Rockwell Automation Employee Health Plan

Aetna Consumer Directed Plan (CDP) Option
Summary Plan Description

For Salaried and Hourly (Non-Bargained) Employees
And Employees who Retired after December 31, 2005
Effective January 1, 2010
Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What's Inside</td>
<td>1</td>
</tr>
<tr>
<td>If You Have Questions</td>
<td>2</td>
</tr>
<tr>
<td>ID Cards</td>
<td>3</td>
</tr>
<tr>
<td>Your Medical Plan</td>
<td>4</td>
</tr>
<tr>
<td>Eligibility</td>
<td>4</td>
</tr>
<tr>
<td>About the Consumer Directed Plan Option (CDP)</td>
<td>4</td>
</tr>
<tr>
<td>Summary of CDP Medical Benefits</td>
<td>5</td>
</tr>
<tr>
<td>Health Reimbursement Account (HRA)</td>
<td>5</td>
</tr>
<tr>
<td>How the CDP Works</td>
<td>6</td>
</tr>
<tr>
<td>CDP Benefits</td>
<td>7</td>
</tr>
<tr>
<td>Who Is Eligible</td>
<td>11</td>
</tr>
<tr>
<td>Employees</td>
<td>11</td>
</tr>
<tr>
<td>Dependents</td>
<td>11</td>
</tr>
<tr>
<td>Qualified Medical Child Support Order</td>
<td>11</td>
</tr>
<tr>
<td>Extending Coverage for Disabled Children and Full-Time Students</td>
<td>11</td>
</tr>
<tr>
<td>Extending Coverage Full-Time Students (Michelle's Law)</td>
<td>11</td>
</tr>
<tr>
<td>If Your Work Status Changes</td>
<td>12</td>
</tr>
<tr>
<td>When Benefits Begin</td>
<td>13</td>
</tr>
<tr>
<td>Employees</td>
<td>13</td>
</tr>
<tr>
<td>Dependents</td>
<td>13</td>
</tr>
<tr>
<td>Pre-Existing Conditions</td>
<td>14</td>
</tr>
<tr>
<td>Enrolling in the Plan</td>
<td>14</td>
</tr>
<tr>
<td>Your Medical Plan Choices</td>
<td>14</td>
</tr>
<tr>
<td>Your Coverage Level</td>
<td>15</td>
</tr>
<tr>
<td>Your Cost</td>
<td>15</td>
</tr>
<tr>
<td>Working Spouse or Domestic Partner Adjustment</td>
<td>16</td>
</tr>
<tr>
<td>Health Management Program and Incentive</td>
<td>17</td>
</tr>
<tr>
<td>When Both Spouses Work for Rockwell Automation</td>
<td>17</td>
</tr>
<tr>
<td>Changing Your Benefits</td>
<td>18</td>
</tr>
<tr>
<td>Timing of Changes</td>
<td>19</td>
</tr>
<tr>
<td>Annual Enrollment</td>
<td>19</td>
</tr>
<tr>
<td>Special Enrollment Provisions</td>
<td>19</td>
</tr>
<tr>
<td>Medical Benefits</td>
<td>21</td>
</tr>
<tr>
<td>Medical Expense Coverage</td>
<td>21</td>
</tr>
<tr>
<td>CDP Benefits Payable</td>
<td>21</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>22</td>
</tr>
<tr>
<td>CDP Option Detail</td>
<td>22</td>
</tr>
<tr>
<td>Foreign Claims</td>
<td>23</td>
</tr>
<tr>
<td>Precertification</td>
<td>24</td>
</tr>
<tr>
<td>What Is Covered</td>
<td>26</td>
</tr>
<tr>
<td>Hospital Expenses</td>
<td>26</td>
</tr>
<tr>
<td>Convalescent Facility Expenses</td>
<td>26</td>
</tr>
<tr>
<td>Topic</td>
<td>Page</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Emergency Room Treatment</td>
<td>27</td>
</tr>
<tr>
<td>Home Health Care Expenses</td>
<td>27</td>
</tr>
<tr>
<td>Routine Preventive Care Expenses</td>
<td>28</td>
</tr>
<tr>
<td>Hearing Aid Benefits</td>
<td>29</td>
</tr>
<tr>
<td>Hospice Care Expenses</td>
<td>30</td>
</tr>
<tr>
<td>Short-Term Rehabilitation Expenses</td>
<td>32</td>
</tr>
<tr>
<td>Skilled Nursing Care Expenses</td>
<td>33</td>
</tr>
<tr>
<td>Spinal Disorder (Chiropractic) Treatment</td>
<td>34</td>
</tr>
<tr>
<td>Pregnancy Coverage</td>
<td>34</td>
</tr>
<tr>
<td>Sterilization Coverage</td>
<td>34</td>
</tr>
<tr>
<td>Mastectomy and Breast Reconstruction</td>
<td>35</td>
</tr>
<tr>
<td>Mouth, Jaws And Teeth</td>
<td>36</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>37</td>
</tr>
<tr>
<td>Other Covered Medical Expenses Under The Plan</td>
<td>37</td>
</tr>
<tr>
<td>National Medical Excellence Program® (NME)</td>
<td>38</td>
</tr>
<tr>
<td>What Is Not Covered</td>
<td>40</td>
</tr>
<tr>
<td>Prescription Drug Benefits</td>
<td>43</td>
</tr>
<tr>
<td>Covered Prescription Drug Expenses</td>
<td>43</td>
</tr>
<tr>
<td>Limitations</td>
<td>44</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse Benefits</td>
<td>46</td>
</tr>
<tr>
<td>Treatment of Mental Disorders</td>
<td>46</td>
</tr>
<tr>
<td>Treatment of Alcoholism or Substance Abuse</td>
<td>46</td>
</tr>
<tr>
<td>General Exclusions—Mental Health/Substance Abuse</td>
<td>47</td>
</tr>
<tr>
<td>Lab Card Program</td>
<td>49</td>
</tr>
<tr>
<td>How Does the Lab Card Program Work?</td>
<td>49</td>
</tr>
<tr>
<td>What Is Covered Under the Lab Card Program?</td>
<td>49</td>
</tr>
<tr>
<td>Health Information Line</td>
<td>51</td>
</tr>
<tr>
<td>Aetna MedQuerySM</td>
<td>52</td>
</tr>
<tr>
<td>Aetna Health Connections®SM Disease Management Program</td>
<td>53</td>
</tr>
<tr>
<td>Vision</td>
<td>55</td>
</tr>
<tr>
<td>Definitions</td>
<td>56</td>
</tr>
<tr>
<td>How to Claim a Benefit</td>
<td>74</td>
</tr>
<tr>
<td>Reporting of Claims</td>
<td>74</td>
</tr>
<tr>
<td>Payment of Benefits</td>
<td>74</td>
</tr>
<tr>
<td>Records of Expenses</td>
<td>74</td>
</tr>
<tr>
<td>Recovery of Benefits Paid (Subrogation Provision)</td>
<td>75</td>
</tr>
<tr>
<td>Recovery of Overpayment</td>
<td>76</td>
</tr>
<tr>
<td>Additional Provisions</td>
<td>76</td>
</tr>
<tr>
<td>Type of Coverage</td>
<td>76</td>
</tr>
<tr>
<td>Assignments</td>
<td>76</td>
</tr>
<tr>
<td>Physical Examinations</td>
<td>76</td>
</tr>
<tr>
<td>Legal Action</td>
<td>77</td>
</tr>
<tr>
<td>Adjustment Rule</td>
<td>77</td>
</tr>
<tr>
<td>Unclaimed Amounts</td>
<td>77</td>
</tr>
<tr>
<td>Filing Health Claims Under the Plan</td>
<td>77</td>
</tr>
<tr>
<td>Effect of Other Benefit Plans</td>
<td>79</td>
</tr>
<tr>
<td>Other Plans Not Including Medicare</td>
<td>79</td>
</tr>
</tbody>
</table>
Other Plan................................................................................................................................. 81
Effect of Medicare........................................................................................................................ 81
Effect of Prior Coverage—Transferred Business................................................................. 83
