Services not covered
	$2,500 for non-surgical TMJ related services	TMJ services not covered
Annual Maximum	$2,000 per *Plan participant*, excluding Orthodontic Services	$1,000 per *Plan participant*

A Look at Your Options

There are two coverage options under the *Plan* for dental coverage: Premium and Basic. Some services are covered in the same manner under both options, but for some services, the percentage of coinsurance is different depending on which option you elected. In addition there are differences regarding:

- ⇒ the limits for certain services (e.g., orthodontic and TMJ services have a lifetime maximum under the Premium option but are not covered at all under the Basic option);
- ⇒ annual maximums for *covered charges* ($2,000 for Premium Dental ; $1,000 for Basic Dental); and
- ⇒ your payroll contributions.

Use of In-Network Providers

When you need to see a *dentist*, you can select an in-network dental *provider* or choose one outside the network – your dental coverage is the same either way. However, if you use an in-network dental *provider*, they will bill at the PPO rate and the cost for services may be lower. This means your benefits will go further before you reach your annual maximum. You may go to any licensed *dentist* in the U.S. Charges for out-of-network *provider*s will be paid based on usual, customary and reasonable rate (*UCR*).

Schedule of Benefits

Type A Benefits - Preventive & Diagnostic		
	Premium Dental	***Basic Dental***
Oral Exams and Prophylaxis Treatment	100% of PPO rate* — 3 per calendar year	100% of PPO rate* — 3 per calendar year
Dental X-rays, Bitewing	100% of PPO rate* — 1 per calendar year	100% of PPO rate* — 1 per calendar year
Dental X-rays, Diagnostic	100% of PPO rate* — not to exceed 12 periapicals per calendar year	100% of PPO rate* — not to exceed 12 periapicals per calendar year
Dental X-rays, Full-Mouth, Panoramic	100% of PPO rate* — 1 every 36 months	100% of PPO rate* — 1 every 36 months
Sealants, covered children under age 19	100% of PPO rate* — 1 treatment per permanent posterior tooth per lifetime	100% of PPO rate*, 1 treatment per permanent posterior tooth per lifetime
Space Maintainers, covered children under age 19	100% of PPO rate*	100% of PPO rate*
Topical Fluoride, covered children under age 19	100% of PPO rate* — 2 treatments per calendar year	100% of PPO rate* — 2 treatments per calendar year
Emergency Palliative Treatment	100% of PPO rate*	100% of PPO rate*

Type B Benefits Major & Minor Restorations, Periodontics, & General Services		
	Premium Dental	***Basic Dental***
Fillings	80% of PPO rate*, subject to deductible	50% of PPO rate*, subject to deductible
Endodontic Treatment	80% of PPO rate*, subject to deductible	50% of PPO rate *, subject to deductible
Dental Implants	80% of PPO rate*, subject to deductible	50% of PPO rate *, subject to deductible
Impactions (surgical removal)	80% of PPO rate*, subject to deductible	50% of PPO rate *, subject to deductible
Crowns, Inlay and Onlays	80% of PPO rate*, subject to deductible	50% of PPO rate *, subject to deductible
Bridges and Dentures	80% of PPO rate*, subject to deductible	50% of PPO rate *, subject to deductible
Diagnostic Casts	80% of PPO rate*, subject to deductible	50% of PPO rate *, subject to deductible
Prosthodontics Maintenance	80% of PPO rate*, subject to deductible	50% of PPO rate *, subject to deductible
Osseous Surgery	80% of PPO rate*, subject to deductible	50% of PPO rate *, subject to deductible
Oral Surgery	80% of PPO rate*, subject to deductible	50% of PPO rate *, subject to deductible
Antibiotic Injections	80% of PPO rate*, subject to deductible	50% of PPO rate *, subject to deductible
General Anesthesia	80% of PPO rate*, subject to deductible	50% of PPO rate *, subject to deductible
Periodontal Treatment	80% of PPO rate*, subject to deductible	50% of PPO rate *, subject to deductible
Temporomandibular Joint Treatment (TMJ) Non-surgical	80% of network rate*, subject to deductible and lifetime maximum	Not Covered

Type C Benefits -Orthodontic Services		
	Premium Dental	***Basic Dental***
Orthodontic Treatment All *Plan Participants*	50% of PPO rate*, subject to lifetime maximum of $1,750	Not Covered
	Claims for diagnostic charges, models, photographs and initial placement fee not to exceed $1,500.	

* Out of Network is subject to Usual, Customary and Reasonable (UCR) charges

Detailed Description of Dental Benefits

Alternate Benefit Provision

When more than one type of dental service can provide appropriate treatment based on accepted dental standards, *Anthem BlueCross BlueShield* will determine the dental service on which payment will be based and charges that will be included as *covered charges.*

Type A Benefits

The *Plan* covers the preventive and diagnostic services as described below according to the Dental Schedule of Benefits.

Oral Examinations: Benefits include oral examinations, diagnosis, and preparation of a treatment plan, as needed.

Prophylaxis Treatment: Benefits are provided for preventive treatments including cleaning, scaling, and polishing of teeth.

Dental X-rays: Benefits are provided for bitewing X-rays, for other *dentally necessary* dental X-rays rendered in connection with the diagnosis for specific conditions requiring treatment, and for full-mouth dental X-rays.

Sealants: Benefits are provided for sealants for covered *dependent children* under age 19, limited to one treatment per non-restored permanent posterior tooth per lifetime.

Space Maintainers: Benefits are provided to covered *dependent children* under age 19 for space maintainers, not made from precious metals which replace prematurely lost teeth.

Topical Fluoride: Benefits are limited to 2 in a calendar year for *dependent children* under age 19.

***Emergency* Palliative Treatment:** Benefits are provided for the *emergency* relief of dental pain as administered by a *dentist*, and are not accepted as any other eligible dental procedure.

Type B Benefits

The *Plan* covers services for crowns, major restorations, minor restorations, periodontics, general services, and oral surgery as described below according to the Dental Schedule of Benefits. All charges relating to bridges, partials, dentures, and crowns are considered for payment at the time they are seated and/or permanently cemented in the *Plan participant*'s mouth.

Fillings: Benefits are provided for one restoration per surface per tooth every 24 months. Fillings may consist of silver amalgam, composite resin, and plastic restorations. Base materials include dycal, engenol, and zinc oxide, and in the treatment of pulp capping are used as a base (or liner) in the prepared (cleaned) cavity prior to filling with silver or a tooth-colored restoration. Composite restorations are covered on all teeth with frequency limitation of once per surface per tooth every 24 months.

Endodontic Treatment: Benefits are provided for endodontic treatment including, but not limited to:

- Pulp Capping – Limited to permanent teeth only; once per lifetime per tooth
- Pulpotomy – Limited to deciduous teeth only; once per lifetime per tooth
- Root Canal Therapy – Limited to once per tooth per lifetime
- Retreatment of a Previous Root Canal – Limited to once per tooth per lifetime
- Apexification – Add to list of exclusions as this procedure is not a covered benefit
- Apicoectomy – Limited to one per lifetime per tooth
- Retrograde Filling – Limited to once per lifetime per tooth
- Hemisection – Limited to once per lifetime per tooth

All charges relating to multiple visit treatment procedures are considered for payment at the time of the last appointment to complete the procedure.

Dental Restorations: Benefits are provided for dental restorations and supplies such as inlays and onlays (not part of a bridge) and crowns (not part of a bridge). One- and two-surface inlays and onlays alternate to amalgam fillings. Benefits for temporary appliances (i.e., crowns, partials, dentures, fixed bridges) will be deducted from the *UCR* amount of the permanent appliance. Benefits are provided for the restoration only if it is at least 5 years from the initial placement or last replacement.

Dentures and Bridges: Benefits are provided for dentures, full and partial, as well as for bridges, fixed and removable, if:

- the denture or bridge is made for an initial placement.
- the denture or bridge is made at least 5 years after a denture or bridge placement or replacement.
- the denture or bridge is not made necessary by reason of the loss or theft of a denture or bridge.
- the denture or bridge is not made necessary by reason of the loss of a tooth (or teeth) missing. Please note, the current pre-existing condition for missing teeth has been removed and replaced with the below provision:
  - Missing Tooth Exclusion: Coverage for a *team member* and/or their dependents, new to the Dental benefits of the *Plan* on or after January 1, 2009 will now exclude any bridge or denture that is made necessary due to the loss of a tooth/teeth that was/were missing prior to the *team member* or dependent's participation date in the Dental benefits.

Benefits under this *Plan* for dentures and bridges are paid according to the Dental Schedule of Benefits for the **standard** procedures for prosthetic services, as determined by the *Plan*. This specifically applies to charges for the construction of a denture or bridge for which the *Plan participant* and the *dentist* decide on personalized restoration or for which special techniques rather than standard procedures are employed.

Prosthodontics Maintenance: Benefits are provided for repair or re-cementing of crowns, inlays, onlays, bridge work, or dentures. Benefits are also provided for the relining, rebasing, or tissue conditioning of dentures if more than 6 months after the installation of an initial or replacement denture. Not more than one maintenance procedure will be covered in any period of 3 consecutive years.

Osseous Surgery: Benefits are provided for osseous surgery, once per quadrant every 12 months. Includes flap entry and osseous graft.

Oral Surgery: Benefits are provided for oral surgery, consisting of diagnosis and treatment of cysts and abscesses, and surgical extractions and impactions.

Antibiotic Injections: Benefits are provided for the injection of antibiotic drugs as administered by the attending *dentist* or *physician*.

General Anesthesia: Benefits are provided for general anesthesia when *dentally necessary* and rendered in connection with oral or dental surgery. Anesthesia is "general" when anesthetic drugs or agents are administered by injection or inhalation and when it is given for relaxing muscles, loss of sensation, or loss of consciousness. (It does not include analgesics, drugs given by local infiltration, or nitrous oxide.)

Periodontal Treatment: Benefits are provided for treatment of periodontal or other diseases of the tissues of the mouth. These benefits are limited to one periodontal *surgical procedure* per quadrant in any 12-month period.

The *Plan* covers charges for periodontal splinting with proper documentation and good prognosis. The *Plan* does not cover prosthodontic appliances to replace teeth lost due to failed splinting within a 5-year period.

Temporomandibular Joint Syndrome – Premium Dental only: Non-surgical services and supplies for the diagnosis and treatment of Temporomandibular Joint Syndrome (TMJ) and are subject to a lifetime maximum. No additional coverage is available through the Medical Plan.

Type C (Orthodontic) Benefits— Premium Dental Only

The *Plan* covers charges for *orthodontic services* as described below according to the Dental Schedule of Benefits and subject to the limitations and exclusions of the *Plan* and to the orthodontic lifetime maximum benefit described in Dental Benefit Limits.

Orthodontic benefits do not cover charges *incurred* after coverage terminates or charges in excess of the lifetime maximum.

Benefits are provided for *orthodontic services*, including benefits for extractions that are *dentally necessary* as part of the orthodontic treatment plan, to correct malposed teeth. When you submit a dental claim for orthodontic benefits, you may be required to provide records and/or allow your *dentist* to provide to *Anthem BlueCross BlueShield* requested records to determine whether your *orthodontic services* are eligible for coverage under the *Plan*. These dental records may include X-rays, photographs, and models.

Payment of claims for orthodontic benefits, based on paying *covered charges* over the course of treatment, are to be as follows:

- You or your *dentist* can submit a claim for diagnostic charges, including models and photographs and the initial placement fee, not to exceed $1500, which is payable at 50% of *UCR*, not subject to the deductible.
- The remainder of the benefit will be paid over the terms of the contract.
- After the initial placement of the appliance, you or your *dentist* must submit a claim form on a monthly basis with the appropriate receipt (or invoice) verifying that services were performed.

Dental Management Services

Dental Necessity of Services

This *Plan* covers only those dental procedures, services, and supplies that are *dentally necessary* as determined by the *Plan*.

When you submit a dental claim, you may be required to provide records and/or allow your *dentist* to provide records to *Anthem BlueCross BlueShield* in the determination of the *dental necessity* of your claim.

Pre-Determination of Dental Benefits

The Pre-Determination of Dental Benefits provision of this *Plan* is a voluntary program to assist you and your *dentist* when planning extensive dental treatment. It assures you in advance that the recommended service is *dentally necessary,* is an allowable expense under the *Plan,* and is a *usual, customary, and reasonable charge*.

When you expect to *incur* dental charges greater than **$300**, ask your *dentist* to complete the “Request for Pre-Determination of Benefits” portion of the dental claim form. This form is available from your Human Resources Representative.

As outlined on the form, request that your *dentist* send to *Anthem BlueCross BlueShield* a description of the expected treatment plan to include:

- copies of appropriate preoperative X-rays,
- findings of the oral examination,
- specific proposal for course of treatment,
- specific diagnostic and treatment codes and fees for each component of the treatment proposal, and
- any other appropriate information to support the necessity of the treatment plan.

Upon review of this information, *Anthem BlueCross BlueShield* will forward to you and to your *dentist* verification of the availability of dental benefits to cover, in whole or in part, the anticipated dental treatment.

Pre-determination of benefits does not guarantee payment. Exact benefits are determined based on the eligibility of the *Plan participant* at the time services are rendered. Also, benefits are determined based on the seat date of the appliance (the date the appliance is placed) rather than the date of initial preparation.

Conditions for Providing Benefits

Benefits are provided only for covered services rendered by a *dentist* or rendered by persons under the direct supervision of a *dentist*, where allowed by the scope of licensure under the Dental Practice Act. Dental benefits are provided on a usual, customary, and reasonable (*UCR*) basis. This means that the *Plan* pays benefits at not more than the *usual, customary, and reasonable charges* for dental services as determined by the *Plan*. Any hospitalization related to a dental service requires the notification steps to be completed as outlined in the Health Management Services section.

Care Outside the United States

If you need *emergency* services when traveling outside the United States, the BlueCard Worldwide program provides coverage through an international network of *hospital*s, doctors and other healthcare *provider*s. With this program, you're assured of receiving care from licensed healthcare professionals. The program also assures that at least one staff member at the *hospital* will speak English, or the program will provide translation assistance. To find participating *provider*s, visit www.bcbs.com and click on "Healthcare Anywhere." In order to access the international directory of *provider*s, You will need to enter Your Anthem identification number that is located on the front of Your Identification Card.

Routine or preventive care is not covered. Any hospitalization requires the same notification steps to be completed as is required for U.S. hospitalization. If a *Plan participant* is covered under another government's health plan, this *Plan* will not pay for the benefits while he or she is in that country.

Exclusions and Limitations - Dental

The following services and supplies are **not** covered by this *Plan*:

∅ **Anesthetic services** performed by and billed for by a *dentist* other than the attending *dentist* or the *dentist's* assistant.

∅ **Athletic guards.**

∅ **Below standard:** services which do not meet accepted standards of dental practice.

∅ **Bonding,** if cosmetic.

∅ **Civil insurrection or riot:** treatment or services for *injuries incurred* or exacerbated while participating in a civil insurrection or riot.

- ∅ **Claims** received by *Anthem BlueCross BlueShield* more than one year from the date in which the charges were *incurred*.

- ∅ **Completion of claim forms.**

- ∅ **Composite, resin fillings** for posterior teeth. These benefits are paid up to the appropriate percentage of the cost of amalgam restorations.

- ∅ **Congenital/developmental malformations.**

- ∅ ***Cosmetic services*** **or aesthetic services** (including complications)

- ∅ **Complications** due to, and services related to, non-covered services.

- ∅ **Costly procedures:** charges in excess of the amount of the least costly procedure in the event there are optional techniques for treatment of a covered service. Should the *Plan participant* elect a more costly procedure, the *Plan participant* is responsible for any amount in excess of what the *Plan* covers.

- ∅ **Court-ordered services**, unless documented to be *dentally necessary*.

- ∅ **Duplicate set of dentures.**

- ∅ ***Experimental*** **treatment**, procedures, facilities, equipment, drugs, devices, supplies, or services.
  - In some cases, the applications of an established procedure, as a course of treatment for a specific condition, may be considered *experimental*, and hence, not covered by this *Plan*.

- ∅ **Facility charges** (including, but not limited to, a *hospital*) in which dental services are rendered, unless there is a concurrent medical condition. Such a facility's fee must be pre-approved, in writing, by the *Plan*.

- ∅ **Felonious act:** treatment or services for *injuries incurred* while committing a felonious act for which the individual is convicted.

- ∅ **Gold fillings.**

- ∅ **Government services:** services furnished by a government or division thereof, except a program for civilian employees of a government.

- ∅ ***Hospital*** **admissions, dental.** These services may be covered under the medical *Plan.*

- ∅ ***Hospital*** **outpatient services, dental,** including anesthesia.

- ∅ **Immediate *family*:** treatment provided by a member of your immediate *family*.

- ∅ **Loss or theft** of any dental appliance, including dentures or bridges.

- ∅ ***Medical services*** (excluded by the dental provisions of the *Plan;* see Medical Benefits).

- ∅ ***Military service:*** treatment or services resulting from or prolonged as a result of performing a duty as a member of the *military service* of any state or country.

- ∅ **Missing Teeth:** Coverage for a *team member* and/or dependent new to the dental benefits of the *Plan* on or after January 1, 2009 excludes any bridge or denture that is made necessary due to the loss of a tooth/teeth that were missing prior to the *team member* or dependent's participation in the Dental benefits of the *Plan*.

- ∅ **Missed appointments.**

- ∅ **More than one *dentist:*** charges in excess of the amount likely to be charged by one *dentist* rendering the services. This applies in the event that a *Plan participant* transfers from the care of one *dentist* to that of another during the course of treatment or if more than one *dentist* renders services for one procedure.
  - This exclusion does not apply to initial *emergency* treatment.

- ∅ **No charge:** services for which the *Plan participant incurs* no charge.

- ∅ **Not eligible:** charges *incurred* while not eligible for a benefit, such as prior to your effective date or subsequent to your coverage termination date.

- ∅ **Not rendered by *dentist:*** services or treatments that are not rendered by a *dentist* nor under the direct supervision of a *dentist*.

- ∅ **Oral hygiene instructions and dietary information.**

- ∅ **Pathology and labs** for oral surgery. See Medical Benefits.

- ∅ **Personal hygiene** or convenience items.

- ∅ **Plaque control programs.**

- ∅ **Prohibited by law:** charges for which the *Plan* is prohibited by law or regulation from providing benefits.

- ∅ **Reimbursement:** *injuries* resulting from an accident for which you are reimbursed or entitled to be reimbursed by another party or insurer; however, the *Plan* may make payment on these claims with the understanding that the *Plan* will be reimbursed in accordance with the reimbursement provision contained in the Reimbursement and Subrogation section of this SPD.

- ∅ **Self-inflicted:** any intentionally self-inflicted *illness* or *injury*.
  - This exclusion does not apply if the self-inflicted *illness* or *injury* is the result of an act of domestic violence or a medical condition (including both physical and *mental health* conditions).

- ∅ **Services furnished** or available to the *Plan participant*, in whole or in part, under the laws of the United States, or any state, or political subdivision thereof, or for which the *Plan participant* would have no legal obligation to pay in the absence of this or any similar coverage.

- ∅ ***UCR,* over:** the portion of any charge which is in excess of the *UCR* charge for the particular service or supply.

- ∅ **Unnecessary:** services which are not *dentally necessary*.

- ∅ **Veneers,** if cosmetic.

- ∅ **War:** treatment or services resulting from or prolonged as a result of participating in a war or act of war, declared or undeclared.
  - This exclusion does not apply to any *Plan participant* who is not a member of the armed forces.

- ∅ **Work-related *illness* or *injury:*** treatment for an *illness* or *injury* arising out of, or in the course of, any employment for wage or profit, including, but not limited to, employment with Terex or its affiliates, for which the eligible *team member* or *covered dependent* is entitled to benefits under Workers' Compensation or similar benefits.

VISION BENEFITS

Vision Benefit Limits

Eligibility	
Plan Participant	See Eligible Team Members and Effective Dates Section.

Limitations	
Per *Plan Participant*	$400 per calendar year for exams, lenses, frames, contacts, and/or vision correction surgery
	One pair of frames and lenses and/or contact lenses per calendar year
	One eye exam per calendar year
***NOTE: Routine eye exams are only covered under this vision benefit. One exam per calendar year is covered with a $20 co-payment. Benefits for exam, lenses, frames, contacts, and vision correction are provided only if vision coverage is elected*.**	

Schedule of Benefits

Service	***Coverage***
Routine Eye Examination	100% after $20 co-payment, subject to annual maximum. Balance of the cost of the exam applies to the annual maximum
Lenses — Single	85%, subject to annual maximum
Lenses — Bifocal	85%, subject to annual maximum
Lenses — Trifocal	85%, subject to annual maximum
Lenses — Lenticular	85%, subject to annual maximum
Frames	85%, subject to annual maximum
Prescription Sunglasses	85%, subject to annual maximum
Contact Lenses	85%, subject to annual maximum
Vision Correction Surgery	85%, subject to annual maximum

Description of Benefits (Reimbursement)

Standard routine eye examination, frames, lenses, contact lenses, and/or vision correction surgery:

- Routine eye examination: Once per calendar year
- Eyeglass lenses and/or frames: One pair per calendar year

This vision benefit does not use a vision provider network. This is a reimbursement program where the member pays up front for their services and submits a reimbursement form to Anthem to receive the covered services

All vision claims must be submitted by the **team member** using the Terex vision claim form available at www.anthem.com/terex under Claim Forms. Attach an itemized statement of charges.

Exclusions and Limitations - Vision

The following services and supplies are **not** covered:

- ***Medical services.*** See Medical Benefits.
- **No charge:** charges for which the *Plan participant* would not be legally required to pay or for which no charge would have been made if there were no vision care benefits.
- **Non-prescription lenses:** lenses obtainable without a prescription.
- **Not necessary**: services or supplies not deemed necessary by a licensed *physician*, optometrist, or ophthalmologist.
- **Orthoptics or vision training** and any associated supplemental testing.
- **Work-related *illness* or *injury*:** treatment for an *illness* or *injury* arising out of, or in the course of, any employment for wage or profit, including, but not limited to, employment with Terex, for which the eligible *team member* or *covered dependent* is entitled to benefits under Workers' Compensation or similar benefits.

BASIC AND VOLUNTARY LIFE INSURANCE BENEFITS

Schedule of Benefits

Eligibility	
Team member	See Eligible Team Members and Effective Dates Section.
Dependents	See Eligible Team Members and Effective Dates Section.

Team Member Basic Life Benefit (Company paid)	
Team member	2 x basic annual earnings

Team Member Voluntary Life Benefit (team member paid)	
Team member	1 x basic annual earnings 2 x basic annual earnings 3 x basic annual earnings 4 x basic annual earnings
Dependent Basic Life Benefit (Company paid)	
Spouse	$2,000
Child(ren) age 14 days to age 26	$1,000

Dependent Voluntary Life Benefit (team member paid)	
Child(ren) age 14 days to age 26	$2,000, $5,000 or $10,000 as elected by the *team member*

Benefit Maximums	
Team member Guaranteed Issue— Basic and Voluntary Coverage	$500,000
Team member Benefit Maximum	6 x basic annual earnings or $900,000, whichever is less
Accelerated Benefit	75% of the *team member's* basic and voluntary benefit or $500,000, whichever is less
Spouse Guaranteed Issue—Basic and Voluntary Coverage	$27,000 ($2,000 basic and $25,000 voluntary)
Spouse Benefit Maximum	50% of the *team member's* basic and voluntary benefit or $450,000, whichever is less
Children Guaranteed Issue—Basic and Voluntary Coverage	$11,000 ($1,000 basic and $10,000 voluntary)
Children Benefit Maximum	$11,000

Basic and Voluntary Life Insurance Coverage

Upon your death or that of your *spouse* or child, a life insurance benefit may be payable under the *Plan*. Your life insurance benefits are provided under an insurance policy with Prudential Insurance Company of America. If the terms of the policy and this Section differ, the policy will govern. The *Company* has delegated to the insurer its entire discretionary authority to make all final determinations regarding claims for life insurance benefits under the policy. Any decision made by the insurer in the exercise of this authority is conclusive and binding on all parties.

Team Member Basic and Voluntary Life Insurance Benefits

Your basic annual earnings means your current salary or wage from the *Company*. It includes commissions, but not bonuses, overtime, shift differential or any other extra compensation. If your current salary includes commissions, your basic annual earnings will be averaged over the previous 24-month period of employment or averaged from your date of employment, whichever is less. Your basic annual earnings will be rounded to the next higher $1,000, if not already a multiple of $1,000.

Your *team member* basic and voluntary life insurance benefits will be reduced by the following percentages upon your attainment of the specified ages:

Team Member Life Insurance Reductions	
Basic Life Insurance	33% at age 65 67% at age 70
Voluntary Life Insurance	35% at age 70 55% at age 75 70% at age 80 80% at age 85 85% at age 90 90% at age 95

Pre or Post Tax:

At the time you enroll for benefits, you will choose whether your life insurance premiums are paid with pre-tax or after-tax payroll dollars. Generally, a life insurance benefit is not taxable to a beneficiary, so in many instances, it is advantageous to select the pre-tax option for your life benefit. This reduces your payroll taxes paid as taxes are calculated after the life premium cost is deducted from your gross income.

However, everyone's personal financial situation is different, and for certain team members the post-tax option may have more favorable taxation results when the proceeds of the coverage are paid to their beneficiary, their estate, or a trust. The Plan cannot advise any team member which option is best for them, so it is recommended an outside financial or tax advisor be consulted if you have questions about what is best for you.

Spouse and Dependent Child Basic and Voluntary Life Insurance Benefits

You will be eligible to receive a dependent basic life insurance benefit in the event of the death of your *spouse* or *dependent child* who is at least age 14 days but under age 26. The dependent life benefits are described in the Schedule of Benefits at the beginning of this section.

Dependent *Spouse* or Child voluntary benefits may be purchased even if the *team member* does not purchase voluntary *team member* life insurance.

The effective date of any dependent life insurance will be delayed if the dependent is *hospital* confined. The amount of your *spouse* voluntary life insurance cannot exceed 50% of your *team member* combined basic and voluntary life insurance and is available in $10,000 increments.

Your dependent voluntary life insurance benefits will be reduced by the following percentages upon their attainment of the specified ages:

Dependent Voluntary Life Insurance Reductions	
Voluntary Spousal Life Insurance	35% at age 70 55% at age 75 70% at age 80 80% at age 85 85% at age 90 90% at age 95

Evidence of Insurability

The insurer may require evidence of insurability for certain amounts of or increases in *team member* or dependent basic and/or voluntary life insurance benefits. Please contact your local *Human Resources Department* for more details.

When you are first eligible for coverage, you may elect up to $500,000 in team member Basic plus Voluntary Life Insurance or up to $27,000 in Spouse Basic plus Voluntary Life Insurance without approval from the insurance company. There are limitations on adding or increasing coverage later on.

If you do not enroll for voluntary coverage when you are first eligible, you will only be able to enroll during an open enrollment period or with a change in *family* status.

Evidence of insurability is required for the following:

- You enroll for more than $500,000 of Basic plus Voluntary *Team Member* Life Insurance when you are first eligible.
- You enroll for more than $27,000 of *Spouse* Basic and Voluntary life insurance when you are first eligible.
- Any increase in Voluntary *Team Member* or *Spouse* life insurance as a result of a change in status (except when adding a *spouse* due to marriage, any amount over $25,000 requires evidence of insurability).

During open enrollment, evidence of insurability is required for the following:

- Elect to increase Voluntary *Team Member* Life Insurance coverage by more than one times your annual pay or increase this insurance so that the total of your *Company*-paid plus voluntary benefits is greater than $500,000.
- Enroll for the first time or increase the amount of your Voluntary *Spouse* Life Insurance coverage.

Evidence of insurability must be submitted to Prudential for determination. If you are approved by Prudential for coverage, you will be enrolled in your elected benefit. Until you are approved, you will be enrolled in the maximum allowable amount.

If evidence of insurability is required, you will be notified by Prudential with instructions to complete the required health statement questionnaire either online or in paper form from Prudential.

Waiver of Premium

If you are not yet age 60, have not retired, and become *totally disabled* while you are insured, you may apply to the insurer to have your *team member* life insurance benefits extended until the earlier of your retirement or attainment of age 70 at no cost. If approved, these benefits will continue but will be subject to the same terms, reductions and terminations at specified ages or retirement as would apply if you were not *disabled*. The benefit is subject to continuing proof of *disability*. This *disability* feature does not apply to the *disability* of your dependents; however, if you, the *team member*, qualify for this benefit and have insured your spouse and/or children, the premium for their coverage is also waived. Once individuals on waiver of premium reach the earlier of age 65 or retirement, they will be terminated from this benefit unless they return to active duty with the *Company*. Your Human Resources department can provide you with the required forms for application of the wavier of premium provision.

For purposes of the Waiver of Premium provision above, *totally disabled* is defined as not working at **any job** for wage or profit; and due to *sickness*, *injury* or both, you are not able to perform for wage or profit, the material and substantial duties of any job for which you are reasonably fitted by your education, training or experience,

Changes to Insurance

Each year, there will be an enrollment period during which you may apply for or make a change to your life insurance. In addition to this annual enrollment period, you may also make a change within 31 days of a change in *family* status (or within 60 days of the date of a birth or a child being placed for adoption). The effective date of any change will be delayed if you are not *actively at work*. Certain increases to your benefits are limited by the insurance carrier and require prior approval before becoming effective. Please contact your local *Human Resources Department* if you have a question regarding either of these enrollment periods, or the effective date of an insurance increase or decrease.

Additional Benefits

Accelerated Benefit

If you (1) have been insured under this Section for at least 60 days, (2) are insured for at least $20,000 of *team member* life insurance, and (3) provide proof to the insurer that you are terminally ill with a life expectancy of 12 months or less, you may be eligible to receive an accelerated life insurance benefit, payable to you. If you are required to name a specific person as the beneficiary of your *team member* life insurance benefit (for example, pursuant to a divorce decree), that person must acknowledge and agree to the accelerated benefit payment in writing.

The accelerated benefit is a lump sum payment of up to 75% (maximum of $500,000) of the life insurance benefit that would otherwise be payable upon your death. Your final *team member* life insurance benefit will be reduced by the amount of any accelerated benefit payment.

Portable Coverage or Conversion to Individual Policy

If your eligibility for all or part of your life insurance benefits under the *Plan* terminates, you may be eligible to apply for portable coverage or to convert your or your *spouse*'s voluntary coverage to an individual policy up to a maximum coverage amount of $500,000. The application must be made within 31 days of the day the insurance would otherwise terminate. Approval from the insurance company is required to port or convert coverage.

Please contact your local *Human Resources Department* for further details on any of these options.

Termination of Team Member Life Insurance Benefits

Your eligibility for life insurance benefits generally will cease on the earliest of the following dates:

- the date the insurance policy or the *Plan* is terminated;
- the date you are no longer in an eligible class of *team member*s;
- the date your employment class is no longer eligible for insurance;
- the date you retire;
- the last day for which any required premium has been paid;
- the date you request, in writing, to have your *team member* insurance terminated; and
- the day you terminate employment or cease to be *actively at work* (unless you are eligible for the *team member* Life Insurance *Disability* Extension).

The *Company* may continue your life insurance for a specified period in the event of your approved leave of absence, paid personal time, or absence from work due to *injury* or *sickness* provided you pay any required insurance premiums on a timely basis as required by the *Company*. In addition, the *Company* may continue your basic life insurance for a specified period in the event of an approved military leave of absence.

Termination of Dependent Life Insurance Benefits

Your dependent's eligibility for life insurance benefits will cease on the earliest of the following dates:

- the date the insurance policy or the *Plan* is terminated;
- the date you cease to be insured;
- the date you are no longer in an eligible class of *team member*s for dependent insurance;
- the date the dependent ceases to qualify as a dependent;
- the last day for which any required premium has been paid;
- the date you request, in writing, to have your dependent insurance terminated;
- the date you die;
- the date you retire; and
- the date the *team member* begins a military leave of absence.

The *Company* may continue your life insurance for a specified period in the event of your approved leave of absence, paid personal time, or absence from work due to *injury* or *sickness* provided you pay any required insurance premiums on a timely basis as required by the *Company*.

Notice and Proof of Claim

The insurer must receive satisfactory written notice and proof of claim before it will pay any life insurance benefit. The notice of claim must be received as follows:

Notice of Claim Deadline	
Death Claim	No later than 30 days after the date of death
Disability Extension (Waiver of Premium)	No later than 12 months after you cease to be *actively at work*

When the insurer has received written notice of claim, it will send the proof of claim forms. If the forms are not received within 15 days after the written notice of claim is sent, proof of claim may be sent to the insurer without waiting for the form.

The insurer must receive the proof of claim as follows:

Proof of Claim Deadline	
Death Claim	No later than 90 days after the date of death
Disability Extension (Waiver of Premium)	No later than 15 months after you cease to be *actively at work*

Benefit Payments

Benefits payable upon your death are payable to your beneficiary living at that time. You must name your beneficiary on a form acceptable to the insurer and executed by you. If no beneficiary is alive on the date of your death, the payment will be made to the first of the following: Your (a) surviving *spouse*; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate. This will apply unless the benefit is otherwise assigned. All other benefits are payable to the *team member*.

Claims Information

Filing Addresses

Life and Accidental Death and Dismemberment Claims and Appeals:
The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, PA 19176

Notice of Decision on Claim

The following claims procedures apply to all claims related to life insurance benefits, except those related to whether you are *totally disabled* (as required for you to be eligible for the Waiver of Premium). For those claims procedures, please see the Claims Information Section under Long-Term *Disability* Benefits.

If a claim is denied, a written notice of the denial will be sent within a reasonable time after the insurer receives the claim but not later than 90 days after receipt of the claim. If a decision cannot be made within 90 days after the insurer receives the claim, the insurer will request extensions of time as permitted under U.S. Department of Labor regulations. Any request for extension of time will specifically explain:

- the standards on which entitlement to benefits is based;
- the unresolved issues that prevent a decision on the claim;
- the additional information needed to resolve those issues;
- the date the decision is expected to be made.

If a period of time is extended because the claimant failed to provide necessary information, the period for making the benefit determination is tolled from the date the insurer sends notice of the extension to the claimant until the date on which the claimant responds to the requests for additional information. The claimant will have at least 45 days to provide the specified information.

Review Procedure

If all or any part of a claim is denied, the claimant may appeal the denial within 60 days after receiving notice of denial.

The claimant may submit written comments, documents, records or other information relating to the claim for benefits, and may request free of charge copies of all documents, records and other information relevant to the claimant's claim for benefits.

The insurer will review the claim on receipt of the written request for review, and will notify the claimant of the insurer's decision within a reasonable time but not later than 60 days after the request has been received. If an extension of time is required to process the claim, the insurer will notify the claimant in writing of the special circumstances requiring the extension and the date by which the insurer expects to make a determination on review. The extension cannot exceed a period of 60 days from the end of the initial review period.

BASIC AND VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

Schedule of Benefits

Eligibility	
Team member	See Eligible Team Members and Effective Dates Section.
Dependents	See Eligible Team Members and Effective Dates Section.

Team Member Basic AD&D Benefit (Company paid)	
Team member	2 x basic annual earnings
Dependent Basic AD&D (Company paid)	
Spouse Child	$2,000 $1,000

Team Member Voluntary AD&D Benefit (team member paid)	
Team member	Option 1 - $25,000; Option 2 - $50,000; Option 3 - $100,000; Option 4 -$200,000; Option 5 - $300,000.
Dependent Voluntary AD&D Benefit (team member paid)	
Spouse (Only Team member and Spouse covered)	60% of the team member's Voluntary AD&D Option in force
Child *(Only Team member and Child covered)*	25% of the team member's Voluntary AD&D Option in force
Family *(Team member, Spouse and Child(ren) covered)*	*Spouse* – 50% of the team member's Voluntary AD&D Option in force Child – 15% of the team member 's Voluntary AD&D Option in force.

Accidental Bodily Injury Benefit Coverage	
Life	100%
Sight of One Eye	50%
One Limb	50%
Speech & Hearing	100%
Speech or Hearing	50%
Thumb and Index Finger of the same hand	25%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%

Team Member Basic and Voluntary AD&D Benefits

Upon your dismemberment, paralysis, loss of sight, speech or hearing, or your death, you or your beneficiary may be eligible to receive an accidental death and dismemberment (AD&D) benefit under the *Plan*. You must meet the eligibility requirements and be *actively at work* before you will be eligible for this benefit.

Your AD&D benefits are provided under insurance policies with Prudential Insurance Company of America. If the terms of a policy and this Section differ, the policy will govern. The *Company* has delegated to the insurer its entire discretionary authority to make all final determinations regarding claims for AD&D benefits under the policies. Any decision made by the insurer in the exercise of this authority is conclusive and binding on all parties.

Your basic annual earnings means your current salary or wage from the *Company*. It includes commissions, but not bonuses, overtime, or any other extra compensation. If your current salary includes commissions, your basic annual earnings will be averaged over the previous 24-month period of employment or averaged from your date of employment, whichever is less. Your basic annual earnings will be rounded to the next higher $1,000, if not already a multiple of $1,000.

Any basic AD&D benefit will be reduced at the same rate as your Basic Life benefit. See the table on page 82. Your basic AD&D benefit will terminate at your retirement.

Spouse and Dependent Child Voluntary AD&D Benefits

You also have the option to purchase dependent voluntary AD&D insurance, as described in the Schedule of Benefits at the beginning of this section.

For purposes of AD&D coverage only, a *dependent child* is from 14 days to age 26.

The effective date of any dependent voluntary AD&D insurance will be delayed if the dependent is *hospital* confined.

Accidental Death or Dismemberment

An AD&D benefit may be payable if the insurer receives notice and proof of claim that you or your *spouse* or dependent (1) died from an accidental drowning while insured, or (2) sustained a loss of life, sight or limb within 365 days of the date of an accidental bodily *injury* or accidental exposure to the elements suffered while insured. The benefit will be the percentage (shown in the Schedule of Benefits at the beginning of this section) of the applicable AD&D benefit in effect on the day of the *injury*:

No more than the applicable maximum AD&D benefit will be payable as a result of any one accident.

Loss of limb means the severance of hand or foot at or above the wrist or ankle joint. Loss of sight, speech or hearing must be total and irrecoverable. Loss of thumb and index finger means severance through or above the metacarpophalangeal joints. Quadriplegia means the total and permanent paralysis of both upper and lower limbs. Paraplegia means the total and permanent paralysis of both lower limbs. Hemiplegia means the total and permanent paralysis of the upper and lower limbs on one side of the body.

Changes to Insurance

Each year, there will be an enrollment period during which you may apply for or make a change to your AD&D insurance. In addition to this annual enrollment period, you may also make a change within 31 days of a change in *family* status (or within 60 days from date of birth or placement for adoption). The effective date of any change will be delayed if you are not *actively at work*. Certain increases to your benefits are limited by the insurance carrier and require prior approval before becoming effective. Please contact your local *Human Resources Department* if you have a question regarding either of these enrollment periods, or the effective date of an insurance increase or decrease.

Additional Benefits (Voluntary Coverage Only)

Seat Belt Benefit

Additional benefits may be payable if the insurer receives proof that an insured person died as a result of an automobile accident while eligible for an accidental death benefit. If the insured person was wearing a seat belt at the time of the accident, a seat belt benefit will be payable in the amount of 25% of the applicable AD&D benefit or $25,000, whichever is less.

Air Bag Benefit

If a seat belt benefit is payable and the insured person was positioned in a seat protected by a factory installed air bag which inflated on impact, an air bag benefit will be payable in the amount of 10% of the applicable AD&D benefit or $5,000, whichever is less.

Dependent Education Benefit

If a *team member* Accidental Death benefit is payable, your eligible dependents may be eligible to receive a dependent education benefit from the insurer. The amount of benefit is the lesser of 5% or the *team member* Accidental Death benefit, $2,500 or the *incurred* expenses. Proof of the child's enrollment and *incurred* expenses must be provided to the insurer prior to payment.

Repatriation Benefit

If an accidental death benefit is payable and the insured person's loss of life occurred at least 100 miles from his or her permanent place of residence, the insurer may reimburse up to $2,000 of certain expenses *incurred* for the preparation of the body and its transportation to its place or burial or cremation. Written proof of the expenses must be submitted to the insurer prior to payment.

Bereavement Counseling Benefit

If an accidental death benefit is payable upon an insured person's death, the insurer may pay a counseling benefit during the bereavement period of an immediate *family* member of the insured person. The benefit will be payable for up to twelve months after the insured person's death, and will not exceed $250 per immediate *family* member or $1,000 per insured person's death. The benefit will be reduced by reimbursements received from other sources. Written proof of the out of pocket expenses must be submitted to the insurer prior to payment.

Rehabilitative Training Benefit

If you receive an accidental dismemberment benefit, you may be eligible to receive a rehabilitative training benefit from the insurer. The amount of the benefit is the lesser of $5,000, 25% of the amount of accidental dismemberment benefit that is payable, or the actual expense you *incur* for the training reduced by any amount you receive from other sources. Written proof of the expenses *incurred* must be provided to the insurer prior to payment.

Voluntary AD&D Benefit Disability Extension

If you are not yet age 60, have not retired, and become *totally disabled* while you are insured, you may apply to the insurer to have your *team member* and dependent voluntary AD&D benefits extended until the earlier of your retirement or attainment of age 70 or until you are no longer *totally disabled*, at no cost. If approved, these benefits will continue but will be subject to the same terms, reductions and terminations at specified ages or retirement as would apply if you were not *disabled*. The benefit is subject to continuing proof of *disability*.

For purposes of the Voluntary AD&D Benefit *Disability* Extension provision above, *totally disabled* is defined as not working at **any job** for wage or profit; and due to *sickness*, *injury* or both, you are not able to perform for wage or profit, the material and substantial duties of any job for which you are reasonably fitted by your education, training or experience,

Portable Coverage

If you elect to apply for portable coverage of any amount of your *team member* basic life insurance, you may also apply to continue any amount of *team member* basic AD&D benefits which ceased due to your termination of employment. If, prior to age 65, your *team member* voluntary AD&D insurance ceases due to your termination of employment, you may apply for portable coverage on your own life, up to the amount of insurance that ceased. The application must be made within 31 days of the day the insurance would otherwise terminate. Please contact the *Human Resources Department* for further details on these options.

Exclusions

No AD&D benefit will be paid for a loss which is due to or results from:

- suicide while sane or insane;
- an intentionally self-inflicted *injury*;
- bodily or mental infirmity, disease, or infection unless due to an accidental bodily *injury*;
- committing or attempting to commit a felony;
- active participation in a war, riot, rebellion or insurrection;
- active duty in armed service during a time of war;
- an *injury* sustained from any aviation activities, other than riding as a fare-paying passenger;
- your voluntary use of any controlled substance, unless administered on the advice of a *physician*; or
- your operation of any motorized vehicle while intoxicated.

Termination of Team Member AD&D Benefits

Your eligibility for AD&D benefits generally will cease on the earliest of the following dates:

- the date the insurance policy or the *Plan* is terminated;
- the date you are no longer in an eligible class of *team members*;
- the date your employment class is no longer eligible for insurance;
- the date you retire;
- the last day for which any required premium has been paid;
- the date you request, in writing, to have your insurance terminated; and
- the day you terminate employment or cease to be *actively at work*.

The *Company* may continue your AD&D insurance for a specified period in the event of your approved leave of absence, paid personal time, or absence from work due to *injury* or *illness* provided you pay any required insurance premiums on a timely basis as required by the *Company*.

Termination of Dependent AD&D Benefits

Your dependent's eligibility for AD&D benefits will cease on the earliest of the following dates:

- the date the insurance policy or the *Plan* is terminated;
- the date you cease to be insured;
- the date you are no longer in an eligible class of *team members* for dependent insurance;
- the date the dependent ceases to qualify as a dependent;
- the last day for which any required premium has been paid;
- the date you request, in writing, to have your dependent insurance terminated;
- the date you die (the *Company* may continue your dependent AD&D insurance for up to twelve months after your accidental death); and
- the date you retire.