When Coverage Ends .................................................................................................................. 84
  During Approved Personal Leave of Absence (Includes Military Reserve Training) .............. 84
  During Approved Medical Leave ......................................................................................... 84
  During Approved Personal Leave of Absence (Includes Military Reserve Training) .............. 84
  During Educational Leave of Absence ................................................................................. 84
  During Family Leave of Absence ......................................................................................... 84
  During Uniformed Services Leave of Absence ................................................................. 84
  Early or Normal Retirement ................................................................................................. 85
  Voluntary Termination of Employment ............................................................................. 85
  Employee Death .................................................................................................................... 85
  In General .............................................................................................................................. 85
COBRA Continuation of Coverage .......................................................................................... 86
HIPAA Medical Privacy and Security ...................................................................................... 90
Your Rights Under the Law ...................................................................................................... 95
  Receive Information About Your Plan and Benefits .......................................................... 95
  Continue Group Health Plan Coverage ............................................................................ 95
  Prudent Actions by Plan Fiduciaries .................................................................................... 96
  Enforce Your Rights ............................................................................................................ 96
  Assistance With Your Questions ......................................................................................... 96
Eligibility Claims ....................................................................................................................... 97
  Definition of Eligibility Claim ............................................................................................. 97
  Procedure for Filing a Claim ............................................................................................... 97
  Defective Claims .................................................................................................................. 98
  Initial Claim Review – Level I Claims ................................................................................ 98
  Initial Benefit Determination .............................................................................................. 98
  Review of Initial Benefit Denial ......................................................................................... 100
Benefit Claims .......................................................................................................................... 103
  Filing an Appeal of an Adverse Benefit Determination ....................................................... 103
Administrative Information ...................................................................................................... 106
  Formal Name of the Plan .................................................................................................... 106
  Identification Numbers of the Plan ..................................................................................... 106
  Type of Plan, Type of Administration ................................................................................. 106
  Plan Sponsor ....................................................................................................................... 106
  Plan Administrator ............................................................................................................. 106
  Claims Administrator ....................................................................................................... 107
  Agent for Service of Legal Process .................................................................................... 107
  Plan Trustee ......................................................................................................................... 107
  Plan Records ....................................................................................................................... 107
  How the Costs of the Benefits Program Are Paid ............................................................... 108
  Plan Continuance ............................................................................................................... 108
  No Contract of Employment .............................................................................................. 109
Appendix A to the Rockwell Automation Employee Health Plan ........................................... 110
What’s Inside

This is your Summary Plan Description (SPD) and Plan document for the medical, prescription drug, and mental health/substance abuse benefits available to you and your family if you are an eligible employee of Rockwell Automation. This replaces any prior SPD you may have received for this benefit. It describes the highlights of your rights and obligations under the plan, as required by the Employee Retirement Income Security Act of 1974 (ERISA). This SPD and Plan document does not create a contract of employment.