Notice and Proof of Claim

The insurer must receive satisfactory written notice and proof of claim before it will pay any AD&D benefit. The notice of claim must be received as follows:

Notice of Claim Deadline	
Accidental Death	No later than 30 days after the date of death
Accidental Dismemberment	No later than 12 months after date of loss
Disability Extension (Waiver of Premium)	No later than 12 months after you cease to be *actively at work*
All Other Claims	No later than 12 months after the insured person's date of loss or the date the expense is *incurred*

When the insurer has received written notice of claim, it will send the proof of claim forms. If the forms are not received within 15 days after the written notice of claim is sent, proof of claim may be sent to the insurer without waiting for the form.

The insurer must receive the proof of claim as follows:

Proof of Claim Deadline	
Accidental Death	No later than 90 days after the date of death
Accidental Dismemberment	No later than 15 months after date of loss
Disability Extension (Waiver of Premium)	No later than 15 months after you cease to be *actively at work*
All Other Claims	No later than 15 months after the insured person's date of loss or the date the expense is *incurred*

Benefit Payments

Benefits payable upon your death are payable to your beneficiary living at that time. You must name your beneficiary on a form acceptable to the insurer and executed by you. If no beneficiary is alive on the date of your death, the payment will be made to the first of the following: Your (a) surviving *spouse*; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate. This will apply unless the benefit is otherwise assigned. All other benefits are payable to the *team member*.

Claims Information

See "Claims Information" in the Life Insurance Benefits section for instructions on how to file and/or appeal an AD&D claim.

If the terms of any policy provided by the insurer and this document differ, the policy's language will govern.

DISABILITY BENEFITS

Schedule of Benefits

Eligibility	
Team member Only, non-bargaining unit	First of the month coinciding with or following 30 days of continuous employment.
Team member Only, bargaining unit	Coverage is provided as stated (and when included as a benefit offered) in the *team member's* bargaining unit contract in force at the time of *disability*.

Benefit		
Short Term *Disability* (STD)	*Company*-paid	67% of base pay
Long Term *Disability* (LTD)	50% option (*Company*-paid)	50% of basic monthly earnings
	60% option (*team member* buy-up)	Increase of 10% for a total of 60% of basic monthly earnings
	67% option (*team member* buy-up)	Increase of 17% for a total of 67% of basic monthly earnings

Minimum and Maximum Monthly Benefit – All Options		
STD	Minimum monthly benefit	None
	Maximum monthly benefit	Will not exceed pre-*disability* monthly earnings Per the contract for collective bargaining units
LTD	Minimum monthly benefit	The greater of $100 or 10% of the Gross Monthly Benefit
	Maximum monthly benefit	$15,000

Elimination (Waiting) Period		
STD	7 calendar days for *sickness* (none for *injury* or hospitalization)	
LTD	All options	*Total disability* for 180 consecutive days

Maximum Period Payable				
STD	Up to 26 weeks			
LTD	**The Maximum Benefit Payable for all Options will be the longer of either the Maximum Period Payable OR the Normal Retirement Age below**			
	Age on the Date Disability Commenced	***Maximum Period Payable***	***Year of Birth***	***Normal Retirement Age***
	60 years or younger	To age 65, but not less than 60 months	Before 1938	Age 65
	61 years	48 months	1938	Age 65 and 2 months
	62 years	42 months	1939	Age 65 and 4 months
	63 years	36 months	1940	Age 65 and 6 months
	64 years	30 months	1941	Age 65 and 8 months
	65 years	24 months	1942	Age 65 and 10 months
	66 years	21 months	1943 through 1954	Age 66
	67 years	18 months	1955	Age 66 and 2 months
	68 years	15 months	1956	Age 66 and 4 months
	69 years or older	12 months	1957	Age 66 and 6 months
			1958	Age 66 and 8 months
			1959	Age 66 and 10 months
			After 1959	Age 67

Disability Coverage

Disability coverage is designed to pay a benefit if you are *totally disabled* for an extended period as a result of a covered *sickness, injury, or hospitalization.* In order to qualify for this benefit, you must be *disabled* as defined by this benefit and the *disability* must begin while you are covered for this benefit.

During the first 26 weeks of *disability*, the *Plan* provides Short Term *Disability* (STD) benefits which are self-insured by Terex with claims administered by Prudential Insurance Company of America (Prudential). If your *disability* requires an elimination period, you will be able to use any paid time off which you may have previously accrued. Short Term *Disability* covers only non-work related disabilities.

Disability related to maternity is typically considered for a maximum period of 6 to 8 weeks. An extended maternity *disability* may be approved when deemed to be medically required.

If your *disability* continues beyond 26 weeks, benefits are provided under a fully-insured Long Term *Disability* (LTD) policy provided by Prudential.

Terex has delegated to the insurer its entire discretionary authority to make all final determinations regarding claims for LTD benefits under this *Plan* or policy. Any decision made by the insurer is conclusive and binding on all parties.

Elimination Period

The elimination period is the period of *disability* before benefits payments begin.

Your elimination period for short-term *disability* due to a *sickness* is 7 calendar days. However, there is no elimination period for short-term *disability* due to *injury* or hospitalization.

Your elimination period for long-term *disability* is 180 days. During this period, you may use any short-term benefits available to you.

Amount of Benefit

The amount of your *Disability* benefit is calculated by using your base salary on the last day you worked preceding your *disability* date, multiplied by the benefit percentage of 67% for STD or in the case of long-term *disability*, the benefit percentage elected during your benefits enrollment. Base salary is pay earned for a normal work week and does not include any bonus, overtime payments, shift differential or other special compensation. However, if your salary includes commissions, your benefit will be calculated using the average of your base salary and commissions from the previous 24-month period of employment or averaged from your date of employment, whichever is less.

If you become *disabled* while you are on a covered layoff or leave of absence, we will use your base pay and any averaged commissions (as noted above) from the *Company* in effect just prior to the date your absence begins.

Terex retains the right to delay short-term disability payments when the TM is applying for benefits under any state paid leave, pending the outcome of the state's benefit determination.

Pre or Post Tax:

At the time you enroll for benefits you may choose how your disability benefits would be taxed should you receive Short-Term disability payments from Terex and/or Long-Term Disability benefits from Prudential.

If the pre-tax benefit option is selected, any disability benefits paid to a team member will be subject to income tax. However, if the post-tax benefit option is selected, those same disability benefit payments would NOT be subject to income tax. If selecting the post-tax option, the team member is required to pay imputed income tax on the value of the self-funded cost to Terex for Short-Term benefits and the premium paid by Terex to provide Long-Term disability benefits to that team member. The imputed taxation is managed through the team member's paycheck.

Calculating Your Short Term Disability Benefit for Partial Disability

You are eligible to receive partial short-term *disability* payments if you are *totally disabled* but are able to work part time and accept rehabilitative employment. Your partial short-term *disability* payment will be calculated using a formula that will determine your percent of lost income.

To determine your percent of lost income, use the following formula:

1. Start with your pre-disability weekly earnings, your weekly salary before your disability began.
2. Subtract your part-time weekly earnings, the amount you earned while working during your partial disability.
3. Divide this result by your pre-disability weekly earnings. This is your lost income percentage.
4. Multiply that percentage by your full disability benefit. This amount is your partial short-term disability benefit payable for that week.

Here is an example of partial disability calculation:

- A team member's pre-disability weekly income is $1,000.
- Their STD benefit is 67%.
- Their full disability weekly payment is $670 (67% of $1,000).
- The TM's disability allows them to work part time and the team member earns $450 for that partial week worked.
- The percent of lost income for this team member is 55% ($1,000 pre-disability income divided by their earnings of $450 for their part time work week).
- 55% times their full disability benefit of $670 equals their partial STD benefit for that week of $368.50.

This team member will receive $450.00 from working earnings and $368.50 for their partial STD benefit, making total earnings for that week of $818.50.

Short Term Disability Benefit Reductions – Other Income

Once your STD benefit has been calculated, it will be reduced by amounts from the following sources:

- Any salary continuation or severance paid to the *team member* by his *Company* if it causes the short-term *disability* benefit payable to exceed 100% of the total monthly earnings.
- Any benefits paid from a state disability program.

Any increases in benefits payable to you from the above sources that become effective after your *total disability* commences will not be used to further reduce the benefit payable under this *Plan*.

Calculating Your Long Term Disability Benefit for Partial Disability

Prudential will send you the monthly payment if you are *disabled* and your monthly ***disability earnings***, if any, are less than 20% of your ***indexed monthly earnings*** due to the same *sickness* or *injury*. If you are *disabled* and your monthly *disability* earnings are 20% or more of your indexed monthly earnings, due to the same *sickness* or *injury*, Prudential will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as *disability* earnings plus the gross *disability* payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly *disability* earnings to your gross *disability* payment.

2. Compare the answer in item 1 to your indexed monthly earnings.

If the answer from item 1 is less than or equal to 100% of your indexed monthly earnings, Prudential will not further reduce your monthly payment. If the answer from item 1 is more than 100% of your indexed monthly earnings, Prudential will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your *disability*.

1. Subtract your *disability* earnings from your indexed monthly earnings.

2. Divide the answer in item 1 by your indexed monthly earnings. This is your percentage of lost earnings.

3. Multiply your monthly payment by the answer in item 2.

This is the amount Prudential will pay you each month.

If your monthly *disability* earnings exceed 80% of your indexed monthly earnings, Prudential will stop sending you payments and your claim will end. Prudential may require you to send proof of your monthly *disability* earnings on a monthly basis. We will adjust your payment based on your monthly *disability* earnings. As part of your proof of *disability* earnings, we can require that you send us appropriate financial records, including copies of your IRS federal income tax return, W-2's and 1099's, which we believe are necessary to substantiate your income.

Disability earnings means the earnings which you receive while you are *disabled* and working, plus the earnings you could receive if you were working to your greatest extent possible. This would be, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

Salary continuance paid to supplement your *disability* earnings will not be considered payment for work performed.

Indexed monthly earnings means your monthly earnings as adjusted on each July 1 provided you were *disabled* for all of the 12 months before that date. Your monthly earnings will be adjusted on that date by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-W) is published by the U.S. Department of Labor. Prudential reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W.

Indexing is only used to determine your percentage of lost earnings while you are *disabled* and working.

Long Term Disability Benefit Reductions – Other Income

Once your LTD benefit has been calculated, it will be reduced by amounts from the following sources that the *team member* is eligible for under:

- Workers' Compensation Law
- Occupational Disease Law
- Unemployment Compensation Law
- Compulsory Benefit Act or Law
- An automobile no-fault insurance plan, or
- Any other act or law of like intent
- The Railroad Retirement Act (including any dependent benefits).
- Any labor management trustee, union, or *team member* benefits plans that are funded in whole or in part by the Company.
- Any *disability* income benefits the *team member* is eligible for under any group insurance plan of the Company or any governmental retirement system as a result of the *team member*'s job with his Company.
- The benefits the *team member* receives under his Company's retirement plan including any *disability* benefits and any Company-paid retirement benefits.
- The *disability* or retirement benefits under the United States Social Security Act as follows:
  - Disability benefits the *team member* is eligible to receive, if they have not filed for Social Security Disability Income (SSDI) benefits
  - Disability benefits the *team member's spouse*, child or children are eligible to receive because of the *team member*'s total or partial *disability*
  - Retirement benefits received by the *team member*
  - Retirement benefits the *team member's spouse*, child or children are eligible to receive because of the *team member*'s receipt of retirement benefits.
  - The amount the *team member* receives from any accumulated sick leave.
  - Any salary continuation or severance paid to the *team member* by his Company if it causes the long-term *disability* benefit payable to exceed 100% of the total monthly earnings.

Should you receive a lump sum payment for any of these Other Income Benefits, the lump sum will be prorated on a monthly basis over the period of time specified for the lump sum payment and that amount will be used to offset your monthly LTD payment.. If no time period is stated, the lump sum payment will be prorated over a reasonable period of time as determined by Prudential. Any of the above Other Income Benefits will include amounts which would have been paid to you had you applied for that other income benefit.

Determining a Disability

Prudential will assess your ability to work and the extent to which you are able to work by considering the facts and opinions from:

- your doctors; and

- doctors, other medical practitioners or vocational experts of our choice.

When we may require you to be examined by doctors, other medical practitioners or vocational experts of our choice, Prudential will pay for these examinations. We can require examinations as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Prudential representative. Refusal to be examined or interviewed may result in denial or termination of your claim. The loss of a professional or occupational license or certification does not, in itself, constitute *disability*.

Types of Disabilities

You are *disabled* when it is determined that:

- you are unable to perform the material and substantial duties of your regular occupation due to your *sickness* or *injury*; and

- you are under the regular care of a doctor.

Total Disability

You are determined to be totally disabled when you meet the definition of disability and you have a 20% or more loss in earnings due to the same sickness or injury.

Partial Disability

You are determined to be partially disabled when you meet the definition of disability, but you are working and have earnings of more than 20% but less than 80% of your pre-disability earnings. You do not have to be totally disabled during the elimination period to be eligible for partial disability benefits.

Recurrent Disability

Short Term – A recurrent disability, due to the same or related causes, will be treated as part of the prior disability if, after receiving disability benefits under this Plan, you return to your regular occupation on a full-time basis for less than 30 days.

Long Term – A recurrent disability, due to the same or related causes, will be treated as part of the prior disability if, after receiving Long Term Disability benefits under this Plan,

- you return to your regular occupation on a full-time basis for less than six months, and
- were continuously insured under the plan for the period between your prior claim and your current disability, and
- perform all the material duties of your occupation.

Definitions

Material and substantial duties: are normally required for the performance of your regular occupation; and cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week, Prudential will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Regular occupation: is the occupation you are routinely performing when your *disability* begins. Prudential will look at your occupation as it is normally performed instead of how the work tasks are performed for a specific employer or at a specific location.

Sickness: is any disorder of your body or mind, but not an *injury*; pregnancy including abortion, miscarriage or childbirth. *Disability* must begin while you are covered under the *Plan*.

Injury or bodily *injury*: is the direct result of an accident; is not related to any cause other than the accident; and results in immediate *disability*.

Regular care: is when you personally visit a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and you are receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for your disabling condition(s) by a doctor whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

Doctor: Is a person who is performing tasks that are within the limits of his or her medical license; and is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Prudential will not recognize any relative including, but not limited to, you, your *spouse*, or a child, brother, sister, or parent of you or your *spouse* as a doctor for a claim that you send to us.

Gainful occupation: is an occupation, including self-employment, that is or can be expected to provide you with an income within 12 months of your return to work, that exceeds:

- 80% of your *indexed monthly earnings*, if you are working; or
- 50% of your monthly earnings, if you are not working and have elected the *company* paid LTD benefit coverage; or
- 60% of your monthly earnings, if you are not working and have elected the 60% buy-up option of LTD coverage; or
- 67% of your monthly earnings, if you are not working and have elected the 67% buy-up option of LTD coverage.

Indexed monthly earnings: is your monthly earnings as adjusted on each July 1 provided you were *disabled* for all of the 12 months before that date. Your monthly earnings will be adjusted on that date by the lesser of 10% of the current annual percentage increase in the Consumer Price index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-W) is published by the U.S. Department of Labor. Prudential reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W.

Indexing is only used to determine your percentage of lost earnings while you are *disabled* and working.

Total Disability Short Term – you are considered *totally disabled* if you are under the care and attendance of a licensed *physician* and because of *injury* or *sickness* your *disability* prevents you from performing each of the material duties of your regular occupation and you have a 20% or more loss in your weekly earnings due to the *sickness* or *injury*.

Total Disability Long Term –

- *Team member*s earning less than $100,000 annually - you are considered *totally disabled* if, because of *injury* or *sickness*, you are not working, are unable to perform the material and substantial duties of your regular occupation due to that *sickness* or *injury*, are under the regular care of a doctor and have a 20% or more loss in your monthly earnings due to that *sickness* or *injury*. The loss of a professional license or certification does not, in itself, constitute *disability*. After 24 months of payments, a *team member* is considered *disabled* when Prudential determines that due to the same *sickness* or *injury*: (1) you are unable to perform the duties of any *gainful occupation* for which he or she is reasonably fitted by education, training or experience; and (2) are under the regular care of a doctor. The loss of a professional or occupational license or certification does not, in itself, constitute a *disability*.
- *Team member*s earning $100,000 or more annually - you are considered *totally disabled* if, because of *injury* or *sickness*, you are not working, are unable to perform the material and substantial duties of your regular occupation due to that *sickness* or *injury*, are under the regular care of a doctor and have a 20% or more loss in your monthly earnings due to that *sickness* or *injury*. The loss of a professional license or certification does not, in itself, constitute *disability*.

Disability Limitations

Changes to Insurance

Each year, there will be an enrollment period during which you may apply for or make a change to your Long-Term Disability coverage. In addition to this annual enrollment period, you may also make a change within 31 days of a change in family status (or within 60 days of a birth or placement for adoption). The effective date of any change will be delayed if you are not actively at work. Certain increases to your benefits are limited by the insurance carrier and require prior approval before becoming effective. Please contact your Human Resources Department if you have a question regarding either of these enrollment periods, or the effective date of an insurance increase or decrease.

General Disability

No benefit will be payable during any of the following periods:

- The *disabled team member* is not under the regular and continuing care of a *physician*.
- The *disabled team member* fails to submit to any medical examination requested by Prudential.
- Any period the *team member* is incarcerated.

Specific Disabilities

Additional information regarding the benefits available for the specific *illness*es listed below is detailed in the insurance carrier's policy. You can request a copy of this policy from your Human Resources department.

No benefit will be payable during any of the following periods:

Pre-existing Conditions (LTD Only)

No benefits will be payable for any *disability* which is caused or contributed to by, or results from, a pre-existing condition and which begins in the first 12 months you are covered.

A pre-existing condition is an *illness* or *injury* for which you received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or had symptoms which would have caused a prudent person to have consulted a health care *provider* for diagnosis, care or treatment in the three months prior to your effective date.

Mental Illness (LTD Only)

Any period for any *disability* due to mental *illness*, unless the *team member* is under the continuing care of a specialist in psychiatric care. Then, benefits are payable for the first 24 months after the elimination period has been completed. Benefits after the first 24 months will only be payable if the *team member* is confined in a *hospital* or institution licensed to provide psychiatric treatment. Benefits may continue for 90 days after discharge subject to certain conditions. Additional information regarding this *illness* is further defined in the Policy.

Drug or Alcohol Illness (LTD Only)

Any period for any *disability* due to drug or alcohol *illness*, unless the *team member* is actively supervised by a *physician* or rehabilitation counselor and is receiving continued treatment from a rehabilitation center or a designated institution approved by the issuer of the Policy. Benefits are payable for the first 24 months after the *team member* completes the elimination period if during the elimination period the *team member* becomes confined in a *hospital* or institution licensed to provide drug and alcohol treatment or begins participating in a rehabilitation program acceptable to the issue of the Policy. Benefits after 24 months are payable only if the *team member* is confined in a *hospital* or institution licensed to provide drug and alcohol treatment. Additional information regarding this *illness* is further defined in the Policy.

Chemical and Environmental Illness, Chronic Fatigue Illness, or Musculosketal and Connective Tissue Illness (LTD Only)

Any period for any *disability* due to Chemical and Environmental *illness*, Chronic Fatigue *Illness* or Musculosketal and Connective Tissue *Illness*, unless the *team member* is under the continuing care of a *physician* providing appropriate treatment and regular examination and testing in accordance with the disabling condition. Benefits are payable for the first 24 months after completing the elimination period.

Benefits after 24 months are payable only if the *team member* is confined in a *hospital* or institution. Additional information regarding these *illnesse*s is further defined in the Policy.

Waiver of Premium (LTD Only)

If you become totally or partially *disabled* and are receiving long-term *disability* payments from this *Plan*, premium payments for long-term *disability* coverage are waived while you continue to receive *disability* payments. When the *disability* ends, and if the *team member* returns to *actively at work*, premium payments must resume to continue the coverage.

Survivor Income Benefit (LTD Only)

Benefits are payable to an eligible survivor when the carrier receives satisfactory proof of the *team member*'s death after the *disability* had continued for 180 consecutive days or more, and while receiving a monthly benefit. The survivor benefit will be a lump sum payment equal to 3 times the *team member*'s last gross monthly benefit.

The eligible survivor is the *team member*'s *spouse*, if living; otherwise, the eligible survivor(s) are the *team member*'s children under age 25. If there is no eligible survivor, payment will be made to the *team member*'s estate.

Termination of Benefit

The *disability* benefit will end when the first of the following occurs:

- the date you are no longer *disabled*;
- the date you die;
- the end of the maximum benefit period; or
- the date your current earnings exceed 80% of your pre-*disability* income.

Note: When your current earnings fluctuate, we will average your earnings over 3 consecutive months rather than immediately terminating your benefit once 80% of your pre-*disability* income has been reached.

Termination of Coverage

- the date the insurance policy or the *Plan* is terminated;
- the date you are no longer in an eligible class of *team members*;
- the date your employment class is no longer eligible for insurance;
- the date you retire;
- the last day for which any required premium has been paid;
- the date you begin a military leave of absence;
- the date you request, in writing, to have your *team member* insurance terminated; and
- the day you terminate employment or cease to be *actively at work*.

The *Company* may continue your short-term and long term *disability* coverage for a specified period in the event of your approved leave of absence, paid time off, or absence from work due to *injury* or *sickness* provided you pay any required insurance premiums on a timely basis as required by the *Company*.

Termination of this coverage will not affect any claim which occurs while the coverage is in force.

Exclusions and Limitations - Short-Term Disability

No benefits will be provided for any *disability* which, directly or indirectly results from:

- intentionally self-inflicted *injury*
- war, declared or undeclared, or any act of war
- active participation in a riot, rebellion or insurrection
- committing or attempting to commit a felony
- *injury* which occurs out of or in the course of work for wage or profit.
- *sickness* or *injury* covered by a Workers Compensation Act, or other workers' *disability* law.

Exclusions and Limitations – Long-Term Disability

No benefits will be provided for any *disability* which directly or indirectly results from:

- intentionally self-inflicted *injury*
- war, declared or undeclared, or any act of war
- active participation in a riot, rebellion or insurrection
- committing or attempting to commit a felony
- a pre-existing condition

The insurance policy includes a more detailed description of some of the terms above. You can request a copy of this policy from your Human Resources department.

Claims Information

Filing Addresses

Short Term and Long Term Disability Claims and Appeals:
The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480,
Philadelphia, PA 19176

Notice of Proof of Claim

You must give the carrier written notice of a claim within 30 days after the *disability* starts. If this is not possible, you must notify the carrier as soon as reasonably possible. You should contact your Human Resources Representative for assistance in filing a claim.

When the carrier receives your notice of a claim, claim forms will be sent to you within 15 days to file proof of loss.

You must give the carrier proof of claim as soon as reasonably possible, but in no event later than one year after the end of the elimination period. The proof must include:

- the date the *disability* started;
- the cause of the *disability*; and
- the severity of the *disability*.

Examination

The carrier, at its own expense, maintains the right to have you examined by a doctor of its choice to determine the extent of any *sickness* or *injury* for which you have made a claim. This right may be used as often as reasonably required. The carrier has the right at any time to conduct an investigation of your claim which may include, but is not limited to, an evaluation of your rehabilitation potential.

Notice of Claim Denial

If a claim is wholly or partially denied, the carrier will furnish the claimant with notice of the denial, within a reasonable period of time (not to exceed 45 days after the carrier receives the claim), providing the following information:

- the specific reasons(s) for the denial of the claim;
- reference to the specific policy provision(s) on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- a description of the carrier's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following a denial on review;
- if the carrier relied upon an internal rule or other similar criterion in denying the claim, the notice of the denial also will include either the specific rule or other similar criterion or a statement that the rule or other similar criterion was relied upon in denying the claim and that a copy of the rule or other similar criterion will be provided free of charge to the claimant upon request;
- if the carrier's denial of the claim was based on a medical necessity, *experimental* treatment or similar exclusion or limit, the notice of the denial also will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the policy to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; and
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

The carrier may extend, for up to 30 days, the 45-day period described above, provided that, prior to the expiration of the initial 45-day period, the carrier both determines that an extension is necessary due to matters beyond its control and notifies the claimant of the circumstances requiring the extension of time and the date by which the carrier expects to make a decision. If, prior to the end of the first 30-day extension period, the carrier again determines that, due to matters beyond its control, a decision cannot be made within that extension period, the period for making that decision may be extended for up to an additional 30 days, provided that the carrier notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the carrier expects to make a decision. In the case of any extension under this paragraph, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant will be afforded at least 45 days to provide the specified information.

Review Procedure

The claimant may appeal the denial within 180 days after he or she receives the carrier's notice denying the claim. On appeal, the claimant may submit written information relating to the claim. The claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all information relevant to the claim. The review of the denial of the claim will take into account all information submitted by the claimant relating to the claim, without regard to whether the information was submitted or considered in the initial decision on the claim. The review of the denial of the claim will not defer to the initial denial of the claim and will be conducted by a fiduciary of the *Plan* who is neither the individual who denied the claim that is the subject of the appeal nor a subordinate of that individual. In deciding an appeal of any denial of a claim that is based in whole or in part upon a medical judgment, the appropriate fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The fiduciary will identify the medical or vocational experts whose advice was obtained in connection with the denial of the claim, regardless of whether that advice was relied upon in deciding such claim. The health care professional whom the fiduciary engages for purposes of a consultation described above will be an individual who is neither an individual who was consulted in connection with the denial of the claim that is the subject of the appeal nor the subordinate of any such individual.

Before the *Plan* can issue an adverse benefit determination on review on a disability claim, the *Plan Administrator* will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the *Plan*, carrier or other person making the benefit determination (or at the direction of the *Plan*, carrier or such other person) in connection with the claim; that evidence must be provided as soon as possible and sufficiently in advance of the date on which the adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. Also, before the *Plan* can issue an adverse benefit determination on review on a disability claim based on a new or additional rationale, the *Plan Administrator* will provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

The claimant will be notified of any denial of an appeal within a reasonable period of time (not to exceed 45 days after receipt of the claimant's request for review), unless special circumstances require an extension of time for processing the claim. If an extension is required, written notice of the extension will be furnished to the claimant prior to the expiration of the initial 45-day period. In no event will such extension exceed a period of 45 days from the end of the initial 45-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the decision on the appeal is expected to be made.

The denial notice will provide the following information:

- the specific reasons(s) for the denial of the appeal;
- reference to the specific policy provision(s) on which the denial is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all information relevant to the claim;
- a statement describing any voluntary appeal procedures offered and the claimant's right to obtain information about such procedures, and a statement of the claimant's right to bring a civil action under ERISA Section 502(a);
- if an internal rule or other similar criterion was relied upon in the denial of the appeal, the notice of the denial also will include either the specific rule or other similar criterion or a statement that the rule or other similar criterion was relied upon in denying the appeal and that a copy of the rule or other similar criterion will be provided free of charge to the claimant upon request;
- if the denial of the appeal was based on a medical necessity, *experimental* treatment, or similar exclusion or limit, the notice of the denial also will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the policy to the claimant's medical circumstances, or a statement that the explanation will be provided free of charge upon request. 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;”

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

If the terms of any policy provided by the insurer and this document differ, the policy’s language will govern.

FLEXIBLE SPENDING ACCOUNTS (FSA)

A Flexible Spending Account (FSA) is a benefit plan under Section 125 of the Internal Revenue Code. Under this *Plan*, you may elect to pay for certain out-of-pocket medical, prescription, dental, vision, and dependent day care expenses with pre-tax dollars through the use of an FSA. Refer to the back page of this booklet for information on the current *claims administrator* for your FSAs.

Your FSA contributions will be deducted from your earnings before Social Security, federal income taxes, and most state income taxes are calculated. In this way, you pay for your benefits with pre-tax dollars, you pay less in taxes, and you take home more pay.

By participating in the flexible benefits plan, money that you would typically pay in taxes becomes part of your take-home pay. Not only do you avoid taxes on the money taken out, but overall, you pay less tax on your earnings. The result is more spendable income for you while you pay for routine or predictable expenses with pre-tax dollars.

The following pages answer most questions asked by *Plan participants*. If you have additional questions, please contact the *claims administrator*, Anthem.

Understanding the Benefit

IMPORTANT: *If you elect a Medical HSA option for medical coverage, you are not eligible to also have a Healthcare FSA through this plan or any other employer plan that offers a Healthcare FSA.*

Dependent Care FSAs are not restricted when electing a Medical HSA option.

Flexible Spending Accounts

A separate account is established for each FSA (health care or dependent care) in which you choose to participate. Through your FSAs, the *Plan* keeps track of the money you set aside for the *Plan Year* to cover qualifying, and otherwise unreimbursed, medical, dental, vision, prescription drug, or dependent care expenses that may occur during the *Plan Year*.

The annual amount you elect to set aside is prorated for each pay period and is subtracted from your wages before your taxes are calculated. Money may be designated for a health care FSA and/or dependent care FSA. You cannot use a health care FSA to pay dependent day care expenses or vice versa. FSAs under this *Plan* are established in accordance with Section 125 of the Internal Revenue Code.

Health Care Flexible Spending Account:

Used for team member and dependent health care expenses

If you contribute to a health care FSA, you may pay for out-of-pocket medical, dental, vision, and prescription drug expenses *incurred* by you and your dependents with pre-tax dollars. Out-of-pocket health care expenses are your *family*'s health care expenses *not* covered and *not* reimbursed by your group health plan or under any other plan or policy. In general, these expenses are any health care costs for you and your tax dependents that the Internal Revenue Service (IRS) allows you to deduct for tax purposes and that are not claimed as deductions on your tax return. Some of the expenses that qualify for reimbursement from your health care FSA include:

- Group health plan deductibles and co-payments;
- General non-reimbursed health and *physician* charges;
- Dental and orthodontic care, unless performed for strictly cosmetic reasons;
- Prescription drug deductible and co-payments;
- Vision care (exams, glasses, contacts); and
- Hearing aids and batteries

Expenses *incurred* for *cosmetic services* generally are not reimbursable from your health care FSA. See the Health Care Expenses section for a more comprehensive list of eligible and ineligible health care expenses.

Dependents Defined

For the purposes of the Health Care FSA, your dependents include:

- Your *spouse* and any child (as defined in Section 152(f) of the Internal Revenue Code) of yours up to age 26. It also can include any other person who is eligible to receive benefits under Section 105(b) of the Internal Revenue Code for whom you claim a deduction on your tax return. This includes any stepchild, parent, grandchild, or sibling for whom you have provided more than one-half of their support during the *Plan Year*. If your same-gender domestic partner qualifies as your tax dependent under the Code, then he or she will qualify as a dependent for health care FSA purposes. (You must notify Terex as soon as possible if your same-gender partner ceases to qualify as your tax dependent.) A domestic partner's child will not be considered a stepchild of the *team member* for health care purposes.

- *Dependent children* placed for adoption with you, regardless of whether the adoption has become final.

Please note that the applicable tax rules are very complicated, so you should consult with your tax advisor to determine which individuals are your "dependents" for the purposes of your Health Care FSA.

It is intended that the Health Care FSA qualify as an accident and health plan within the meaning of Section 105(e) of the Internal Revenue Code, and that the benefits provided under this *Plan* be eligible for exclusion from your income for federal income tax purposes under Section 105(b) of the Code.

Dependent Care Flexible Spending Accounts
Used for child daycare and/or eldercare costs

IMPORTANT: *This account does **NOT** cover your dependent's health care costs, such as deductibles or coinsurance. Those are covered under the Healthcare FSA described above.*

The dependent care flexible spending account allows you to pay for work-related dependent care expenses with pre-tax dollars. By law, in order to qualify for participation in a dependent care FSA, the dependent care service must be necessary to allow you and your *spouse* to work. In general, eligible expenses are any dependent care costs that meet IRS guidelines and can be claimed on your tax return.

Some of the expenses that typically qualify for reimbursement from your dependent care FSA include:

- Fees of a licensed child care facility that cares for your *dependent child*;
- After-school care expenses;
- Wages of individuals who provide care inside or outside your home for your *dependent child* under age 13 or your dependent over age 13 who is incapable of self-support;
- Federal and state employment taxes you pay for an individual you employ to provide dependent care;
- Pre-school tuition.

If you are married, you can use this account if both you and your *spouse* work, or, in some situations, if your *spouse* goes to school full-time or is *disabled*. If you are single with dependents, you can also use this account.

An eligible dependent is any member of your household who is under age 13 and for whom you claim a deduction on your federal income tax return under Section 151(c) of the Internal Revenue Code. Other eligible dependents include adults who live with you at least eight hours per day and who are physically or mentally unable to care for themselves.

An eligible caregiver may not be your *spouse* or a dependent under age 19. In the case of a day care center, the center must comply with all state and federal laws and be fully licensed to provide day care services, and must provide full-time or part-time care for more than six individuals on a regular basis and require a fee, payment, or grant for the services provided.

Pre-Tax Advantage

The money you choose to place in an FSA is considered to be pre-tax. This means that your taxable income is reduced by the amount of your pay that you allocate to your FSAs. No federal income taxes, Social Security taxes, or, in most cases, state taxes will be withheld for the portion of your wages allocated to your FSAs. Since your taxable income is reduced, you pay less tax.

It is important to determine the difference between the benefits of an FSA and those of filing a medical expense tax deduction with your tax returns. If you have questions concerning tax credits or the FSAs, contact the *claims administrator*, *Anthem BlueCross BlueShield*, for assistance.

Dependent Care Flexible Spending Accounts Versus Tax Credits

Every situation is different. For some, it may be more advantageous to use the dependent care flexible spending account and for others it may be better to take the child care tax credit when preparing their federal income tax returns (using Federal Form 2441). However, in most cases, you will save more by participating in the dependent care FSA because you reduce not only federal taxes, but state taxes and Social Security contributions as well.

The rules for qualifying expenses and dependents, as well as earned income limitations, are generally the same for the dependent care FSA and for claiming the tax credit. However, the resulting tax savings may be different, depending on several factors.

Consistent with IRS regulations, you may contribute up to $5000 to your dependent care FSA each *Plan Year.* However, if you are married, federal law limits the amount you may contribute for child or dependent care to that of your annual earned income or your *spouse*'s annual earned income or $5000 ($2500 if married and filing separately), whichever is less. For example, if your annual income is $15,000 and your *spouse* works part-time and earns an annual income of $500, the maximum you could contribute for child or dependent care that year would be $500.

Please note that the applicable tax rules are very complicated, so you should consult with your tax advisor to determine whether to participate in a dependent care FSA.

Effect of Pre-Tax Deductions on Your Tax Return

The compensation you elect to set aside in your FSA to pay for health care expenses is not taxable as income. Expenses that are reimbursed through the *Plan* cannot be claimed as income tax deductions and they cannot be used in calculating an income tax credit.

Effect of Pre-Tax Deductions on Social Security Benefits

The money you have authorized for payroll deduction for benefits under the *Plan* is not taxed for FICA (Social Security). This means that the contributions you make and the contributions the *Company* makes for the federal Social Security system are reduced. It is possible, therefore, that your Social Security benefits may be reduced. However, in the long run, the reduction in benefits, if any, should be minimal.

Cost of Plan Administration

Currently, Terex is paying the entire cost of administering the *Plan* for active *team members*. If you elect to continue coverage through COBRA, your COBRA premium may include the reasonable cost of administration for your participation.

Mid-Year Election Changes

Generally, you may make a change to your FSA election only at the next annual enrollment period. The annual enrollment period takes place prior to the beginning of each Plan Year. However, please see the "Changes in Plan Elections on a Pre-Tax Basis" section for further information on exceptions to this rule. Please note that many change in status events do not apply to FSAs.]

Effect of Termination of Employment on Plan Participation

If you terminate employment with Terex, your participation in this *Plan* will terminate on the last day you are *actively at work*, unless you elect to continue your participation in accordance with the guidelines provided in the COBRA section. Any eligible expenses you *incurred* prior to the date of termination will be reimbursed by the *Plan* in accordance with the guidelines in the How to File a Claim section. Your participation in this *Plan* will also terminate if the *Company* decides to terminate this *Plan*.

If your participation in a health care FSA terminates because you are no longer eligible to participate, you may be eligible to continue your participation in accordance with the COBRA section. If you are eligible for COBRA continuation coverage but do not elect COBRA coverage or do not make payments in accordance with COBRA, it will be assumed that you elected not to continue your participation in the health care FSA.

If you elect not to continue your participation in the health care FSA as provided in the COBRA section, and you return to eligible employment with Terex within the same *Plan Year*, you will not be permitted to participate in a health care FSA for the remainder of the Plan Year.

Making Contributions to the Plan

Plan Contributions

Once you make your annual elections, FSAs are created in your name under the *Plan* to keep track of the elections you selected, the amounts contributed to the *Plan*, and the amount you have been reimbursed for submitted claims.

Each pay period, the amount you have specified is subtracted from your earnings and allocated to your specified account(s).

It is important to understand that the amount you elect to contribute to your account(s) is subtracted from your check each pay period. The annual amount you elect to contribute is prorated for each pay period. For example, if you expect to *incur* $520 in medical expenses that are not covered by your group health plan and you are paid bi-weekly (deductions will be taken from 26 pay periods per year), then, for each pay period, $20 will be subtracted from your wages on a pre-tax basis and allocated to your health care FSA.

Your withholding taxes are calculated *after* the money is allocated to your account(s).

Health Care FSA Contribution Minimum and Maximum

The maximum contribution is subject to the IRS maximum for that Plan Year..

Dependent Care FSA Contribution Minimum and Maximum

Consistent with IRS regulations, you may contribute up to $5,000 (subject to change by the IRS) to your dependent care FSA each *Plan Year.* However, if you are married, federal law limits the amount you may contribute for child or dependent care to that of your or your *spouse*'s annual earned income or $5000 ($2500 if married and filing separately), whichever is less. For example, if your annual income is $15,000 and your *spouse* works part-time and earns an annual income of $500, the maximum you could contribute for child or dependent care that year would be $500.

Contribution Limitations for Highly Compensated Team Members

If you are a highly compensated *team member* as defined by the Internal Revenue Code, your amount of contributions and benefits may be limited or changed during the middle of the year so that the *Plan* does not unfairly favor highly compensated *team members*, their *spouses*, or their *dependent children*.

The *Plan Administrator* will notify you if your contributions or benefits exceed these annual limits.

Determining the Amount of Plan Contributions

Every *family* situation is different. You must evaluate *your family*'s health care needs to determine the appropriate amount to contribute to your health care FSA. To help you in making that assessment, use the

Flexible Spending Account Worksheet provided by the *Plan Sponsor*. It is very important that you make these choices carefully. All money set aside in an FSA must be spent on eligible expenses by the end of the time period specified in the Making Claims to the Plan section. Any funds left in an account at the end of this time period will be forfeited (although you will have a 90-day "run-out" period after the end of this time period or, if earlier, 90 days following the termination of your participation in the *Plan* to file claims for eligible expenses.)

Estimate your *family*'s expenses for health care costs *not* covered and *not* reimbursable by your (or your *spouse*'s) health care plan(s). In other words, estimate how much money will come out of your pocket for health care services or supplies which are not covered or are not reimbursable by any health plan during the *Plan Year*. For example, if you want the cost of deductibles to be paid from the account, estimate your deductibles for the year. Based on your estimates, select the amount of money you want in your health care FSA for the *Plan Year*. Remember that your health care FSA may not reimburse you for expenses *incurred* by your domestic partner unless the domestic partner qualifies as your tax dependent.

Once you have set aside money in the health care FSA, however, you may spend it for any qualified medical expense you pay for out of your own pocket. For example, if you set aside money you intend to use for orthodontia work, and then later *incur* unreimbursable *emergency* room bills, you may spend the money on whichever expense you choose.

Determination of Non-Compliance

You should be aware that in the event it is determined that the contributions you made under the *Plan* do not qualify as non-taxable contributions under a "cafeteria plan" under Section 125 of the Internal Revenue Code, those contributions will be treated as salary and, to the extent not yet expended, will be returned to you. You may be responsible for:

- Any state or federal income taxes due with respect to the contributions, together with any interest or penalties imposed on them.
- Your share (as determined in good faith by the *Plan Sponsor*) of any applicable FICA or FUTA contributions which would have been withheld from such amounts by the *employer* had such amounts originally been treated as salary.
- An amount (as determined in good faith by the *Plan Sponsor*) equal to the portion of any applicable penalties and interest payable by the *Plan Sponsor* as the result of the failure to withhold and pay such amounts to the appropriate payee allocable to you.

Instructions for Submitting a Claim Form

General Instructions

- Submit a Flexible Spending Account Request for Reimbursement form to the *claims administrator*.
- Expenses claimed from your flexible spending account cannot be claimed as income tax deductions or as tax credits.
- Indicate the dollar amount requested for reimbursement from your flexible spending account.
- The date of service for the item submitted must be both within the *Plan Year* (or the applicable grace period) and during your participation in the *Plan* or it will be considered an ineligible expense. If there is no date of service on the invoice or receipt, it will be considered an ineligible expense.

Grace Period for filing FSA Claims

You may make a claim for reimbursement of eligible expenses you have *incurred* at any time during the *Plan Year* or by March 15 following the end of the *Plan Year* and while you participated in the *Plan*.

Also, you may submit requests for eligible expenses until June 15 following the end of the *Plan Year* or, if earlier, 90 days following the termination of your participation in the *Plan*.

For example:

	Period to *Incur* Claims	Deadline to Submit Claims
2018 *Plan Year* Election	January 1, 2018–March 15, 2019	June 15, 2019
2019 *Plan Year* Election	January 1, 2019–March 15, 2020	June 15, 2020

Automatic Submission for Health Care FSA Claims

If you participate in this *Plan's* medical, dental or vision benefits which are administered by Anthem and the prescription drug benefit administered by ESI, and you have a Health Care FSA, you may elect to have non-covered medical, prescription drug, dental or vision expenses (i.e. deductibles, co-payments, coinsurance) automatically submitted to your FSA for reimbursement. You will not have to submit a separate FSA Request for Reimbursement Form for these expenses.

However, it will still be necessary for you to submit a claim form to obtain reimbursements for dependent day care expenses, other unreimbursed health expenses, or other eligible expenses not processed by Anthem or ESI.

If you have any expenses submitted to your group health plan that may be payable by another health plan (such as your spouse's), you cannot elect Automatic Submission.

To elect automatic submission, select this option when you enroll online or by phone for your Health Care FSA.

To receive reimbursement of an expense which you believe is eligible for reimbursement, you must first review the list of eligible and ineligible health care expenses as listed in the Flexible Spending Account (FSA) section. After determining that the expense is eligible for reimbursement, submit a Flexible Spending Account Request for Reimbursement form to the *claims administrator*. You must provide the following information:

- The name of the person or persons on whose behalf the expenses have been *incurred*.
- The nature of the expenses *incurred*.
- The date the expenses were *incurred*.
- Evidence that such expenses have not otherwise been paid through insurance or reimbursed from any other source.

You should also submit written evidence from an independent third party documenting the above information. For example, if the expenses are for services not covered by your group health plan, attach a copy of the receipt including the date(s) of service, an explanation of services, and the name of the *provider*. If the expenses are for services which are not reimbursed under your group health plan coverage, attach a copy of the Explanation of Benefits (EOB) or denial letter from your group health plan. Canceled checks or balance due statements are not acceptable forms of statements for services rendered.

You must also submit a signed statement in the form determined by the *Plan Administrator* certifying that the expenses for which you are seeking reimbursement are expenses which you believe in good faith are eligible for reimbursement under the *Plan*.