If you are eligible for and want to participate in Rockwell Automation medical coverage, you may choose one of the following options (if available in your area):

- Preferred Provider Organization (PPO) or Out-of-Area for PPO participants who live outside the network service area. (separate SPD)

- Consumer Directed Plan (CDP). This SPD describes your benefits under the Aetna Consumer Directed Plan option with Health Reimbursement Account (HRA).

- High Deductible Plan (HDP) with Health Savings Account (separate SPD)

- Health Maintenance Organization (HMO)—separate certificate of coverage

If you enroll in the CDP plan option, this SPD describes your medical benefits (including prescription drug and mental health coverage).

If you enroll in the Preferred Provider Organization Plan (PPO) or the High Deductible Plan (HDP), complete details of your benefits will be found in a separate SPD.

If you enroll in a locally-offered Health Maintenance Organization (HMO), complete details on Eligibility, When Coverage Begins, When Coverage Ends, and your benefits will be found in the Certificate of Coverage provided by the HMO. You should read this SPD along with the HMO documents for a full understanding of your healthcare benefits through Rockwell Automation.

Your SPD contains valuable information about:

- How to use your benefit program

- When benefits start

- What is covered

- How to file claims
Please note that for legal purposes, all of the benefit plans and options shall be deemed one health plan—the Rockwell Automation Employee Health Plan. Rockwell Automation hopes to continue its benefit plans indefinitely, but reserves the right to amend, suspend, or terminate the Plans in whole or in part at any time. This SPD and Plan document is not a contract of employment between you and Rockwell Automation.

Inside, you will find detail about the Consumer Directed Plan benefit option. Additional information (including a listing of Network Providers) is also available on Aetna’s Web site.

<table>
<thead>
<tr>
<th>Rockwell Automation Employee Health Plan</th>
<th>Aetna Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Directed Plan (CDP) with Health Reimbursement Account (HRA)</td>
<td>Choice POS II</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
</tbody>
</table>

**If You Have Questions**

If you have any questions about your benefits, medical options, or eligibility, you should use the *Your Benefits* tab on the EmployeeConnect Web site ([employeeconnect.rockwellautomation.com](http://employeeconnect.rockwellautomation.com)).

To check if a particular medical service is covered or to check the status of a medical claim, you should contact the Claims Administrator directly at the number listed in the “Administrative Information” section of this SPD.

You can also call the Rockwell Automation Service Center at **1.877.OUR.RASC** (1.877.687.7272). Representatives are available to assist you from 8:00 a.m. to 4:00 p.m. CST, Monday through Friday.

In addition to EmployeeConnect and the Rockwell Automation Service Center, here are other resources to call if you have questions. Also, refer to the “Administrative Information” section of this SPD for Web site and address information about the contacts listed in the chart below.

<table>
<thead>
<tr>
<th>About</th>
<th>Whom to Call</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Aetna</td>
<td>1.866.547.2665</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Aetna</td>
<td>1.866.547.2665</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>Aetna</td>
<td>1.866.547.2665</td>
</tr>
<tr>
<td>Lab Card Benefits</td>
<td>LabOne (Quest Diagnostics)</td>
<td>1.800.646.7788</td>
</tr>
<tr>
<td>Nurseline</td>
<td>Aetna</td>
<td>1.800.556.1555</td>
</tr>
<tr>
<td>Disease Management Program</td>
<td>Aetna</td>
<td>1.866.269.4500</td>
</tr>
<tr>
<td>COBRA Continuation Coverage</td>
<td>Rockwell Automation Service Center</td>
<td>1.877.687.7272</td>
</tr>
</tbody>
</table>
**ID Cards**

After you enroll in coverage, you should receive ID cards from Aetna for you and your dependents to provide proof of medical coverage.

LabOne (Quest Diagnostics) will send you an ID card for your Lab Card Benefits.

If you need to request additional ID cards, you should contact the Claims Administrator directly at the numbers listed in the chart on the previous page.
Your Medical Plan

Eligibility
In order to be eligible to participate in the Rockwell Automation Employee Health Plan, you must be:

• A regular full-time or part-time active salaried or hourly employee scheduled to work at least 32 hours per week; or

• A regular part-time active salaried or hourly employee scheduled to work between 20 and 31 hours per week.

If you’re considered a student associate, you are only eligible for coverage under the PPO medical option if you are not eligible for coverage under any other group medical plan and you work a minimum of 20 hours per week.

Note: Part-time employees at Ladysmith are not eligible for the benefits described in this SPD.

Retiree Eligibility
• Depending on your age, years of service, and employee classification at the time you retire, you may be eligible to continue your medical coverage during retirement. Retiree benefits will be described in a separate Appendix to this SPD.