The *Plan Administrator*, at its sole discretion, reserves the right to verify to its satisfaction the eligibility of all claimed expenses prior to reimbursement and to refuse to reimburse any amounts that it determines are not eligible for reimbursement under this *Plan*.

Where to Submit Health Care Flexible Spending Account Claims

Send paper claims to:
Anthem Blue Cross and Blue Shield
P.O. Box 660165
Dallas, TX 75266

Dependent Care Flexible Spending Account Claims

To receive reimbursement for an eligible expense under a dependent care FSA, you must complete and submit a Dependent Care Reimbursement Account Request form to the *claims administrator*. The form must include the following information:

- A list of names of the eligible dependents for whom the expenses were *incurred*, the ages of such dependents, and each dependent's relationship to you.
- If any of the services were performed outside of your home for a dependent incapable of caring for himself or herself, a statement as to whether the dependent regularly spends at least eight hours per day in your home.
- If any of the services are performed for a dependent who is physically or mentally incapable of caring for himself or herself, a statement to that effect.
- A description of the nature and dates of performance of the qualifying services for which cost you wish to be reimbursed.
- A description of the relationship, if any, to you of the person or persons who performed the services.
- A statement indicating that you will include on your federal income tax return the name, address, and (except in the case of a tax-exempt qualifying day care center) the taxpayer identification number of the *provider* of the services.
- If you are married, a statement as to whether you plan to file a separate federal income tax return from your *spouse*.
- If you are married, and your *spouse* is employed, a statement of your *spouse's* compensation.
- If you are married and your *spouse* is not employed, a statement that your *spouse* is incapacitated, or that your *spouse* is a student, and indicating the months of the year during which the *spouse* attends an educational institution on a full-time basis.
- A statement as to the amount, if any, of tax-exempt dependent care assistance benefits received from any other employer by you or your *spouse* during the *Plan Year*.
- Evidence of indebtedness or payment by you to the third party who performed the services.
- Written evidence from an independent third party stating that the expenses have been *incurred*, the amount of such expenses, the date of services, and such other information as the *Plan Administrator*, at its sole discretion, may request.
- A statement as to where the services were performed.
- A statement indicating whether the services are necessary to enable you to be gainfully employed.
- A statement that the expenses have not been reimbursed and are not reimbursable under any other plan or by any other entity.
- A statement, signed by you and in such form as determined by the *Plan Administrator*, certifying that the expenses for which reimbursement is sought are expenses that you believe in good faith are eligible for reimbursement.

You must also attach a paid receipt from your day care *provider* or from the individual who provides the care. The Social Security number or the federal tax identification number of the *provider must* appear on the claim form or receipt. The individual who provides the care may not be your *spouse* or a dependent under the age of 19, and expenses claimed under your dependent care FSA may not exceed the lesser of your or your *spouse*'s income.

Excess or Shortage of Funds in Your Flexible Spending Account When Making a Claim

As required by IRS regulations, any monies or excess funds are forfeited if left in your FSA 90 days after the end of the grace period following the *Plan Year* or, if earlier, 90 days following the date your participation in this *Plan* ends. Unclaimed funds and uncashed checks will also be forfeited. All requests for reimbursement for any *Plan Year* must be made no later than the earlier of either 90 days following the end of the grace period following the *Plan Year* or 90 days after your participation in the *Plan* terminates.

Since it is possible that you might forfeit amounts in your FSA, it is important that during the election period, you carefully and conservatively decide how much to place in each account. You need to plan so that the amount you decide to place in each account is used up entirely. (See Making Contributions to the Plan.)

Health Care Flexible Spending Account

When you make an eligible claim to your health care FSA that exceeds your account balance, the claim will be reimbursed for the amount of the claim, not to exceed the amount of your annual election less any amounts that have already been reimbursed from your health care FSA.

For example:

- ⇒ If you submit an eligible claim for $400 but have accumulated only $50 in your account, the *claims administrator* may still issue a check for $400 depending on your annual election amount and reimbursements you may already have received.
- ⇒ If your annual election was $600 and you have already received reimbursement for $200, you have $400 of unreimbursed elected contributions. When you submit your $400 claim, the *claims administrator* will issue a check for $400. No additional claims will be paid from your account for the remainder of the *Plan Year*.

In the examples shown above, where benefits have been paid up to the maximum annual election amount before the end of the *Plan Year*, your contributions will continue to be deducted for the remainder of the *Plan Year* to reach the annual election amount.

To assist you in determining if your claim is an eligible expense, refer to the Health Care Expenses section of this Summary Plan Description for a list of some typical eligible expenses, as well as a list of ineligible expenses. If you have additional questions regarding the eligibility of an expense, check with your personal tax adviser or obtain a copy of IRS Publication 17, “Your Federal Income Tax,” for further guidance.

Dependent Care Flexible Spending Account

When you make a claim to your dependent care FSA and the requested claim is an eligible expense, but exceeds your account balance, you will be reimbursed for the amount that is currently in your account. The balance of the claim will be paid monthly as future deposits for that *Plan Year* are added to your account. You do not need to resubmit the claim each month.

For example:

- If you submit an eligible claim for $400 but only have $50 in your account, *Anthem BlueCross BlueShield* will issue a check for $50. The next process date, and for every following process date, *Anthem BlueCross BlueShield* will issue a check for the balance of the unpaid portion of the claim based on deposits added to your account. This will continue until the claim is paid in full.

You will be reimbursed up to, but not exceeding, the amount of your annual election less any amount you have already been reimbursed from your dependent care FSA.

Transfer of Funds Between Flexible Spending Accounts

The IRS does not permit you to transfer money from one account to the other. This is one more reason to be very careful when you estimate your anticipated expenses for the *Plan Year*. Examples of Eligible Health Care Expenses

Eligible Items

The examples listed in the section are intended only to give you a convenient reference to the types of expenses that **may** be eligible for reimbursement. This list is subject to change at any time there are changes to the IRS Code.

Determination of covered expenses allowed will be in accordance with Section 213(d) of the Internal Revenue Code as stated at the time the expense is *incurred*.

- Allergy tests and shots
- Acupuncture
- Alcoholism treatment
- Ambulance services
- Artificial limbs
- Automobile modifications required by medical conditions
- Birth control pills
- Birth prevention surgery
- Braille materials (books and magazines)
- Capital expenses for home improvements required by medical condition (cost of the improvement is reduced by the increase in property value)
- Chiropractic services
- Christian Science practitioners' fees
- Condoms
- Contact lenses and supplies
- Contact lens solution
- Co-payments
- Crutches
- Deductibles on you or your *spouse*'s group plan
- Dental fees
- Dentures
- Eye glasses including examination fees
- Guide dog
- Healing services
- Hearing aids and batteries
- *Home health care*
- *Hospital* costs not covered by group health plan
- Hysterectomy
- Insulin
- Laboratory fees
- Laser vision correction/radial keratotomy
- Obstetrical expenses
- Oral surgery
- Orthodontic services
- Osteopath fees
- Oxygen
- Podiatrist fees
- Prescription drugs
- Psychiatric care
- Psychologist fees
- Rental of medical equipment
- Routine physical examination
- Seeing eye dog and its upkeep
- Smoking cessation programs
- Special communication equipment for the deaf
- Sterilization
- Surgical fees
- Therapeutic care for *substance abuse* (drug or alcohol)

- Transportation expenses to obtain *medical services*
- Tubal ligation
- Charges in excess of the usual, customary and reasonable allowance
- Over the counter medications, only if prescribed by a physician
- Vasectomy
- Weight loss program prescribed by a *physician* for obesity
- Wheelchair
- Wigs due to a medical condition

Examples of Ineligible Health Care Expenses

This list should not be considered all-inclusive, and determination of ineligible expenses will be in accordance with Internal Revenue Code Section 213 as stated at the time the expense is *incurred*.

- Cosmetic surgery
- Dental or Orthodontic services for cosmetic reasons
- Funeral expenses
- Health club dues
- Insurance premiums for health insurance
- Massage therapy (unless medically necessary)
- Nursing home expenses
- Over the counter medication not prescribed by a physician (except insulin)
- Rogaine
- Weight loss programs for general health improvement

Examples of Eligible Dependent Care Expenses

- After school care expenses
- In-home daycare fees
- Day care center fees
- Federal and state employment taxes you pay for an individual you pay to provide dependent care
- Pre-school or pre-kindergarten tuition
- Wages of individuals who provide care inside or outside your home

Examples of Ineligible Dependent Care Expenses

- Claims submitted without the caregivers' federal tax ID and/or Social Security Number
- Nursing home expenses
- "Sleep away" camp expenses, i.e., camp expenses other than day camp in lieu of the child's regular day care. Specialty camps, e.g., tennis camps and basketball camps. However, services may be covered if they occur during the hours an employee or *spouse* is working or looking for work
- Wages for a caregiver who is your *spouse* or dependent under age 19
- Kindergarten tuition for educational purposes only

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Terex provides all *team member*s, their *spouse*s and *dependent child*ren, an employee assistance program (EAP) that provides services we can use in our everyday lives. Terex pays the cost to provide this benefit; there is no cost to the *team member* for this benefit.

Listed below are the services offered categorized by the types of benefit or assistance provided:

Confidential Counseling

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by Guidance Consultants—highly trained masters and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling and other resources for:

- Stress, anxiety and depression
- Job pressures
- Relationship/marital conflicts
- Grief and loss
- Problems with children
- Substance abuse

Financial Information and Resources

Speak by phone with Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Retirement planning
- Credit card or loan problems
- Estate planning
- Tax questions
- Saving for college

Legal Support and Resources

Talk to attorneys by phone. If you require representation, you will be referred you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees for services thereafter. Call about:

- Divorce and family law
- Real estate transactions
- Debt and bankruptcy
- Civil and criminal actions
- Landlord/tenant issues
- Contracts

Work-Life Solutions

Specialists will do research for you, providing qualified referrals and customized resources for:

- Child and elder care
- College planning
- Moving and relocation
- Pet care
- Making major purchases
- Home repair

Guidance Resources Online

Guidance Resources Online is your one stop for expert information on the issues that matter most to you; relationships, work, school, children, wellness, legal, financial, free time and more:

- Timely articles, Help Sheets, tutorials, streaming videos and self-assessments
- “Ask the Expert” personal responses to your questions
- Child care, elder care, attorney and financial planner searches

For more information or assistance, or to use the EAP benefit, call: 1-866-923-7249
Go online: **guidanceresources.com and** use the company Web ID: **TerexEAP**

HEALTH ADVOCACY SERVICES

Terex provides all *team member*s, their *spouse*s and *dependent child*ren, and their parents and parent-in-laws an advocacy service that provides assistance in many areas of healthcare. There is no cost to the *team member* for this benefit. Listed below are the services offered categorized for the assistance provided:

Clinical Services

***Care Coordination**:* Coordinating care among vendors and *provider*s, coordinating benefits in dual coverage scenarios, facilitating members' access to care management programs, facilitating the transfer of medical records and lab results between *provider*s, coordinating *physician*s' visits and testing, and much more.

***Advocates of Excellence**:* Identifying top medical institutions, critical *illness provider*s and specialized medical programs across the country.

***Physician Locator**:* Identifying primary and specialist *physician*s, *hospital*s, *dentist*s and related healthcare *provider*s, with a focus on in-network resources.

Rx Advocate: Providing members with assistance on prescription drug issues including formulary and benefit questions.

Healthcare Coaching: Providing authoritative health information to members, preparing members for doctors' visits, helping members understand conditions and treatment options, and much more.

Administrative Services

***Claims & Billing Assistance**:* Resolving claims and related paperwork problems, researching out-of-pocket responsibilities, correcting balance-billing issues, resolving eligibility discrepancies and claim denials, resolving coding issues around condition-specific vs. preventive care charges, and much more.

***Fee Negotiation**:* Where appropriate, negotiating fees with healthcare *provider*s to lower the member's out-of-pocket costs.

***Appeals Advice**:* Providing advice or assistance to members when filing a complaint or grievance with their health insurer or health plan administrator.

***Coverage Advantage**:* Assisting members to resolve a range of coverage issues, including obtaining referrals for required services, obtaining exceptions for a member to see *provider*s outside of their capitated relationships where appropriate, counseling members regarding current benefit costs and the cost of alternative approaches, providing information regarding coverage comparisons for various *provider*s, transitioning members from out-of-network to in-network *provider*s, assisting members with the preauthorization and predetermination process, assisting employees with *disability* coverage questions, and much more.

***Benefits Education**:* Helping members understand their benefit offering, from routine terms like deductible and co-insurance to the financial implications of in- and out-of-network choices, guiding members in accessing benefit services, and much more.

Information and Service Support

***CareQuest**:* Locate and make arrangements for members' special service needs, including locating homemaker, adult day care and rehabilitation services not covered by the member's health plan, locating inpatient private duty nursing, finding group homes for individuals with special needs, and much more.

***M.D. Direct**:* In the case of serious medical *illness*, helping members access experts for consultations and second opinions.

Complementary and Alternative Medicine: Identifying and coordinating a range of wellness services including those offered by Complementary and Alternative Medicine (CAM) practitioners.

***Healthy Wheels**:* Arranging transportation services to support members' healthcare needs.

***MindMatters**:* Helping members find an appropriate *mental health provider* to meet their specific needs.

***Senior Care Navigator**:* Locating alternative care facilities, obtaining coverage for medical supplies, providing information on adult day care programs, assisting with the transition from private insurance to *Medicare*, and much more

To contact Health Advocate for any of the services above, call 1-866-695-8622. For more information or if you would like a brochure, contact your local Human Resources Representative.

GROUP LEGAL SERVICE

Terex provides its' *team member*s with the option to purchase coverage that provides limited legal assistance to the *team member* and their *family* members. The cost for this benefit can be paid through convenient payroll deductions. *Team member*s can add or drop this coverage at any time during the *Plan Year.* See your local Human Resources representative for more information or assistance with enrolling.

Who's covered

- The *team member* as the primary member
- The *team member*'s *spouse* or significant other listed on the membership
- Never-married, children up to age 21 who live at home
- Never-married, children who are full-time college students and any *dependent child*, regardless of age, who is mentally or physically *disabled* and dependent upon you for support

Below are some of the services provided. Other services may be available to you based on the state you live in. Not all services offered are available in all states. More detailed information is available from the LegalShield website, or by calling 1-800-654-7757

Preventive Legal Services

Phone Consultations on Any Subject Matter - As a member, you can consult with your Provider Law Firm toll-free by phone on any personal or business-related matter. Just call your Provider's toll-free number during regular business hours when you have a legal question or concern.

Letters and Phone Calls - A phone call or letter from your Provider Lawyer can get you the results you want fast. Your Provider Lawyer will furnish a specific number of preventive letters or phone calls per year on your behalf. In many cases, this seemingly simple benefit resolves the legal issue. However, if it doesn't, additional assistance for the same subject would be available at the Preferred Member's Rate, which includes a 25% discount.

Contract and Document Review- You can have an unlimited number of personal legal documents, up to a specified number of pages each, reviewed by your Provider Law Firm. Your Provider Lawyer will analyze the documents and make recommendations or suggest changes for your benefit before you sign.

Will Preparation - A Last Will & Testament can be the most valuable gift you can give your *family* members. As part of your membership, the main member as well as the covered *family* members can have their will prepared at no additional charge. In addition, every covered person can have their will reviewed annually; again at no additional charge. If the member, in conjunction with their legal counsel, feels that a trust would be the best option, it can be prepared at the Preferred Member's Rate which includes a 25% discount.

Motor Vehicle Related Benefits

Moving Traffic Violation Assistance - Your Provider Lawyer will represent you or your covered *family* members against moving traffic violations. A minimum fee is required for each occurrence. Now you can have help with traffic tickets and not have to worry about the cost of representation.

Auto-Related Criminal Charge Representation - Your Provider Lawyer will defend you or your covered *family* members when you are charged with Manslaughter, Involuntary Manslaughter, Negligent Homicide, or Vehicular Homicide at a discount rate. Contact Group Legal directly for current rates.

Driver's License Recovery - Your Provider Lawyer will assist you and your covered *family* members with driver's license reinstatement at a discount rate. Contact Group Legal directly for current rates.

Personal *Injury* and Property Damage Claims - You'll also receive assistance with collection of personal *injury* or property damage claims of $2,000 or less resulting from driving, riding in or being struck by any motor vehicle or boat, at a at a discount rate. Contact Group Legal directly for current rates.

HOW TO FILE A CLAIM

The following section applies to medical, prescription, dental, vision, and FSA claims. For all other benefits, refer to the claims filing provisions included within that benefit's section of this Summary Plan Description. A list of all *claims administrators* and their contact information are on the inside front and back covers of this Summary Plan Description.

The *claims administrator* is responsible for keeping the records of each *Plan participant*'s benefits and for processing claims filed with the *Plan.* **Each *Plan participant* is responsible** for making sure that claims are submitted on a timely basis. Ordinarily, this will not require the submission of a claim form since most *providers* submit bills for service directly to the *claims administrator*. FSA claims, however, typically require the submission of a claim form unless they are covered through the automatic submission process.

In some cases you may be required to submit a bill and claim form directly to the *claims administrator*. See the Submission of Claims section for detailed instructions on claim submission. In either case, you must make sure that all bills are submitted according to the Timely Filing Provision section of this document.

Timely Filing Provision – Other than FSA Claims

You or your *provider* may submit claim requests any time during the calendar year, January 1 through December 31.

Except for special filing rules for FSA claims, all claims must be received by *Anthem* no later than one year from the date you received the services. Claims filed later than that date will be denied. It is the member's (not the provider's) responsibility to ensure the claim is filed within this period.

Benefits are based upon the *Plan*'s provisions at the time the charges were *incurred*.

A pre-service non-urgent claim (including a concurrent claim that also is a pre-service non-urgent claim) is considered to be filed when the request for approval of treatment or services is made and received by the *claims administrator* in accordance with the *Plan*'s procedures.

A post-service claim is considered to be filed when the following information is received by the *claims administrator*, together with a Form HCFA or Form UB92:

- The date of service;
- The name, address, telephone number, and tax identification number of the *provider* of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges (including re-pricing information);
- The name of the *Plan*;
- The name of the covered *team member*; and
- The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the *Plan*.

The *claims administrator* will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the *claims administrator* within 45 days from receipt by the *Plan participant* of the request for additional information. **Failure to provide the information by this deadline may result in claims being declined or reduced.**

Hospital Claims

Most *hospitals* will submit your claim directly to the *claims administrator*. You need only present your identification card to the *hospital* admitting office when you or a *covered dependent* is admitted as a *hospital* inpatient or receives treatment as a *hospital* outpatient.

When you are discharged or a few days after discharge, you should receive an itemized bill from the billing office. If the bill does not indicate that it has been submitted to the *claims administrator*, contact the billing office for clarification of the *hospital*'s billing procedures.

Physician Claims

In most cases, when you or a *covered dependent* receives treatment at a *physician*'s office*,* the office submits the claim directly to the *claims administrator* on your behalf. If it does not, you must submit the claim directly. In those instances, see the Submission of Claims section.

Medical/Dental Expenses - not submitted by a *provider*

Any time you *incur* expenses for *covered charges* that are not submitted by the *provider*, you must obtain a detailed receipt that can be submitted with your claim form. You must keep separate records for each *Plan participant*. When submitting a claim yourself, follow the directions in the Submission of Claims section below.

Vision Expenses

While the plan does not contract with a preferred provider network, if an in network BlueCross BlueShield provider submits your claim, the plan may only reimburse up to the preferred provider contracted rates and you would be responsible for the balance.

Instead, when you incur vision related expenses for a routine eye exam, eyeglass lenses or frames, contact lenses or vision correction surgery, submit a Terex Vision Claim Form, available at www.anthem.com/terex. Attach to the claim form an itemized statement of expenses. When you submit the claim, reimbursement will be made to the team member. It is your responsibility to make payment to the vision provider.

Prescription Drug Expenses

When you purchase prescription drugs at a *participating pharmacy* (a pharmacy that honors your prescription drug card), simply present your Anthem ID card and make the required payment.

Should you require a prescription drug and a *participating pharmacy* is not available (for example, when you are on vacation), you may have your prescription filled at a *non-participating pharmacy*. However, you must pay that pharmacy the total amount of the charges. You may make a claim for those charges by obtaining the necessary form from a Human Resources Representative. You must complete the form, attach the receipts, and forward it to the address listed on the claim form. You will be reimbursed for the amount the medication would have cost the *Plan* at the *participating pharmacy*, minus the payment you would have been required to pay if you would have used a *participating pharmacy*.

Facility of Payment

If the *Plan Administrator* deems any person incapable of receiving benefits to which he or she is entitled by reason of minority, *illness*, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the *Plan Administrator* to disburse it. Such payments shall, to the extent thereof, discharge all liability of the *Plan Administrator*.

Lost Distributees

Any benefit payable under this *Plan* will be deemed forfeited if the *Plan Sponsor* is unable to locate you when payment is due, provided, however, that the benefit will be reinstated if a claim is made by you for the forfeited benefit.

Submission of Claims

If you find that you must submit a non-FSA claim directly to the *claims administrator*, follow these guidelines so that your claim can be processed as easily and quickly as possible:

- Contact a Human Resources Representative to obtain the required forms for submitting a claim or go online to www.anthem.com/terex and click on Claim Forms.
- A separate claim form should be submitted for each *Plan participant*.
- You are responsible for completing the *team member* section of the claim form and for submitting the form to the *claims administrator*.
- Request that the *provider* complete the remaining portions. (Frequently the *provider*'s receipt contains the pertinent information.)
- The form must be signed by the *team member* or *covered dependent* (except in the case of a minor).
- Information must be provided for each section of the claim form or it will be returned, and processing delayed.
- Each claim should include all necessary *provider* bills. The claim cannot be processed without these documents. Forward the claim form and necessary receipts to the *claims administrator*.

- All bills must include:
    - *Team member*'s member identification number.
    - Group *Plan* number.
    - Patient's full name.
    - Diagnosis.
    - Type of service or supply.
    - Itemized charge.
    - Date(s) of service.
    - *Provider*'s name, title, tax ID number, and address.
- Be sure to designate on the form whether payment is to be made to you directly or to your *provider.*
- Canceled checks, balance due statements, or cash register receipts are not acceptable forms of statements for services rendered and are not accepted in place of bills.
- When requested, you must furnish any required information regarding other group or third party medical benefits for which the *Plan participant* is eligible.
- The *Plan participant* is required to fully and truthfully complete the claim for benefits and supply any pertinent information from personal or professional sources, as may be required by the *claims administrator*.

If you need to contact the *claims administrator*, be sure to identify yourself as a *Plan participant* of the Terex Corporation Health and Welfare Benefits Plan.

Release of Information

Part of the claim form is a release of information. You must allow the *claims administrator* to review your medical records, as needed, if the *Plan* is to provide coverage. The *Plan Administrator* may, without the consent of or notice to any person, release to or obtain from any organization or person any information that the *Plan Administrator* deems to be necessary. This information is used only to determine your benefits. Sometimes additional information is needed before coverage can be provided.

This usually relates to the coordination of benefits, subrogation, or the eligibility of certain children.

Effective Date

Payment for *covered charges* is made only when charges are *incurred* on or after the *Plan participant*'s effective date of coverage and prior to the *Plan participant*'s effective date of termination of coverage.

Questions, Assistance and Mailing Addresses

Any time you have questions about your benefits or require assistance in making a claim, contact the *claims administrator* at:

Medical Claims – In-network filed by the provider:
In-network *provider*s should send claims to the local Anthem or Blue Cross or Blue Shield claims address

Medical Claims – Out-of-network filed by the provider or the team member:
Anthem BlueCross BlueShield
P.O. Box 54159
Los Angeles, CA 90054-0159

1-800-889-4169
8:00 a.m. – 8:00 p.m. EST/EDT
http://www.anthem.com/terex

Dental Claim:
Anthem BlueCross BlueShield
P.O. Box 659444
San Antonio, TX 78265-9444

1-800-889-4169
8:00 a.m. – 8:00 p.m. EST/EDT
http://www.anthem.com/terex

Vision Claim filed by the team member for reimbursement of paid expenses:
Anthem BlueCross BlueShield
Attn: Kimberly Cowart GA082E-0003
P.O. Box 9907
Columbus, GA 31908
Or email to terexvision@anthem.com

1-800-889-4169
8:00 a.m. – 8:00 p.m. EST/EDT
http://www.anthem.com/terex

Flexible Spending Account Claim:
Anthem BlueCross BlueShield
P.O. Box 660165
Dallas, TX 75266

Phone 1-800-889-4169
Fax 1-888-347-5212
8:00 a.m. – 8:00 p.m. EST/EDT
http://www.anthem.com/terex

Prescription Drug Claims:
Express Scripts, Inc.
P.O. Box 14711
Lexington, KY 40512

1-800-711-0917
24 hours
http://www.express-scripts.com

Life and Accidental Death and Dismemberment Claims:
The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517,
Philadelphia, PA 19176

1-800-524-0542
http://www.prudential.com/mybenefits

Policy Number 46792 (all Prudential benefits)

Short Term and Long Term Disability Claims:
The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480,
Philadelphia, PA 19176

Phone 1-877-367-7781
Fax: 1-877-889-4885
http://www.prudential.com/mybenefits

Policy Number 46792 (all Prudential benefits)

When you contact the *claims administrator*, be sure to provide the following information:

- Your name (and name of patient if not the same).
- The name of your *employer*.
- The name of your *Plan*, the Terex Corporation Health and Welfare Benefits Plan.
- Your Social Security number.
- The date(s) of service.
- The name of the service *provider*.

Claims Procedures – Medical, Dental, Prescription, Vision and Health Care FSA

The following procedures pertain to medical, dental, prescription drug, vision, and/or health care FSA claims. For all other benefits see the claims procedures section for that benefit. *Plan participants* must follow the procedures outlined below to obtain payment of health benefits under this *Plan*.

Claims

All claims and questions regarding health claims should be directed to the *claims administrator*. The *Plan Administrator* is ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the *Plan* will be paid only if the *Plan Administrator* decides at its discretion that the *Plan participant* is entitled to them. The responsibility to process claims in accordance with the SPD may be delegated to the *claims administrator*, provided, however, that the *claims administrator* is not a fiduciary of the *Plan* and does not have the authority to make decisions involving the use of discretion.

Each *Plan participant* claiming benefits under the *Plan* will be responsible for supplying, at such times and in such manner as the *Plan Administrator,* at its sole discretion, may require, written proof that the expenses were *incurred* under the *Plan*. If the *Plan Administrator,* at its sole discretion, determines that the *Plan participant* has not *incurred covered charges* under the *Plan*, or if the *Plan participant* fails to furnish such proof as is requested, no benefits will be payable under the *Plan*.

Under the *Plan*, there are three types of health claims: pre-service non-urgent, concurrent, and post-service.

Pre-Service Non-Urgent Claims

A “pre-service claim” is a claim for a benefit under the *Plan* where the *Plan* conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A “pre-service urgent care claim” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the *Plan participant* or the *Plan participant*’s ability to regain maximum function, or, in the opinion of a *physician* with knowledge of the *Plan participant*’s medical condition, would subject the *Plan participant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to notify the *Plan* in advance. The *Plan participant* should obtain such care without delay.

Further, because the *Plan* does not require the *Plan participant* to provide notification of a health care service in an urgent care situation prior to getting treatment, there are no pre-service urgent care claims under this *Plan*; rather, the *Plan* requires notification only for pre-service non-urgent claims. In an urgent care situation, the *Plan participant* simply follows the *Plan*’s procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Concurrent Claims

A “concurrent claim” arises when the *Plan* has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the *Plan* determines that the course of treatment should be reduced or terminated, or (b) the *Plan participant* requests extension of the course of treatment beyond that which the *Plan* has approved.

If the *Plan* does not require the *Plan participant* to provide notification of a health care service prior to getting treatment, then there is no need to contact the *Plan Administrator* to request an extension of a course of treatment. The *Plan participant* simply follows the *Plan*’s procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Post-Service Claims

A “post-service claim” is a claim for a benefit under the *Plan* after the services have been rendered.

Timing of Claim Decisions

The *Plan Administrator* will notify the *Plan participant,* in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service non-urgent claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-Service Non-Urgent Care Claims

- If the *Plan participant* has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim, unless an extension has been requested; then prior to the end of the 15-day extension period.

- However, if the *Plan participant* has not provided all of the information needed to process the claim, then the *Plan participant* will be notified as soon as possible as to what specific information is needed, but no later than 5 days after receipt of the claim. Once the *Plan participant* has provided all of the information necessary to process the claim, he or she will be notified of a determination of benefits. In this case, the 15-day period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to the *Plan participant* until the date on which the *Plan participant* responds to the request for additional information.

Concurrent Claims

- ***Plan* Notice of Reduction or Termination:** If the *Plan Administrator* is notifying the *Plan participant* of a reduction or termination of a course of treatment (other than by *Plan* amendment or termination), before the end of such period of time or number of treatments, the *Plan participant* will be notified sufficiently in advance of the reduction or termination to allow the *Plan participant* to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- **Request by *Plan Participant* Involving Non-Urgent Care:** If the *Plan Administrator* receives a request from the *Plan participant* to extend the course of treatment beyond the period of time or number of treatments that is
  a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or as a post-service claim).

Post-Service Claims

- If the *Plan participant* has provided all of the information needed to process the claim, in a reasonable period of time, but no later than 30 days after receipt of the claim, unless an extension has been requested; then prior to the end of the 15-day extension period.
- However, if the *Plan participant* has not provided all of the information needed to process the claim, then the *Plan participant* will be notified as soon as possible as to what specific information is needed. The *Plan participant* will have 45 days to provide the applicable information. Once the *Plan participant* has provided all of the information necessary to process the claim, he or she will be notified of a determination of benefits. In this case, the 30-day period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to the *Plan participant* until the date on which the *Plan participant* responds to the request for additional information.

Extensions – Pre-Service Non-Urgent Care Claims

This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies the *Plan participant*, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

Extensions – Post-Service Claims

This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies the *Plan participant*, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the *Plan*.

Notification of an Adverse Benefit Determination

The *Plan Administrator* shall provide a *Plan participant* with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the Summary Plan Description upon which a denial is based;
- Specific reason(s) for a denial;
- A description of any additional information necessary for the *Plan participant* to perfect the claim and an explanation of why such information is necessary;
- A description of the *Plan*'s review procedures and the time limits applicable to the procedures, including a statement of the *Plan participant*'s right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;

- A statement that the *Plan participant* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *Plan participant*'s claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the *Plan* did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol, or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the *Plan participant*, free of charge, upon request); and
- In the case of denials based upon a medical judgment (such as whether the treatment is *experimental*), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *Plan participant*'s medical circumstances, or a statement that such explanation will be provided to the *Plan participant,* free of charge, upon request.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the *Plan participant* believes the claim has been denied wrongly, the *Plan participant* may appeal the denial and review pertinent documents. The claims procedures of this *Plan* provide a *Plan participant* with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the *Plan* provides:

- *Plan participants* at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
- *Plan participants* the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the *Plan*, who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by the *Plan participant* relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based, in whole or in part, upon a medical judgment, the *Plan* fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the *Plan* in connection with a claim, even if the *Plan* did not rely upon their advice; and
- That a *Plan participant* will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *Plan participant*'s claim for benefits in possession of the *Plan Administrator* or the *claims administrator*; information regarding any voluntary appeals procedures offered by the *Plan*; any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *Plan participant*'s medical circumstances.

Requirements for Appeal

The *Plan participant* must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the *Plan participant*'s appeal must be mailed to the *claims administrator* at:

Medical Claim:
Anthem BlueCross BlueShield
P.O. Box 6007
Los Angeles, CA 90060

Dental Claim:
Anthem BlueCross BlueShield
P.O. Box 659444
San Antonio, TX 78265-9444

Vision Claim:
Anthem BlueCross BlueShield
Attn: Kimberly Cowart GA082E-0003
P.O. Box 9907
Columbus, GA 31908

Flexible Spending Account Claim:
Anthem BlueCross BlueShield
P.O. Box 660165
Dallas, TX 75266

Prescription Drug Claims
Express Scripts, Inc.
Attn: Benefit Coverage Review Department
P.O. Box 66587
St, Louis, MO 63166-6587

Life and Accidental Death and Dismemberment Claims:
The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, PA 19176

Short Term and Long Term Disability Claims:
The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480,
Philadelphia, PA 19176

The *claims administrator* will forward the appeal to the *Plan Administrator* for review.

It is the responsibility of the *Plan participant* to submit proof that the claim for benefits is covered and payable under the provisions of the *Plan*. Any appeal must include:

- The name of the *Plan participant*;
- The *Plan participant*'s member identification number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories** or facts in the appeal will result in their being deemed waived. In other words, the *Plan participant* will lose the right to raise factual arguments and theories that support the claim if the *Plan participant* fails to include them in the appeal;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information the *Plan participant* has that indicates that the *Plan participant* is entitled to benefits under the *Plan*.

If the *Plan participant* provides all of the required information, it may be that the expenses will be eligible for payment under the *Plan*.

Timing of Notification of Benefit Determination on Review

The *Plan Administrator* will notify the *Plan participant* of the *Plan*'s benefit determination on review within the following timeframes:

Pre-Service Non-Urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt of the appeal.

Concurrent Claims: Within the appropriate time period based upon the type of claim (pre-service non-urgent or post-service).

Post-Service Claims: Within a reasonable period of time, but no later than 60 days after receipt of the appeal.

Calculating Time Periods: The period of time within which the *Plan*'s determination is required to be made will begin at the time an appeal is filed in accordance with the procedures of this *Plan*, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

In the event of an adverse benefit determination, the *Plan Administrator* will provide a *Plan participant* with notification, in writing or electronically, of a *Plan*'s adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the SPD on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the *Plan* did not rely upon their advice;
- A statement that the *Plan participant* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *Plan participant*'s claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the *Plan participant* upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *Plan participant*'s medical circumstances, will be provided free of charge upon request;
- A statement of the *Plan participant*'s right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; 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."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the *Plan Administrator* will provide such access to, and copies of, documents, records, and other information described above as appropriate.

Decision on Review to Be Final

If, for any reason, the *Plan participant* does not receive a written response to the appeal within the appropriate time period set forth above, the *Plan participant* may assume that the appeal has been denied. The decision by the *Plan Administrator* or other appropriate named fiduciary of the *Plan* on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law.

External Review

You must include Your Member Identification Number when submitting an appeal.

If the outcome of the mandatory first level appeal is adverse to you and it was based on a medical judgment, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- The date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem National Accounts, ATTN: Appeals, P.O. Box 105568, Atlanta, GA 30348

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

All claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the *Plan*'s claim review procedures have been exhausted.

Resubmitting a Denied Claim

A claim may not be resubmitted if it has already been submitted, denied, appealed, and denied on appeal, whether in whole or in part. A previously denied appeal is never to be considered a new claim, even if filed in accordance with the *Plan*'s procedures.

Appointment of Authorized Representative

A *Plan participant* is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a *Plan participant* to a *provider* will not constitute appointment of that *provider* as an authorized representative. To appoint such a representative, the *Plan participant* must complete a form that may be obtained from the *Plan Administrator* or the *claims administrator.* In the event a *Plan participant* designates an authorized representative, all future communications from the *Plan* will be with the representative, rather than the *Plan participant*, unless the *Plan participant* directs the *Plan Administrator,* in writing, to the contrary.

Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *Plan participant* whose condition, *sickness,* or *injury* is the basis of a claim. All such examinations will be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan* may reasonably require during the pendency of a claim. The *Plan participant* must comply with this requirement as a necessary condition to coverage.

Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *Plan participant* whose condition, *sickness*, or *injury* is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits

All benefits under this *Plan* are payable, in U.S. dollars, to the covered *team member* whose *sickness* or *injury*, or whose *covered dependent*'s *sickness* or *injury*, is the basis of a claim. In the event of the death or incapacity of a covered *team member* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his or her estate, this *Plan* may, at its sole discretion, make any and all such payments to the individual or institution that, in the opinion of this *Plan*, is or was providing the care and support of such *team member*.

Assignments

Benefits for medical expenses covered under this *Plan* may be assigned by a *Plan participant* to the *provider*; however, if those benefits are paid directly to the *team member*, the *Plan* will be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered *team member* and the assignee, has been received before the proof of loss is submitted.

Recovery of Payments

The *Plan* reserves the right to deduct from any benefits properly payable under this *Plan* the amount of any payment that has been made:

- In error;
- Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- Pursuant to a misstatement made to obtain coverage under this *Plan* within two years after the date such coverage commences;
- With respect to an ineligible person;
- In anticipation of obtaining a recovery in subrogation if a *Plan participant* fails to comply with the *Plan*'s provisions regarding subrogation; or
- Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or disease to the extent that such benefits are recovered. This provision will not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

The deduction may be made against any claim for benefits under this *Plan* by a covered *team member* or by any of his or her *covered dependents* if such payment is made with respect to the covered *team member* or any person covered or asserting coverage as a dependent of the covered *team member*.

Medicaid Coverage

A *Plan participant*'s eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such *Plan participant.* Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the *Plan participant,* as required by the state Medicaid program, and the *Plan* will honor any subrogation rights the state may have with respect to benefits that are payable under the *Plan*.

Claims Procedures – Dependent Care Flexible Spending Accounts (FSA)

Following is a description of how the *Plan* processes claims for dependent care FSA benefits. A claim is defined as any request for a *Plan* benefit, made by a claimant or by a representative of a claimant that complies with the *Plan*'s reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is received. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

If you have any questions regarding this procedure, please contact the *Plan Administrator*.

Claims Review Time Frames – Plan Administrator			
Type of Claim	**Initial Claims Determination**	**Extensions**	**Appeals**
Complete Claim	In a reasonable time, but not more than 90 days	May be extended once up to 90 days, if (1) not within control of *Plan*, and (2) claimant notified before end of 90-day period	In reasonable time, but not more than 60 days
Incomplete Claim	If response extended because of incomplete information, response period tolled until information received, then the remainder of 90-day period	Claimant has 90 days to respond	N/A

If the *Plan Administrator* determines that an extension is required due to matters beyond the control of the *Plan*, the *Plan Administrator* shall provide written notice to you prior to the termination of the initial 90-day period. The extension notice shall indicate the special circumstances requiring an extension of time, a specific description of further information required, if any, and the date by which the *Plan* expects to render the benefit determination.

Notice to Claimant of Adverse Benefit Determinations

The *Plan Administrator* shall provide written or electronic notification of any adverse benefit determination. The notice will state, in an understandable manner:

- The specific reason or reasons for the adverse determination.
- Reference to the specific *Plan* provisions upon which the determination was based.
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.
- A description of the *Plan*'s review procedures.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided to you free of charge upon request.

Appeals

Your appeal must be filed with the appropriate claim administrator. To file an appeal in writing, your appeal must be mailed to the *claims administrator* at Anthem BlueCross BlueShield, Dependent Care FSA, Attention Appeals, P.O. Box 660165, Dallas, TX 75266

If you receive an adverse benefit determination, you have 60 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you so request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

The review shall take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Requirements for an Appeal

You must file an appeal of an adverse benefit determination in writing within 60 days following receipt of the notice of the adverse determination. To file an appeal in writing, you must send the appeal to the *Plan Administrator*.

It is your responsibility to submit proof that the claim for benefits is covered and is payable under the provisions of the *Plan*. An appeal must include:

- Your name.
- Your Social Security number.
- The group name or identification number.
- All facts and theories supporting the claim for benefits. **Failure to include any theories** or facts in the appeal will result in their being deemed waived. In other words, you will lose the right to raise factual arguments and theories that support this claim if you fail to include them in the appeal.
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
- Any material or information you have that indicates that you are entitled to benefits under the *Plan*.
- If you provide all of the required information, it may be that the expenses will be eligible for payment under the *Plan*.

Timing of Notification of Benefit Determination on Review
The *Plan Administrator* shall notify you of the *Plan*'s adverse benefit determination upon review within a reasonable time, but not longer than 60 days after the date the appeal is filed pursuant to the procedures in this *Plan*.

Manner and Content of Notification of Adverse Benefit Determination on Review
The *Plan Administrator* shall provide you with notification, either electronically or in writing, of the *Plan*'s adverse benefit determination on review. The notification shall contain the information listed above under Notice to Claimant of Adverse Benefit Determinations.

Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on review, the *Plan Administrator* shall provide access to and copies of documents, records, and other information described in the section Manner and Content of Notification of Adverse Benefit Determination on Review listed above.

Decision on Review to Be Final
If, for any reason, you do not receive a written response to the appeal within the appropriate time period set forth above, you may assume that your appeal has been denied. The decision by the *Plan Administrator* or other appropriate named fiduciary of the *Plan* on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the *Plan*'s claim review procedures have been exhausted.

PLAN ADMINISTRATION

Plan Administrator

The *Plan* is administered by the *Plan Administrator* in accordance with the applicable provisions of ERISA. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* will appoint a new *Plan Administrator* as soon as reasonably possible. The inclusion of any benefit under this *Plan* that is not otherwise subject to ERISA Is not intended to subject that benefit to ERISA

The *Plan Administrator* will administer this *Plan* in accordance with its terms and will establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* will have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make determinations regarding issues that relate to eligibility for benefits (including the determination of what services, supplies, care, and treatments are *experimental*), to decide disputes that may arise relative to a *Plan participant*'s rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* as to the facts related to any claim for benefits and the meaning and intent of any provision of the *Plan*, or its application to any claim, will receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrator* decides, at its discretion, that the *Plan participant* is entitled to them.

Duties of the Plan Administrator

The duties of the *Plan Administrator* include the following:

- To administer the *Plan* in accordance with its terms;
- To determine all questions of eligibility, status, and coverage under the *Plan*;
- To interpret the *Plan*, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
- To make factual findings;
- To decide disputes that may arise relative to a *Plan participant*'s rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them, and to uphold or reverse such denials;
- To keep and maintain the *Plan* documents and all other records pertaining to the *Plan*;
- To appoint and supervise a third party administrator to pay claims;
- To perform all necessary reporting as required by ERISA;
- To establish and communicate procedures to determine whether a *medical child support order* is a *QMCSO*;
- To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the *Plan*'s administration.

Nondiscriminatory Operation

If, in the judgment of the *Plan Administrator*, the operation of the *Plan* in any *Plan Year* would result in discrimination in favor of highly compensated *team members* as defined in the Internal Revenue Code, the *Plan Administrator* may either exclude an individual from all or some coverage under this *Plan*, or reduce the amount that the individual is able to contribute to this *Plan*.

Liability of Administrative Personnel

Neither the *Plan Administrator*, nor any of its *team members*, nor any *provider* of services, shall be liable for any loss due to an error or omission in the administration of the *Plan* unless the loss is due to the gross negligence or willful misconduct of the party to be charged or is due to the failure of the party to be charged to exercise a fiduciary responsibility, if one is owed, with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

ERISA INFORMATION

This *Plan*, regulated by the Employee Retirement Income Security Act of 1974 (ERISA), is required to make available to all *Plan participants* specific information about the *Plan*. The following sections describe basic *Plan* information and your rights under ERISA with respect to any benefit that is subject to ERISA

Plan Name

Terex Corporation Health and Welfare Benefits Plan

Plan Sponsor

Terex Corporation
200 Nyala Farm Road,
Westport, CT 06880,
Phone: 203-222-7170
Plan Sponsor's Identification number: 34-1531521

Plan Administrator

Terex Corporation
Benefits Committee
200 Nyala Farm Road
Westport, CT 06880
Phone: 203-222-7170

Plan Number

Group Benefits Plan 501

Plan Type

This is a welfare plan that offers:

- medical,
- prescription drug,
- dental,
- vision,
- life insurance,
- accidental death and dismemberment,
- short-term *disability*,
- long-term *disability*,
- flexible spending accounts,
- employee assistance program
- health advocacy services and,
- group legal

Plan Effective Date

The effective date of the amended *Plan* as described in this SPD is January 1, 2019.