About the Consumer Directed Plan Option (CDP)
• The CDP features a company-funded Health Reimbursement Account (HRA) that helps you pay for your deductible, prescription drug costs, and other eligible health care expenses. Unused HRA balances carry over from year to year, as long as you continue to participate in the CDP. The Aetna HRA does not cover amounts above Reasonable & Customary expenses. You are responsible for those costs. See “Health Reimbursement Account (HRA)” section of this SPD for additional information about the HRA.

• Once you satisfy the deductible, the plan pays coinsurance similar to a PPO. Any available HRA benefits will be used to pay your share after the plan pays. After you exhaust your HRA balance, you pay any remaining coinsurance until you reach the annual coinsurance maximum.

• The CDP allows you to see any provider you choose; however, you’ll pay lower fees and receive higher benefits when you use network providers.

• You do not have to obtain a referral to see a specialist. Your costs depend on your choice of seeking medical care from network or non-network providers.

• The CDP includes prescription drug coverage, mental health and substance abuse benefits, and also covers routine preventive care.
Summary of CDP Medical Benefits

Aetna is the medical carrier that administers the CDP benefits described in this SPD.

Health Reimbursement Account (HRA)
Through the Health Reimbursement Account (HRA) feature of the CDP, Rockwell Automation makes an annual contribution to your own individual health fund account. You can use this money to pay for your deductibles as well as other covered medical services such as routine or emergency care or prescription drugs. However, expenses above the Reasonable and Customary limit, any other plan limits, over-the-counter items and any non-covered expenses under the CDP are not eligible for reimbursement under the HRA. The time limit for filing medical benefit claims also applies to your HRA account.

The chart below details Rockwell Automation’s HRA contributions by coverage level.

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Rockwell HRA Contribution Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>You Only</td>
<td>$1,000</td>
</tr>
<tr>
<td>You + Spouse/Domestic Partner, or You + Child(ren)</td>
<td>$1,700</td>
</tr>
<tr>
<td>You + Family</td>
<td>$2,800</td>
</tr>
</tbody>
</table>

Each year, you can carry over any unused HRA balance. This allows you to build your available health care dollars over time. You may not use current year HRA contributions for prior year expenses.

Note: If you experience a qualified change in status during the year that results in a reduction from family to individual coverage, your Rockwell Automation-funded HRA allocation will not change until the beginning of the next Plan year. If the change in status results in an increase from You Only to You + Spouse/Domestic Partner, You + Child(ren), or You + Family coverage, you will receive an additional HRA allocation equal to the difference between the You Only and your new coverage level allocation. If your participation ends for any reason, any balance in your HRA will be forfeited back to Rockwell Automation.
**How the CDP Works**

There are two underlying components to your medical coverage under the CDP. The HRA (described in the previous section) and the Comprehensive Medical and Prescription Drug (PPO-type) coverage. In addition to your HRA, the Plan offers health coverage to protect you and your family in case you incur significant health care expenses or if your expenses exceed your annual Rockwell Automation-funded HRA allocation.

This PPO-type coverage begins once your deductible has been met. You’ll pay a certain percentage of the cost of covered medical services and prescription drugs through coinsurance. Generally, the Plan will pay 90% of the cost of most covered services in-network (60% out-of-network) and your coinsurance will be the remaining 10% (40% out-of-network).

The out-of-pocket maximum is the most you’ll pay for covered services in a Plan year. This includes your deductible and coinsurance maximum amounts.

The deductible and out-of-pocket maximums for the CDP option are shown in the chart below.

| Aetna Consumer Directed Plan (CDP) Option with Health Reimbursement Account |
|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
|                               | You only                      | You + Spouse/Domestic Partner or You + Child(ren) | You + Family                 |
|                               | In-Network                   | Out-of-Network                | In-Network                   |
| HRA                           | $1,000                       | $1,700                        | $1,700                       |
| Total Deductible *            | $2,000                       | $2,700                        | $3,200                       |
| Coinsurance                   | 90%                          | 60%                           | 90%                          |
| Coinsurance Maximum           | $750                         | $2,050                        | $1,125                       |
| Out-of-Pocket Maximum **      | $1,750                       | $3,750                        | $2,625                       |
| Lifetime Benefit Maximum      | $3,000,000 per individual    |

*The total deductible is the sum of the HRA contribution and the deductible.

**The out-of-pocket maximum is the sum of the deductible and the coinsurance maximum.
Mid-year plan administrator changes

If you move and are assigned a new plan administrator based on your home zip code, the new administrator will give you credit toward your annual deductible and coinsurance limits for Medical Expenses incurred while you were covered under previous administrator if:

- The expense incurred was applied to the deductible or coinsurance amount by the previous administrator; and
- The expense incurred qualifies as a covered expense under the policy; and
- You submit documentation such as the previous administrator’s Explanation of Medical Benefits to the new administrator showing the accumulated annual deductible and coinsurance.

The following chart shows the benefits available under the Aetna CDP medical option. You receive the benefit percentage shown after you satisfy any deductible amounts. See the “Medical Benefits” section for more details.