Eligible Participants

Please refer to the Eligibility and Enrollment section for the applicable benefit.

Claims Administrators

Medical Claims
Anthem BlueCross BlueShield
P.O. Box 54159
Los Angeles, CA 90054-0159

1-800-889-4169
8:00 a.m. – 8:00 p.m. EST/EDT
http://www.anthem.com/terex

Dental Claims:
Anthem BlueCross BlueShield
P.O. Box 659444
San Antonio, TX 78265-9444

1-800-889-4169
8:00 a.m. – 8:00 p.m. EST/EDT
http://www.anthem.com/terex

Vision Claims:
Anthem BlueCross BlueShield
Attn: Brenda Branton-Hooton GAG303-0001
P.O. Box 9907
Columbus, GA 31908

1-800-889-4169
8:00 a.m. – 8:00 p.m. EST/EDT
http://www.anthem.com/terex

Flexible Spending Account Claims:
Anthem BlueCross BlueShield
P.O. Box 660165
Dallas, TX 75266

1-800-889-4169
8:00 a.m. – 8:00 p.m. EST/EDT
http://www.anthem.com/terex

Prescription Drug Claims:
Express Scripts, Inc.
P.O. Box 14711
Lexington, KY 40512

1-800-711-0917
24 hours
http://www.medcohealth.com

Life and Accidental Death and Dismemberment Claims:
The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517,
Philadelphia, PA 19176

1- 800-524-0542

Policy Number 46792 (all Prudential benefits)

http://www.prudential.com/mybenefits

Short Term and Long Term Disability Claims:
The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480,
Philadelphia, PA 19176

Phone 1-877-367-7781
Fax: 1-877-889-4885

Policy Number 46792 (all Prudential benefits)

http://www.prudential.com/mybenefits

Plan Funding

This *Plan* is funded by contributions from the *Plan Sponsor* and the *team members*. The *Plan*'s medical, dental, vision, flexible spending account, prescription drug, and short-term disability benefits are paid from the general assets of the *Plan Sponsor*. The *Plan*'s life/accidental death and dismemberment, and long-term disability benefits are insured. *Team member* contributions are calculated annually.

Administration of Plan

The *Plan* is a partially self-insured and partially insured welfare benefit plan established pursuant to, and generally is governed by, ERISA. *Anthem BlueCross BlueShield* processes claims for the medical, vision and dental benefits and relies on Terex to provide the funds needed to pay such claims. The *Plan Sponsor* has a stop loss, or excess loss, insurance policy to finance large health care claims under the *Plan*. The stop loss carrier does not directly pay benefits of the *Plan*. Rather, the insurance carrier pays the *Plan Sponsor* consistent with the self-insured status of the *Plan*'s health care benefits and the use of stop loss is merely a means of financing by the *Plan Sponsor.*

Plan Service of Legal Process

The *Plan*'s agent for service of legal process is:
c/o Terex Corporation Plan Administrator
200 Nyala Farm Road
Westport, CT 06880
203-222-7170

This *Plan* is a legal entity. Service of legal process may be made upon the *Plan Administrator*.

Benefit Records – Calendar Year

The benefit records are kept January 1 through December 31 for processing claims.

Plan Records - Plan Year

The fiscal records are kept January 1 through December 31 for Department of Labor reporting.

Plan Document

The *Plan* has a legal document called the *Plan Document*. A copy of the *Plan Document* is available upon written request to the *Plan Administrator,* who may make a reasonable charge for the copies.

Statement of ERISA Rights

As a participant in the *Plan*, you are entitled to certain rights and protections under ERISA. ERISA provides that all *Plan participants* are 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 *Plan*, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the *Plan Administrator,* copies of documents governing the operation of the *Plan,* including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and copies of the updated Summary Plan Description. The *Plan Administrator* may make a reasonable charge for the copies.

- Receive a summary of the *Plan*'s annual financial report. The *Plan Administrator* is required by law to furnish each *Plan participant* with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your *spouse,* or your dependents if there is a loss of the applicable 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 continuation coverage rights, if any.

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* or your union, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under

Enforce Your Rights

If your claim for a 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 it within 30 days, you may file suit in a federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and 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 that is denied or ignored, 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 *medical child support order*, you may file suit in federal court. If it should happen that *Plan* fiduciaries misuse the *Plan*'s money, or if you are discriminated against for asserting 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 your *Plan,* 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,* 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.

Plan Modification, Amendment, and Termination

Terex Corporation has established this *Plan* with the intention of maintaining it for an indefinite period of time. However, Terex Corporation, acting through its Board of Directors or the *Plan Administrator*, reserves the right, at its sole discretion, to amend this *Plan* in whole or in part, at any time. Additionally, Terex Corporation reserves
the right to suspend or terminate this *Plan*, in whole or in part, at any time by action of its Board of Directors. No consent is required on the part of any *Plan participant* for Terex Corporation to take any of the actions indicated above. The preceding provisions will apply regardless of any oral or written statement to any person to the contrary.

HIPAA PRIVACY AND SECURITY

This section applies only to the *Plan*'s health care, vision, dental, prescription drug, employee assistance program and health care FSA benefits.

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the *Plan* may disclose Summary Health Information to the *Plan Sponsor*, if the *Plan Sponsor* requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this *Plan* or (b) modifying, amending, or terminating the *Plan*. However, neither the *Plan* nor any health insurance issuer or HMO with respect to the *Plan* is permitted to disclose genetic information to the *Plan Sponsor* for underwriting purposes.

"Privacy Standards" means the Standards for Privacy of Individually Identifiable Health Information issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). "Summary Health Information" may be individually identifiable health information. It summarizes the claims history, claims expenses, or type of claims experienced by individuals in the *Plan*, but excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure below and obtaining written certification, the *Plan* (or a business associate, health insurance issuer or HMO on behalf of the *Plan*) may disclose PHI and electronic PHI to the *Plan Sponsor*, provided the *Plan Sponsor* uses or discloses it only for plan administration purposes. In order that the *Plan Sponsor* may receive and use applicable PHI for plan administration purposes, the *Plan Sponsor* agrees to:

- Not use or further disclose PHI other than as permitted or required by the SPD or as required by law (as defined in the Privacy Standards);
- Ensure that any agents, including subcontractors, to whom the *Plan Sponsor* provides PHI received from the *Plan* agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *Plan Sponsor,* except pursuant to an authorization that meets the requirements of the Privacy Standards;
- Report to the *Plan* any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor* becomes aware;
- Make available PHI for inspection or coping in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services (HHS), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the *Plan* with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq.);
- If feasible, return or destroy all PHI received from the *Plan* that the *Plan Sponsor* still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Ensure that adequate separation between the *Plan* and the *Plan Sponsor,* as required in Section 164.504[f][2][iii] of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

- Access to PHI is limited to certain employees. The individual must:
    - perform functions directly on behalf of the group health plan,
    - have access to PHI on behalf of the *Plan Sponsor* for its use in "*Plan* administrative functions" and must have access to PHI, and
    - be authorized or designated by the Terex Corporation Vice President of Human Resources.

The access to and use of PHI by the individuals described above will be restricted to the *Plan* administrative functions that the *Plan Sponsor* performs for the *Plan*. The *Plan Sponsor* will ensure that these provisions are supported by reasonable and appropriate security measures to the extent the persons designated above create, receive, maintain or transmit electronic PHI on behalf of the *Plan*.

HIPAA Privacy Information

- In the event any of the individuals described above do not comply with the provisions of the SPD relating to use and disclosure of PHI, the *Plan Administrator* will impose reasonable sanctions as necessary, at its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay, and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation. "*Plan* administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the *Plan* or solicit bids from prospective issuers. *Plan* administration functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. They do not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The *Plan* will disclose PHI to the *Plan Sponsor* only upon receipt of a certification by the *Plan Sponsor* that (a) the SPD has been amended to incorporate the above provisions and (b) the *Plan Sponsor* agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504[f][1][iii] of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the *Plan* may disclose to the *Plan Sponsor* information on whether an individual is participating in the *Plan* or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the *Plan*. Enrollment and disenrollment functions performed by the *Plan Sponsor* are performed on behalf of *Plan participants* and beneficiaries, and are not plan administration functions. Enrollment and disenrollment information held by the *Plan Sponsor* is held in its capacity as an *employer* and is not PHI.

Disclosure of PHI to Obtain Stop Loss or Excess Loss Coverage

The *Plan Sponsor* hereby authorizes and directs the *Plan*, through the *Plan Administrator* or the *claims administrator*, to disclose PHI to stop loss carriers, excess loss carriers, or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop loss or excess loss coverage related to benefit claims under the *Plan*. Such disclosures will be made in accordance with the Privacy Standards.

Disclosure of Electronic PHI to the Plan Sponsor for Plan Administration Functions

To enable the *Plan Sponsor* to receive and use applicable electronic PHI for *Plan* administration functions (as defined in 45 CFR 164.504[a]), the *Plan Sponsor* agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the *Plan*;
- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in 45 CFR 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom the *Plan Sponsor* provides electronic PHI created, received, maintained, or transmitted on behalf of the *Plan*, agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- Report to the *Plan* any security incident of which it becomes aware.

Any terms not otherwise defined in this SPD will have the meanings set forth in the Security Standards.

Other Disclosures and Uses of PHI

With respect to all other disclosures and uses of PHI, the *Plan* will comply with the Privacy Standards.

MISCELLANEOUS INFORMATION

Conformity with Applicable Laws

This *Plan* will be deemed to be amended automatically to conform as required by any applicable law, regulation, or order or judgment of a court of competent jurisdiction governing provisions of this *Plan*, including, but not limited to, stated maximums, exclusions, or limitations. In the event that any law, regulation, or order or judgment of a court of competent jurisdiction causes the *Plan Administrator* to pay claims that are otherwise limited or excluded under this *Plan*, such payments will be considered as being in accordance with the terms of this SPD. It is intended that the *Plan* will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable law.

Fraud

The following actions by any *Plan participant*, or a *Plan participant*'s knowledge of such actions being taken by another, constitute fraud and may result in immediate termination of all coverage under this *Plan* for the entire *family* of which the *Plan participant* is a member:

- Attempting to submit a claim for benefits (including attempting to fill a prescription) for a person who is not a *Plan participant*;
- Attempting to file a claim for a *Plan participant* for services that were not rendered or drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the *Plan*; or
- Providing any false or misleading information to the *Plan*.

Headings

The headings used in this SPD are for convenience of reference only. *Plan participants* are advised not to rely on any provision because of the heading.

Gender and Number

Pronouns and other similar words used in the masculine gender are to be read as the feminine gender where appropriate and the singular form of words is to be read as the plural where appropriate.

No Waiver or Estoppel

No term, condition, or provision of this *Plan* will be deemed to have been waived, and there will be no estoppel against the enforcement of any provision of this *Plan*, except by written instrument of the party charged with such waiver or estoppel. No such written waiver will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *Plan participant* for benefits from this *Plan*. In so acting, the *Plan Administrator* will be free from any liability that may arise with regard to such action. Any *Plan participant* claiming benefits under this *Plan* must furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

Right of Recovery

Whenever payments have been made by this *Plan* in a total amount, at any time, in excess of the maximum amount of benefits payable under this *Plan*, the *Plan* will have the right to recover such payments, to the extent of such excess, from any one or more of the following as this *Plan* determines: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations that the *Plan* determines are responsible for payment of such amount, and any future benefits payable to the *Plan participant*.

PLAN DEFINITIONS

Words you find in the body of the text that are *italicized* are defined in this section. The presence of the following definitions is not an indication that charges for particular care, supplies, or services are eligible for payment under the *Plan*; please refer to the appropriate sections of this SPD for that information. The singular form of terms in this section is intended to include the plural.

- ***accidental injury:*** an accidental physical *injury* to the body caused by unexpected means that does not arise out of or in the course of employment.
- ***actively at work:*** the *team member,* as hired by the *employer,* is working full-time and is paid regular earnings (temporary or seasonal employment is excluded) for a specified task or set of responsibilities.

  This includes:
  - working a specified number of hours each week on an annual basis, and
  - working at the *employer*'s usual place of business or at a location to which your *employer*'s business requires you to travel.

  A *team member* who does not complete his or her work assignments due to an unpaid leave of absence, strike, or layoff is not *actively at work.* Paid personal time and holidays count as active work days if you were *actively at work* on your last regularly scheduled work date just prior to the personal time day or holiday.

  If a *team member* or eligible dependent is *hospital* confined (or confined in any other institution providing medical care, or receiving professional nursing care from a *home health care* agency, or otherwise *totally disabled*) on the date coverage would be effective, that *team member* or dependent will be considered to be *actively at work* for eligibility purposes of the *Plan*.

  Once a *team member* terminates employment with the *Company,* the *team member* will cease to be considered *actively at work* and generally will lose coverage under the *Plan,* regardless of whether the *team member* terminated employment due to a health factor or *disability*.

- ***ambulatory care center:*** any licensed public or private establishment that does not provide services or other accommodations for patients to stay overnight, but does provide:
  - an organized medical staff of *physicians*.
  - permanent facilities that are equipped and operated for the purpose of medical and/or surgical care.
  - continuous *physician* services and registered professional nursing services whenever a patient is in the facility.
- ***Anthem BlueCross BlueShield:*** the *claims administrator* for the medical, dental, vision, and flexible spending account plans.
- ***cardiac care unit:*** see *intensive care unit*.
- ***Blue Distinction Centers (BDC):*** a medical facility that specializes in one or more types of *transplant* procedures and has met certain criteria supporting each of its performance-based *transplant* programs. The criteria include, but are not limited to, patient and graft survival outcomes, annual volume, experience of the *transplant* professional team, national accreditations, and patient and caregiver education. Each specific type of *transplant* is independently analyzed at each center. The analysis of this criteria is performed by an independent, impartial national *Center of Excellence transplant* network. This *BDC transplant* network enters into an agreement with the *BDC transplant* center to which the *Plan* has access to render specific *transplant*s at pre-negotiated rates. The BDC *transplant* network used to determine BDC facility status will be stipulated by the *Plan.*
  - It is important to note that a specific medical center may have a *transplant* program that meets the criteria for a *BDC* while another type of *transplant* program at the same facility may not meet the criteria. The specific *transplant* program needed by the patient at a facility must qualify under the criteria as a *BDC* in order for the *Plan participant* to receive *transplant* benefits under this plan. The *BDC* facility may or may not be located near the geographic area in which the recipient resides.
  - The term "*Center of Excellence"* is not to be used interchangeably with the term "preferred *provider* organization (PPO) network."

- ***claims administrator:*** Anthem BlueCross BlueShield. (*Anthem*), Express Scripts, Inc, and Prudential Insurance Company of America, the organizations designated by the *employer* to administer claims to the *Plan*.
- ***Company:*** Terex Corporation and its' subsidiaries.
- ***confinement:*** all periods of hospitalization of a *Plan participant* that result from the same or related causes.
- ***cosmetic services:*** services designed to alter appearance without restoring function or as specifically provided herein.
- ***covered charges:*** expenses or charges that are eligible for payment under the *Plan*.
- ***covered dependent:*** a legally married *spouse*, or *dependent child* who is eligible for coverage and enrolled under the *Plan*.
- ***covered health service:*** a health service provided for the purpose of preventing, diagnosing, or treating a *sickness*, *injury*, mental *illness*, or *substance abuse* condition, or its symptoms. *Covered health services* are:
    - < services or supplies that are listed as such in the Medical Benefits section and that are not listed as exclusions,
    - < generally provided in accordance with accepted medical practice and professionally recognized standards,
    - < provided safely at the appropriate level of care or service, and
    - < not provided solely for the convenience of the *Plan participant* or the *provider*.

  In determining *covered health services*, consideration is given to the customary practices of *providers* in the community or field of specialty. However, the fact that a *provider* may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service a *covered health service*.
- ***custodial care:*** any type of service designed essentially to assist the recipient, whether *disabled* or not, in the activities of daily living. This would include, but not be limited to, bathing, dressing, toileting, cooking and feeding, house cleaning, transportation, and shopping. All services rendered by a home health aide are *custodial care*.
- ***dentally necessary:*** A service is *dentally necessary* if, in the *Plan*'s judgment, it meets all of the following requirements. It must be:
    - < Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, *accidental injury*, or condition harmful or threatening to the covered person's dental health, unless provided for preventive services when specified as covered under the *Plan*.
    - < Appropriate and consistent with authoritative dental or scientific literature.
    - < Not primarily for the convenience of the *Plan participant*, the *Plan participant*'s *family*, the *Plan participant*'s *dentist*, or another *provider*.
    - < The least costly of the alternative levels of service which can safely be provided to the covered person.
    - < It must not be primarily for research or data accumulation.
    - < The fact that covered services were furnished, prescribed or approved by a *dentist* does not in itself mean that the services were *dentally necessary*.
- ***dentist:*** A state licensed:
    - < Doctor of Dental Surgery (D.D.S.)
    - < Doctor of Dental Medicine (D.M.D.)

  The benefits of the *Plan* are also available for professional services provided by a state-licensed *dentist*, but only when the *dentist* is providing service within the scope of that license and the *Plan*'s benefits would be payable if the service were provided by a *dentist* as defined above.
- ***dependent child:*** any:
    - < natural children, stepchildren, or eligible foster children of the *team member*, legally adopted children of the *team member* from the date the *team member* assumes legal responsibility, and children for whom the *team member* assumes legal sole or co-guardianship. Also included are the *team member*'s children (or children of the *team member*'s opposite gender or same gender *Spouse*) for whom the *team member* has legal responsibility resulting from a valid court decree.
        - With respect to any individual described above, the individual will cease to be a *dependent child* as of the end of the month in which his or her 26th birthday occurs.

- children who are incapable of self-support because of mental retardation or a permanent, chronic, and *total disability* that commenced prior to age 26, is principally supported by the *team member*, and is continuously *totally disabled* and covered thereafter. Certification of the *disability* is required within 31 days of attainment of age 26. A certification form is available from the *Claims Administrator* and may be required periodically.
- children named in a *Qualified Medical Child Support Order* as being the responsibility of the *team member* for health benefits coverage.

- ***disability (****or* ***disabled):*** the inability of a *team member* (because of *injury* or *illness*) to perform the material duties pertaining to his or her employment with the *employer*. *Disability* of a *covered dependent* is the inability (because of *injury* or *illness*) to perform all regular and customary activities usual for that *covered dependent*'s age and *family* status. A *team member* or *covered dependent* is not considered to be suffering from a *disability* if he or she is performing any work or engaging in any occupation or employment for wage or profit, unless related to rehabilitation.
- ***disabled:*** see *disability*.
- ***durable medical equipment:*** equipment that is:
  - able to withstand repeated use,
  - primarily and customarily used to serve a medical purpose,
  - prescribed by a *physician*, and
  - not generally useful to a person in the absence of *illness* or *injury*, and
  - provided solely for use by the patient.
- ***emergency:*** any service that, if delayed, would result in harm to the patient. For this *Plan*, an *emergency* is any event that requires immediate attention.
- ***emergency illness:*** a sudden and serious condition such that a *prudent layperson* could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of his or her bodily functions would result unless immediate medical care is rendered. Examples of an *emergency illness* may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.
- ***employer:*** Terex Corporation and the affiliated businesses that are designated as participating *employers* in the *Plan*.
- ***enrollment date:*** the first day of coverage or, if the *Plan* has a waiting period, the first day of the waiting period. The *enrollment date* for a *late enrollee* or anyone who enrolls during a special enrollment period is considered to be the first date of coverage under this *Plan.*
- ***experimental (or investigational):*** any drug, surgical or medical treatment, procedure, equipment, device, service, or supply that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition by those practicing within the appropriate medical specialty. Meeting at least one of the following criteria establishes any of the above-stated items or services as *experimental*, *investigational,* or unproven:
  - it is within the research, *investigational*, or *experimental* stage of development or is performed within or restricted to use in clinical trials; or
  - it is a medical procedure or drug that does not have scientific evidence that permits conclusions as to its effect on health outcomes. Scientific evidence is evidence that is obtained only from well-designed and soundly-conducted studies. Such studies must have been published in recognized peer review journals. Such a study must show a measurable effect on health outcomes that can be duplicated outside of the study's setting. Decisions to cover or exclude a treatment for benefits will be based on the conclusions of prevailing medical research; or
  - in the case of a drug, substance, or device, has not been approved by the United States Food and Drug Administration. This includes the application of "approved" drugs not approved for the treatment of specific conditions or if a drug has been labeled "Caution: limited by federal law to investigational use," even though a charge may be made to the patient. Off-label use of FDA-approved medications will be evaluated and considered for approval if there is compelling evidence that their use would represent the standard of care. This evidence includes:
    - practice guidelines or position papers from relevant professional societies, or
    - well-controlled studies directly applicable to the patient and the diagnosis in the absence of equally well-designed studies that do not support its use.

- ***Express Scripts, Inc.(ESI):*** *Express Scripts, Inc. is the claims administrator for the prescription drug benefit.*
- ***extended skilled nursing facility:*** an institution, or part of an institution, that meets all of the following criteria:
    - < It is licensed pursuant to the law or approved by the appropriate authority.
    - < It provides 24-hour nursing care and/or rehabilitation services for sick and injured patients on an inpatient basis.
    - < It has nursing care and service policies developed with the advice of, and subject to review by, professional personnel.
    - < It has a *physician*, a registered nurse, or other medical staff responsible for the execution of the aforementioned nursing care, and service policies developed with the advice of, and subject to review by, professional personnel.
    - < It requires every patient to be under the care of a *physician*.
    - < It makes a *physician* available to furnish medical care in case of an *emergency*.
    - < It maintains clinical records on all patients, has appropriate methods for dispensing drugs and medicines, and has at least one registered nurse employed on a full-time basis.
    - < Is approved by *Medicare* or would qualify for *Medicare* approval if requested.
    - < It provides for a group of *physicians* to periodically review admissions, continuation of *confinements*, duration of stay, and adequacy of care.