<table>
<thead>
<tr>
<th>CDP Benefits</th>
<th>Aetna CDP Option</th>
<th>In-Network</th>
<th>Out-of-Network *</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Primary doctor office visit</td>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>• Specialist office visit</td>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Annual physical exam</td>
<td>100%</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>• Well-woman exam (includes PAP)</td>
<td>100%</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>• Mammogram</td>
<td>100%</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>• Pediatric exams</td>
<td>100%</td>
<td>Not Covered</td>
<td></td>
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<tr>
<td>• Immunizations (child)</td>
<td>100%</td>
<td>Not Covered</td>
<td></td>
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<tr>
<td>• Cancer screenings</td>
<td>100%</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Services continued</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cardiovascular screenings</td>
<td>100%</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>• Allergy tests and treatments</td>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

* Subject to Reasonable and Customary limits
<table>
<thead>
<tr>
<th>Aetna CDP Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>You will save money when you use network providers and facilities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network *</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient surgery</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Outpatient laboratory services (100% covered in- and out-of-network at LabOne facilities)</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Outpatient physical therapy (Reviewed for medical necessity after 20 visits or when deemed medically necessary.)</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Outpatient X-ray</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Outpatient occupational therapy (Reviewed for medical necessity after 20 visits or when deemed medically necessary.)</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Outpatient speech therapy (Limited to 60 visits per year combined in- and out-of-network, reviewed for medical necessity after 20 visits or when deemed medically necessary.)</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Family Planning/Maternity Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre/postnatal office visits</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• In-hospital delivery services</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Newborn nursery services</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Fertility services (GIFT and ZIFT not covered)</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• In vitro fertilization</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Artificial insemination</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Female tubal ligation (Reversals not covered)</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Male vasectomy (Reversals not covered)</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Hearing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hearing evaluations (Audiometric and hearing aid evaluation limited to once every 36 months)</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Hearing aids (Limited to $750 per ear every 36 months)</td>
<td>90% (no deductible)</td>
<td>60% (no deductible)</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine vision exams</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Lenses and frames</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Contact lenses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Outpatient Services continued</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dental implants</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Accidental injury to teeth (Limited to treatment of natural teeth,</td>
<td>90%</td>
<td>60%</td>
</tr>
</tbody>
</table>
### Aetna CDP Option

You will save money when you use network providers and facilities

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network</th>
<th>Out-of-Network *</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surgical removal of tumors, cysts, and impacted teeth</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Inpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Room and Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital semi-private room</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient lab and X-ray</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Inpatient physician and surgeon services</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Emergency Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency room services not followed by admission</td>
<td>90% (50% for non-emergency use)</td>
<td>90% (50% for non-emergency use)</td>
</tr>
<tr>
<td>• Urgent care clinic visits</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Ambulance services</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Prescription Drug Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Retail generic</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Retail formulary brand</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Retail nonformulary brand</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Mail order</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mail order generic</td>
<td>90%</td>
<td>N/A</td>
</tr>
<tr>
<td>• Mail order formulary brand</td>
<td>90%</td>
<td>N/A</td>
</tr>
<tr>
<td>• Mail order nonformulary brand</td>
<td>90%</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient mental health coverage</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>• Inpatient mental health coverage</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient detoxification and rehabilitation coverage</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse Coverage continued</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient detoxification and rehabilitation coverage</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Other Care and Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>90%</td>
<td>60%</td>
</tr>
</tbody>
</table>

*Note: The Out-of-Network coverage for Inpatient services is subject to lifetime maximum benefit limits.*

- Treatment must be completed within the calendar year of the accident or the following calendar year.
- Outpatient mental health coverage includes psychiatric care for children.
- Outpatient detoxification and rehabilitation coverage includes substance abuse treatment.
- Chiropractic care is limited to 25 visits per year combined in-and out-of-network.
### Aetna CDP Option

You will save money when you use network providers and facilities

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture (in lieu of anesthesia)</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Home Health Care (noncustodial)</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>(Limited to 120 days per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>combined in- and out-of-network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care (noncustodial)</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>(Limited to 90 days per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>combined in- and out-of-network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>90%</td>
<td>60%</td>
</tr>
</tbody>
</table>

* Subject to Reasonable and Customary limits
Who Is Eligible

**Employees**
If you are a Rockwell Automation employee (see the definition of employee in the “Definitions” section of this SPD), you are eligible for the benefits described in this book on the date of your employment. Employees covered under a collective bargaining agreement are not eligible unless such bargaining agreement provides for participation in this Plan.

**Dependents**
Your dependents are eligible for medical benefits on the date you are eligible for coverage or on the date they become eligible dependents, whichever is later.

Dependent children are covered through the end of the month in which they turn age 21, unless they are full-time students. Full-time students are covered through the end of the month in which they turn age 24 – at which time, COBRA coverage is offered.

Refer to the definition of dependent in the “Definitions” section of this SPD for additional detail’s about who qualifies as your dependent as well as full-time student coverage.

**Qualified Medical Child Support Order**
Health coverage for children will be provided if required under a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order issued by a court or authorized agency that provides for medical child support in the event of a divorce or other family law action.

All medical child support orders served upon the Plan must be received and approved by the Plan Administrator before any action will be taken. If you have any questions about this process or to request a copy of the Plan’s QMCSO procedures, contact the Hewitt Qualified Order Team, the QMCSO Administrator, through the Rockwell Automation Service Center at 1.877.OUT.RASC (1.877.687.7272).

**Extending Coverage for Disabled Children and Full-Time Students**
To arrange for continued coverage under the Plan for a child who is disabled or for a child who is a full-time student over age 21, you must be able to submit proof of your child’s disability or schooling.

If your child is disabled or becomes disabled, you should contact your medical Claims Administrator directly to learn how to certify his or her disability status.
If your child is a full-time student (according to the school’s definition of full-time), you must certify his or her full-time student status each year (generally August). When you enroll for benefits, you’ll receive a message asking you to certify your child’s full-time student status. As long as the certification is accepted, you can continue coverage for your child. If you state that your child is no longer a student or you do not respond to the notification, your dependent’s coverage will terminate at the end of the month in which you receive verification notification.

Michelle’s Law
Extended Coverage for Full-time Students
Coverage for an enrolled Dependent child who is a Full-time Student at a post-secondary school and who needs a medically necessary leave of absence will be extended until the earlier of the following:
- one year after the medically necessary leave of absence begins; or
- the date coverage would otherwise terminate under the Plan.
Coverage will be extended only when the enrolled Dependent is covered under the Plan because of Full-time Student status at a post-secondary school immediately before the medically necessary leave of absence begins.

Coverage will be extended only when the enrolled Dependent’s change in Full-time Student status meets all of the following requirements:
- the enrolled Dependent is suffering from a serious Sickness or Injury;
- the leave of absence from the post-secondary school is medically necessary, as determined by the enrolled Dependent’s treating Physician; and
- the medically necessary leave of absence causes the enrolled Dependent to lose Full-time Student status for purposes of coverage under the Plan.

A written certification by the treating Physician is required. The certification must state that the enrolled Dependent child is suffering from a serious Sickness or Injury and that the leave of absence is medically necessary.

For purposes of this extended provision, the term “leave of absence” shall include any change in enrollment at the post-secondary school that causes the loss of Full-time Student status.

If you do not provide any required documentation when asked, your child’s coverage may be canceled.

If Your Work Status Changes
If, while you are covered, your work status changes to that of an hourly employee covered by a collective bargaining agreement, you may be eligible for different benefit programs. If so, your new benefits will be effective on the first day of the month following your change of work status, and you will receive an SPD describing your new benefits.
When Benefits Begin

Employees
Benefits take effect on your eligibility date or on the date you enroll for medical benefits, whichever is later (see also “Enrolling in the Plan”).

Dependents
Benefits for dependents will begin on the effective date of your employee benefits. Benefits for a new dependent will take effect on the date that person becomes your dependent, as long as you notify Rockwell Automation through the Your Benefits tab on the EmployeeConnect Web site or by calling the Rockwell Automation Service Center at 1.877.OUR.RASC (1.877.687.7272) within 31 days of acquiring the Dependent.

Eligible newborn children are covered from birth – regardless of their health – for the first 31 days. However, you must complete the enrollment process by notifying the Rockwell Automation Service Center at 1.877.OUR.RASC (1.877.687.7272) within 31 days of the birth or coverage will terminate at the end of the 31-day period.

Pre-Existing Conditions
There is no “pre-existing condition” exclusion in the Plan. Coverage for you or an eligible dependent will not be denied or delayed due to health status.
Enrolling in the Plan

Your Medical Plan Choices
As an employee, you may enroll in one of several medical options depending on where you work. You may choose the Consumer Directed Plan (CDP) option, the PPO option, the High-Deductible Plan (HDP) option, or an HMO (if offered in your area). If you enroll any dependents, they must be enrolled in the same medical option as you.

This SPD describes the benefits offered under the Aetna Consumer Directed Plan (CDP) option.

Other Benefits You Receive
Prescription drug benefits, as well as mental health/substance abuse benefits, are integrated within the CDP and coverage remains administered through Aetna. These benefits are described later in this SPD.

If you’re enrolled in the PPO option, you will automatically be enrolled in Prescription Drug Program and Mental Health/Substance Abuse benefits carved out under different administrators (Caremark and ValueOptions, respectively). These benefits are described in detail in the PPO SPD.

If you’re enrolled in the HDP or an HMO, your prescription drug and mental health and substance abuse coverages are covered under those options directly and described in those SPDs.

If You Do Not Enroll
If you do not enroll in a medical plan within 31 days after you are eligible, you and your dependents (if any) will have no medical coverage for the remainder of the calendar year through Rockwell Automation and will have to wait until annual enrollment to elect coverage for the next calendar year.

If You Decline Medical Coverage
You may decide to decline medical coverage by certifying that you have other coverage. If you decline medical coverage, you will not be eligible for Rockwell Automation prescription drug or mental health and substance abuse benefits.
**Your Coverage Level**

Coverage level means the family members you choose to cover for medical benefits. You may choose one of the following coverage levels:

- **You Only**

- **You + Spouse/Domestic Partner or You + Child(ren)**

- **You + Family**

You must choose a coverage level – and the level you choose will apply to all health care benefits (i.e., medical, prescription drug, and mental health and substance abuse).

You can change your coverage level only during annual enrollment for the following year (January 1st through December 31st). However, you may be allowed to change your coverage level if you experience a qualified change in status. See the “Changing Your Benefits” section.

If you do not enroll your dependents when they are first eligible, no coverage will be in effect for those dependents. You will have to wait until the next annual enrollment before you can add those dependents to your coverage (see the “Annual Enrollment” section).