  The term *"extended skilled nursing facility"* does not include an institution that is primarily for intermediate or *custodial care*.
- ***family:*** the *team member* and each *covered dependent* who participates in the *Plan* because of his or her relationship to the *team member*.
- ***halfway house:*** a residential facility providing transitional care to patients between their discharge from the *hospital* or other treatment and their return to the community.
- ***home health care:*** see *home health services*.
- ***home health services:*** a program for care and treatment established and approved in writing, including an estimation of the duration of such program by the attending *physician,* together with such *physician*'s confirmation that the proper treatment of the *injury* or *illness* would require *confinement* as a bed patient in a *hospital* in the absence of the services and supplies provided. Ongoing authorization is required and is based upon regular updates from the *home health care* agency or *provider*.
- ***hospice:*** a coordinated program of home, outpatient, and inpatient care for terminally ill patients with a prognosis of less than six months to live, operated by a licensed public agency or private organization, that provides all of the following:
    - < nursing care by or under the supervision of a registered nurse.
    - < medical social services under the direction of a *physician*.
    - < medical supplies, including drugs and biologicals and the use of medical appliances.
    - < *physicians'* services.
    - < short-term inpatient care, including both palliative care and *respite services* and procedures.
- ***hospital:*** an institution authorized to operate as a *hospital* by the state in which it is operating, engaged mainly in providing medical care and treatment of ill, pregnant, and injured persons on an inpatient basis for compensation, that meets the following criteria:
    - < It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located (for example, *hospitals* in Ohio must be licensed according to Chapter 1739 of the Ohio Revised Code), or
    - < It is accredited as a *hospital* by one of the following: a) the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); b) the American Osteopathic Hospital Association (AOHA); c) the American Osteopathic Association (AOA); or d) the Commission on Accreditation of Rehabilitative Facilities (CARF).
    - < It is a *hospital,* a tuberculosis *hospital,* or a *mental health hospital,* as these terms are defined by *Medicare*, that is qualified to participate and eligible to receive payment under and in accordance with the provisions of *Medicare* (with the exception of a mental institution owned and operated by a state or political subdivision thereof).
    - < It maintains on-premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment by or under the supervision of duly qualified *physicians.* (This does not apply to a mental institution.)

- It continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse.
- It is operated continuously with organized facilities for operative surgery on the premises. (This does not apply to a mental institution.)

The term *"hospital"* does not include a hotel, rest home, *extended skilled nursing facility*, *intermediate care facility*, nursing home, convalescent home, health resort, facility for *custodial care* of the mentally ill or of the aged, or an institution primarily for the treatment of drug addiction or alcoholism.

- ***illness:*** a mental or physical disease or infirmity, including pregnancy or pregnancy-related conditions, of a *Plan participant*.
- ***incur (****or* ***incurred):*** the taking on of a *covered charge* on the date a service is rendered or a supply is obtained, unless otherwise specifically set forth in this SPD. With respect to a course of treatment or procedure that includes several steps or phases of treatment, *covered charges* are *incurred* for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, *covered charges* for the entire procedure or course of treatment are not *incurred* upon commencement of the first stage of the procedure or course of treatment.
- ***incurred:*** see *incur*.
- ***infertility:*** the inability to conceive naturally.
- ***initial enrollment date***: the earliest time during which an eligible individual may enroll under the *Plan*.
- ***injury:*** an accidental physical *injury* to the body caused by unexpected external means that does not arise out of or in the course of employment. All *injuries* sustained in connection with one accident are considered to be one *injury.*
  The term *"injury"* does not include disease or infection, except pyogenic infection occurring through an accidental cut or wound.
- ***intensive care unit (ICU):*** a unit that accommodates critically or seriously ill or injured patients requiring constant audiovisual observation, specialized registered nursing and other nursing care, and special equipment or supplies immediately available on a standby basis, segregated from the rest of the *hospital* facilities. This includes *cardiac care units*.
- ***intermediate care facility:*** an institution recognized under and licensed under state law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment that a *hospital* or *extended skilled nursing facility* is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) that can be made available to them only through institutional facilities. Public institutions for care of the mentally retarded or people with related conditions are also included.
- ***investigational:*** see *experimental.*
- ***late enrollee:*** an eligible *team member* or dependent who enrolls in the *Plan* other than on his or her *initial enrollment date* or during a special enrollment period.
- ***maintenance care:*** treatment provided for the sole purpose of preventing a decline of a medical condition and that does not result in improvement of the condition, but is rather intended to maintain a level of symptoms or severity of a condition. *Maintenance care* programs are those for which the patient can independently administer care and treatment to prevent the worsening of a condition.
- ***medical child support order:*** any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:
  - provides for child support with respect to a *Plan participant*'s child or directs the *Plan participant* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
  - enforces a law relating to medical child support described in Social Security Act §1908 (as added by the Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.
- ***medical services:*** professional services rendered by the attending *physician* which do not involve:
- operative or cutting procedures for the treatment of disease or *injury*.
- treatment of fractures, dislocations, and other *accidental injuries.*
- obstetrical procedures, including prenatal and postnatal care.
- ***Medicare:*** the health insurance program for the aged and *disabled* under Title XVIII of the Social Security Act, as amended.

- ***mental health:*** all forms of *illness* including, but not limited to, bipolar affective disorder, schizophrenia, psychotic *illness*, manic depressive *illness*, depression and depressive disorders, anxiety and anxiety disorders, and any other mental and nervous condition classified in the DSM.
- ***mental health treatment facility:*** a facility, or distinct part thereof, for the treatment of mental or nervous disorders, that meets all of the following criteria:
    - < It is nationally accredited , or it is a mental institution owned and operated by a state or political subdivision thereof.
    - < It is primarily engaged in providing, at a charge to its patients, a program for diagnosis, evaluation, and effective treatment of mental or nervous disorders.
    - < It is not primarily a school or a custodial, recreational, or training institution.
    - < It provides all normal, infirmary-level *medical services* required during the treatment period, whether or not related to the mental or nervous disorder.
    - < It provides, or has an agreement with, a *hospital* in the area to provide any other *medical services* that may be required.
    - < It is under the continuous supervision of a psychiatrist who has the overall responsibility for coordinating patient care, and who is at the facility on a regularly scheduled basis.
    - < It is staffed by *mental health physicians* who are directly involved in the treatment program, at least one of whom is present at all times during the treatment day.
    - < It continuously provides the services of a *mental health* nurse and a *mental health social worker.*
    - < It continuously provides skilled nursing services under the direction of a full-time registered nurse, with licensed nursing personnel on duty at all times.
    - < It requires a written, individual treatment plan prepared and maintained for each patient based on a diagnostic assessment of the patient's medical, psychological, and social needs with documentation that the plan is under the supervision of a *mental health physician*.
    - < It meets any applicable licensing standards established by the jurisdiction in which it is located.
- ***military service:*** uniformed services covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), which includes service in the Armed Forces, Army and Air National Guards, commissioned corps of the Public Health Service, Coast Guard, or any other category of service designated by the President of the United States.
- ***national medical support notice (****or* ***NMSN):*** a notice that contains the following information:
    - < The name of an issuing state agency;
    - < The name and mailing address (if any) of a *team member* who is a *Plan participant*;
    - < The name and mailing address of one or more alternate recipients (e.g., the child or children of the *Plan participant* or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipient[s]); and
    - < The identity of an underlying child support order.
- ***natural tooth (****or* ***natural teeth):*** a hard, bony appendage borne on the jaw.
- ***NMSN:*** see *national medical support notice*.
- ***non-participating pharmacy:*** any pharmacy licensed to dispense prescription drugs that is not included as a participant under the prescription drug program, offering pre-paid drug benefits to eligible *Plan participants*.
- ***participating pharmacy:*** any pharmacy licensed to dispense prescription drugs which is included as a participant under the prescription drug program, offering pre-paid drug benefits to eligible *Plan participants*.
- ***physician:*** any doctor of medicine (M.D.), osteopathy (D.O.), podiatry (D.P.M.), naturopathy (N.D.), chiropractic (D.C.), dental surgery (D.D.S.), or medical dentistry (D.M.D.), duly qualified, currently licensed, and acting within the scope of his or her license at the time and place the service is rendered. This may include a doctoral level, state licensed psychologist (Ph.D. or Psy.D.), duly qualified, currently licensed, and acting within the scope of his or her license at the time and place the service is rendered.
- ***Plan:*** the Terex Corporation Health and Welfare Benefits Plan for Terex *team member*s. The *Plan* is a component of the Terex Corporation Health and Welfare Benefits Plan, a single "employee welfare benefit plan" under ERISA Section 3(1).
- ***Plan Administrator:*** Terex Corporation Benefits Committee.
- ***Plan Document:*** the legal document governing the administration and interpretation of the Terex Corporation Health and Welfare Benefits Plan as it applies to Terex *team member*s.

- ***Plan participant:*** a covered *team member* or his or her *covered dependent*.
- ***Plan Sponsor:*** Terex Corporation.
- ***Plan Year:*** the 12-consecutive-month period that ends on December 31.
- ***pre-admission testing:*** outpatient X-ray and laboratory tests that meet each of the following criteria:
    - They are made within 7 days before admission as a registered bed patient in a *hospital*.
    - They are for the same *injury* or *illness* causing the hospitalization of the *Plan participant*.
    - They are ordered by the same *physician* (or his or her *physician* consultant) who ordered the hospitalization.
    - They are accepted by the *hospital* where hospitalization is to occur, in lieu of similar tests being made during hospitalization.

  The term *"pre-admission testing"* includes outpatient X-rays and laboratory tests that would have satisfied all the tests set forth in this section, except that the expected hospitalization does not occur because of the results of such tests. The term *"pre-admission testing"* does not include tests for routine physical check-ups.
- ***provider:*** the person, institution, or other entity who or that provided the service or supplies on account of which payment may be due under this *Plan*. Each *provider* must be duly qualified, currently licensed, and acting within the scope of his or her license at the time and place the service is rendered. For this *Plan*, depending upon the services provided and the eligibility of benefits, a recognized *provider* may include, but may not be limited to, any of the following:
    - Advanced Registered Nurse Practitioner (ARNP)
    - Audiologist (MACCC-A)
    - Certified Chemical Dependency Counselor (CCDC)
    - Certified Nurse Midwife (CNM)
    - Chiropractor (DC)
    - Doctor of Dental Medicine (DDM)
    - Doctor of Dental Surgery (DDS)
    - Doctor of Medical Dentistry (DMD)
    - Doctor of Medicine (MD)
    - Doctor of Optometry (OD)
    - Doctor of Osteopathy (DO)
    - Doctor of Podiatric Medicine (DPM)
    - Doctor of Psychology (PhD or PsyD)
    - Licensed Acupuncturist
    - Licensed Clinical Social Worker (LCSW)
    - Licensed Family Counselor (LFC)
    - Licensed Independent Social Worker (LISW)
    - Licensed Massage Therapist
    - Licensed Occupational Therapist (LOT)
    - Licensed Physical Therapist (LPT)
    - Licensed Practical Nurse (LPN)
    - Licensed Professional Clinical Counselor (LPCC)
    - Licensed Professional Counselor (LPC)
    - Licensed Social Worker (LSW)
    - Licensed Speech Therapist (MACCC-SLP)
    - Master of Social Work (MSW)
    - Medical Assistant (MA)
    - Naturopathic Physician (ND)
    - Nurse Practitioner
    - Registered Nurse (RN)
    - Registered Physical Therapist (RPT)
    - Surgical Physician's Assistant
- ***prudent layperson:*** a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.
- ***Prudential Insurance Company of America: (Prudential)*** is the *claims administrator* for the life/accidental death & dismemberment/short-term disability/long-term disability benefits.
- ***QMCSO:*** see *Qualified Medical Child Support Order*.

- ***qualified beneficiary:*** any individual covered by a group health plan on the day before a COBRA qualifying event. A *qualified beneficiary* may be a *team member*, a *team member*'s *spouse,* or a *team member*'s *dependent child.* A child who is born to or placed for adoption with the covered *team member* during a period of continuation coverage is considered a *qualified beneficiary*.
- ***Qualified Medical Child Support Order (****or* **QMCSO):** a *medical child support order* that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits to which a *covered dependent* is entitled under this *Plan.* In order for such order to be a *QMCSO*, it must clearly specify the following:

    < The name and last known mailing address (if any) of the *Plan participant* and the name and mailing address of each such alternate recipient covered by the order;
    < A reasonable description of the type of coverage to be provided by the *Plan* to each alternate recipient, or the manner in which such type of coverage is to be determined;
    < The period of coverage to which the order pertains; and
    < The name of this *Plan.*

    In addition, a *national medical support notice* will be deemed a *QMCSO* if it:

    < Contains the information set forth in the definition of *"national medical support notice"*;
    < Identifies either the specific type of coverage or all available group health coverage. If the *employer* receives an *NMSN* that does not designate either specific type(s) of coverage or all available coverage, the *employer* and the *Plan Administrator* will assume that all are designated;
    < Informs the *Plan Administrator* that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the *NMSN* is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the *Plan*'s default option (if any); and
    < Specifies that the period of coverage may end for the alternate recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the *Plan,* or upon the occurrence of certain specified events.

    However, such an order need not be recognized as "qualified" if it requires the *Plan* to provide any type or form of benefit, or any option, not otherwise provided to the *Plan participants,* except to the extent necessary to meet the requirements of a state law relating to *medical child support orders,* as described in Social Security Act §1908 (as added by the Omnibus Budget Reconciliation Act of 1993 §13822).

    For qualified orders other than those received from a state or national agency, coverage for an otherwise eligible *dependent child* will become effective on the date of the order, if it is received by the Terex Human Resources Department within 30 days after the date of the order, or, if later, the date the *team member* enrolls in the *Plan.*

    For state or national agency orders administering Medicaid, coverage for an otherwise eligible *dependent child* will become effective on the date the order is received by Terex.

    A change in contributions, if required, will begin from the effective date of coverage for the child.

    Please contact the Terex Benefits Department for additional information.
- ***rehabilitation facility:*** a facility that meets all of the following criteria:
    < The patient's condition must require the 24-hour availability of a *physician* to provide treatments that can be provided only in an in-*hospital* setting. This need should be verifiable by entries in the patient's medical record that reflect frequent and direct *physician* involvement in the patient's care.
    < The patient's condition must require 24-hour availability of a registered nurse with specialized training or experience in rehabilitation.
    < The patient must require an intense (at least 4 hours per day) level of physical and/or occupational therapy in addition to any other required therapies or services.
    < The patient must require a multidisciplinary team approach to the delivery of the program. This includes a *physician*, psychiatrist, rehabilitation nurse, *social worker,* and/or psychologist.

- The patient's records must reflect evidence of a coordinated program, e.g., documentation that periodic team conferences were held with regularity.
- The patient's records should reflect a realistic goal and significant improvement. Coverage stops when progress toward the established goal is unlikely, or when it can be achieved in a less intensive setting.

- ***residential care facility:*** an establishment that furnishes food and shelter to adult persons unrelated to the proprietor and may provide care and services beyond food, shelter, and laundry to any one or more such persons. This includes boarding homes for sheltered care and homes for the aged.
- ***respite services:*** short-term or intermittent care for persons with chronic or debilitating conditions that provides an interval of rest or relief to *family* members or caregivers who are responsible for those services on a day-to-day basis. Coverage of these services is included in any *hospice* benefit, limitation, or exclusion.
- ***semi-private room:*** the charge made by a *hospital* for a room containing two or more beds.
- ***sickness:*** any *illness*, other than an *injury*, not covered by Workers' Compensation laws or any occupational disease law. The term *"sickness"* includes pregnancy.
- ***skilled nursing care:*** services that:
  - are deemed to be reasonable*,*
  - are provided by a registered nurse or a licensed practical nurse,
  - are under the direct supervision of a *physician,*
  - include a plan of care established by a *physician,* and
  - are rendered intermittently to a patient who is homebound.
- ***skilled nursing facility:*** see *extended skilled nursing facility*.
- ***social worker:*** a properly licensed person holding the degree of Licensed Social Worker (LSW), Licensed Clinical Social Worker (LCSW), Licensed Independent Social Worker (LISW), Licensed Professional Clinical Counselor (LPCC), or Master of Social Work (MSW), legally qualified and licensed and acting within the scope of his or her license at the time and place the service is rendered.
- ***spouse:*** a *team member*'s legally married husband or wife of the same or opposite gender and have **NOT** been divorced from nor legally separated from the team member.
- ***substance abuse:*** the dependence on, or abuse of, a chemical substance or alcohol as classified by the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM)or a comparable manual if the American Psychiatric Association stops publishing the DSM.
- ***substance abuse treatment facility:*** a facility for the treatment of alcoholism and drug abuse that meets all of the following criteria:
  - It is nationally accredited .
  - It is primarily engaged in providing, at a charge to its patients, a program for diagnosis, evaluation, and effective treatment of alcoholism and drug abuse.
  - It provides all medical detoxification services necessary in addition to its effective treatment program.
  - It provides all normal, infirmary-level *medical services* required during the treatment period, whether or not related to the alcoholism or drug abuse.
  - It provides, or has an agreement with, a *hospital* in the area to provide any other *medical services* that may be required.
  - At all times during the treatment period, it is under the supervision of a staff of *physicians* and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered nurse.
  - It prepares and maintains a written individual plan of treatment for each patient based upon a diagnostic assessment of the patient's medical, psychological, and social needs, with documentation that the plan is under the supervision of a *physician*.
- ***surgery center:*** any public or private establishment that meets the following criteria:
  - It has an organized medical staff of *physicians*.
  - It is a permanent facility equipped and operated primarily for the purpose of performing *surgical procedures.*
  - It provides continuous *physician* services and registered professional nursing services whenever a patient is in the facility.
  - It does not provide services or other accommodations for patients to stay overnight.
  - It provides, or has an agreement with, a *hospital* in the area to provide any other *medical services* that may be required.

- ***surgical procedures:*** procedures limited to the following:
    - a cutting operation.
    - suturing of a wound.
    - treatment of a fracture.
    - reduction of a dislocation.
    - electrocauterization.
    - diagnostic and therapeutic endoscopic procedures.
    - injection treatment of hemorrhoids and varicose veins.
    - cardiac catheterization.
- ***Team member:*** an employee of Terex Corporation or its U.S. subsidiaries on the U.S. payroll. The definition of *team member* does not include individuals who are not reported on the payroll records of Terex Corporation or its subsidiaries as common law employees (even if a court or administrative agency determines that such individuals are common law employees).
- ***total disability (****or* ***totally disabled):*** an *employee* is considered *totally disabled* if, because of *sickness* or *injury*, he or she is not working or is earning less than 20% of his or her monthly earnings and is unable to perform the material duties or substantial duties of his or her own occupation.
- ***totally disabled:*** see *total disability*.
- ***transplant:*** the *transplant* of organs from human to human. A *transplant* includes only the following *transplants*: heart, heart and lung, lung (single or double), liver, kidney, pancreas, kidney and pancreas, human bone marrow, and stem cell *transplantation* and reinfusion. A *transplant* must be performed at a *transplant facility* in order to be considered for reimbursement under this *Plan*. Skin and cornea *transplants* are not considered *transplants*, but may be covered under this *Plan.*
- ***transplant facility:*** a *hospital* or facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations to perform a *transplant* and:
    - for organ *transplants* is an approved member of the United Network for Organ Sharing for such *transplant* or is approved by *Medicare* as a *transplant facility* for such *transplant*.
    - for unrelated allogeneic bone marrow or stem cell *transplants* is a participant in the National Marrow Donor Program.
    - for an autologous stem cell *transplant* is approved to perform such *transplant* by the state where the *transplant* is to be performed, or *Medicare*, or the Foundation for the Accreditation of Hemopoietic Cell Therapy. Outpatient facilities must be similarly approved.
- ***transplantation:*** see *transplant.*
- ***transplanted:*** see *transplant.*
- ***UCR:*** see *usual, customary, and reasonable charges*.
- ***usual, customary, and reasonable charges (****or* ***UCR):*** charges made for health care services or supplies essential to the care of the individual that are in accordance with each of the following:
    - the usual fee an individual *provider* most frequently accepts as payment for the same service within a geographic area for the majority of his or her patients for the procedure performed.
    - the customary fee, established by the *Plan,* to be the charge for the range of usual amounts charged and accepted by most *providers* of similar training and experience and in comparable geographic economic areas for the procedure performed.
    - the reasonable fee accepted as payment in light of all circumstances, including unusual circumstances involving medical complications or requiring additional time, skill, and experience.
    - The *Plan* uses industry-recognized sources to determine *UCR.*

Claims Administrators

Medical, Dental, Vision, and Flexible Spending Account Benefits
Administered by Anthem BlueCross BlueShield 1-800-889-4169
8:00 a.m. – 8:00 p.m. EST/EDT
http://www.anthem.com/terex

Medical Claims:
P.O. Box 54159
Los Angeles, CA 90054-0159

Dental Claims:
P.O. Box 659444
San Antonio, TX 78265-9444

Vision Claims:
Attn: Kimberly Cowart GA082E-0003
P.O. Box 9907
Columbus, GA 31908
Or email to: terexvision@anthem.com

Flexible Spending Account Claims:
P.O. Box 660165
Dallas, TX 75266
Or fax to: 1-888-347-5212

Prescription Drug Benefits
Administered by Express Scripts, Inc.
1-800-711-0917
24 hours a day
http://www.express-scripts.com

Express Scripts, Inc.
P.O. Box 14711
Lexington, KY 40512

Life, Accidental Death & Dismemberment, Long-Term Disability and Short-Term Disability Benefits
Prudential Insurance Company of America
Policy Number 46792
Life and AD&D – 1-800-524-0542
Disability – 1-877-367-7781
http://www.prudential.com

ComPsych Guidance Resources
1-866-923-7249
www.guidanceresources.com

Health Advocate Service
1-866-695-8622
www.healthadvocate.com

Voluntary Legal Services
LegalShield , Inc.
One Pre-Paid Way
Ada, Oklahoma 74820
1-800-654-7757

www.legalshield.com