Falsification of dependent status may lead to disciplinary action by Rockwell Automation, up to and including discharge. Rockwell Automation or the Claims Administrator may ask for evidence of dependent status if there is a question as to the eligibility of an employee’s listed dependent(s).

**Coverage for Dependents Living Outside Your Area**

If you enrolled in the CDP plan option, you’ll select a physician for your dependent child from the network where he or she lives to receive network benefits.

He or she should know where to go for urgent or emergency care. If your child resides outside of a network area, he or she should call Aetna to receive information on network providers in the area. Dependents are encouraged to read and print a copy of the medical plan Summary Plan Description.

**Your Cost**

The Rockwell Automation medical plan options (except for the HMOs) are self-insured. Rockwell Automation pays the full cost of all claims, plus additional administrative costs, less your contributions.

Employee contributions are based on the plan option you elect, your coverage level, and your annual benefits pay (using a five-tier scale). The medical plan costs are the same for full-time employees and part-time employees who work between 32 and 39 hours per week. The costs are higher (approximately double) for part-time employees who work between 20 and 31 hours per week.
Any required contributions from employees for chosen benefits under this Plan are paid on a before-tax basis under the Rockwell Automation Flexible Benefits Plan. The ability to make required employee contributions on a before-tax basis generally results in additional take-home pay. The Internal Revenue Service does not allow health benefits to be provided on a pre-tax basis to individuals who are not federal tax dependents. While your contributions for coverage will continue to be taken on a pre-tax basis, income will be imputed to you in an amount equal to the value of the benefits you provide to your domestic partner or children of your domestic partner. For example, if the full value of medical coverage provided to your domestic partner is $200 per biweekly paycheck, your income for federal tax purposes will be increased by $200 on each paycheck and by $5,200 for the year on your W-2. Note that someone who earns less than IRS guidelines per year may be your dependent for federal tax purposes. Check with your tax advisor on the possibility of deducting the cost of coverage on your individual income tax return in that case.

Participation in the Flexible Benefits Plan will not affect the amount of any required contributions under this Plan, which is determined independently.

At the time of your initial enrollment under this Plan, you will be deemed to have elected to pay the required premium for the chosen coverage on a before-tax basis under the Flexible Benefits Plan. If you do not wish to pay the premium on a before-tax basis, you should call the Rockwell Automation Service Center at 1.877.OUR.RASC (1.877.687.7272). You are permitted to change or revoke your election only during annual enrollment or if you experience a qualified change in status as described under the “Changing Your Benefits” section.

Your election concerning before-tax payments under the Flexible Benefits Plan for chosen benefits under this Plan will remain in effect for all of your years of employment with the employer until you modify or revoke it. In addition, the amount of your before-tax premium payments made pursuant to your election will be increased or decreased automatically during the annual enrollment period in accordance with any yearly changes in the amount of employee required premiums under this Plan for the following plan year.

**Working Spouse or Domestic Partner Adjustment**

When you choose to provide medical coverage through Rockwell Automation for your spouse or domestic partner who is eligible for primary medical coverage under another employer (even if your spouse or domestic partner does not enroll or apply for that coverage), you pay a monthly adjustment in addition to any monthly contribution you make for medical coverage. If you change your spouse or domestic partner's coverage as a result of a qualified change in status, any changes to the adjustment are effective with the earliest possible payroll deduction following your notice to the Rockwell Automation Service Center.

The working spouse or domestic partner adjustment is connected to the “birthday rule.” This is a method used by insurance companies to decide which parent’s coverage is primary for the children and which is secondary when both the spouse and domestic partner have insurance available to them. The birthday rule states that the spouse or domestic partner whose birthday falls first in the calendar year provides primary coverage for dependent children.
The spouse or domestic partner whose birthday falls last in the calendar year provides secondary coverage. Concerning your children, the working spouse or domestic partner adjustment will apply if your spouse or domestic partner’s plan is primary according to the birthday rule, your spouse or domestic partner did not enroll the children in that plan, and you choose to cover those children under a Rockwell Automation-sponsored plan. The working spouse or domestic partner adjustment also applies to employees who elect to cover dependents as secondary for medical coverage under the Rockwell Automation plan. The purpose of the adjustment is to encourage a working spouse or domestic partner and any dependent children to elect coverage through the spouse or domestic partner’s employer’s plan when available. The adjustment amount is $35 per month if your base pay is less than $50,000 annually and $75 per month if your base pay is $50,000 or more annually. Only one adjustment will apply, regardless of the number of dependents you have enrolled who are eligible for coverage under another employer’s plan.

The adjustment won’t apply if your spouse or domestic partner is eligible for coverage as a retiree of a former employer, is self-employed, or is a Rockwell Automation employee. It also won’t apply if a divorce decree requires you to provide medical coverage for your dependent children.

The Working Spouse and Domestic Partner Adjustment ends at the end of the month in which you terminate your active employment. This Working Spouse and Domestic Partner Adjustment is not continued if you elect COBRA.

**Health Management Program and Incentive**

We have partnered with StayWell® Health Management—a leading provider of health management programs—to administer our Health Management program. Our program begins with a voluntary Health Risk Questionnaire (HRQ). This short, confidential on-line questionnaire addresses topics such as nutrition, stress and well-being, physical activity and health history. When you’re finished, you’ll receive instant results that identify what you’re doing well and areas of your health that may need improvement. You’ll receive a personalized action plan and in some cases you may be offered the services of a health coach. The assessment is free and the results are completely confidential.

StayWell® will track points for your program participation. When you meet the program requirements for the year, you qualify for a credit to be applied to your employee medical plan contribution for the following calendar year. At this time only employees, and not dependents, are eligible to participate and earn the incentive. All employees are eligible to participate in the program and receive HRQ results, personalized action plans, and health coaching where appropriate, but only employees enrolled in a Rockwell Automation medical plan are eligible for the incentive. Employees who become eligible for the Rockwell Automation medical plan after Annual Enrollment is closed may not be able to earn points, but will be granted the incentive for that year. You can access program requirements, health resources, your HRQ, action plan and points bank balance online at https://ra.staywell.com or by phone at 800.721.2696. The Health Management program is available to all employees year round for health related questions and online health information and interactive programs.

**When Both Spouses Work for Rockwell Automation**

When both a husband and wife are employees of Rockwell Automation, one employee may decline coverage as an employee and be covered as a dependent of the other Rockwell Automation employee. However, if both husband and wife wish to enroll separately as employees, neither can
enroll the other as a dependent. A child may be enrolled as a dependent of only one employee. This provision does not apply to domestic partners because they are not eligible for pre-tax benefits under one another.

**Changing Your Benefits**

Normally, you can change your medical plan option or decline medical coverage only during annual enrollment. For example, you could change from the CDP option to the PPO (or an HMO, if available in your area) during Annual Enrollment. Changes take effect on the next January 1st and stay in effect through December 31st.

However, you may make limited changes in your coverage during the year if you experience one of the following qualified changes in status:

- A change in your legal marital status, including lawful marriage, domestic partner relationship, death of a spouse, divorce, legal separation or annulment.

- A change in the number of your dependents, including birth, adoption, placement for adoption, death of a dependent, or loss of custody of a dependent.

- A change in the employment status of you or your dependent, including:
  - Termination or commencement of employment;
  - Commencement of or return from an unpaid leave;
  - A change in worksite;
  - A change from part-time status; and
  - Any other change in employment status that affects benefit eligibility.

- Your dependent satisfies or ceases to satisfy the eligibility requirements under the CDP Plan option.

- You or your dependent gains or loses eligibility for Medicare or Medicaid (this event does not apply to other state benefit programs).

- You receive or obtain a Qualified Medical Child Support Order or other court order that requires you or your former spouse or domestic partner relationship to provide health care and/or dental care coverage for a dependent child.

- You change residence.

Any election change must be consistent with the change in status. For example, if you get married, enter into a domestic partner relationship, you may not change from the CDP option to the PPO Plan, but you may add your new spouse or domestic partner to your medical plan. Changes are not automatic. You must provide notification within 31 days of the event to request a change, and you
may be asked to provide documentation (such as a copy of your marriage certificate) to make the change effective.

You can provide notification through the *Your Benefits* tab on the EmployeeConnect Web site or by calling the Rockwell Automation Service Center at **1.877.OUR.RASC (1.877.687.7272)**.

If you change medical plan options, any amount that you previously incurred continues to apply towards your lifetime benefit maximum. For example, if you incurred $500,000 in medical claims under the CDP option but switched to the PPO Plan option due to a qualified change in status, the $500,000 incurred under the CDP still applies to the $3,000,000 lifetime benefit maximum applicable to the PPO Plan.

**Timing of Changes**
If you experience a qualified change in status and need to change your coverage during the year, you must do so within 31 days of the event that makes the change necessary. Otherwise, you can’t make a coverage change before the next annual enrollment period – unless you or an eligible family member has another qualified change in status.

If your coverage change results in a pricing difference from the amount you’re currently contributing, changes to your employee contributions will be effective on the first payroll following the processing of the change. However, your coverage change will be effective as of the date of the qualified change in status.

**Annual Enrollment**
Annual enrollment is held each fall so that you can review your benefits and see if you want to make any changes for the following year. During annual enrollment, you may choose another medical plan option for which you are eligible. If you enroll in a different medical plan option, you may not change plan options again until the next annual enrollment, except as follows:

- If you move out of that plan option’s service area, you may then enroll in another medical plan option for which you are eligible. You will need to contact the Rockwell Automation Service Center at **1.877.OUR.RASC (1.877.687.7272)**.

- If you experience a qualified change in status (see the “Changing Your Benefits” section).

**Special Enrollment Provisions**
Effective as of April 1, 2009, the enrollment provisions of the Health Benefits Plan have been amended to reflect certain provisions of the Children’s Health Insurance Program Reauthorization Act of 2009 as follows:

If you have declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or the Children's Health Insurance Program, you or your dependents may have a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, you must request enrollment within 60 days after the government-provided coverage ends.
In addition, if you have declined enrollment in the Plan for yourself or your dependents (including a spouse), and later become eligible for state assistance through a Medicaid or Children’s Health Insurance Program which provides help with paying for Plan coverage, you and your dependents may have a right to enroll in this Plan. However, you must request enrollment within 60 days after the determination of eligibility for the state assistance.
Medical Benefits

Medical Expense Coverage
Medical expense coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that the Plan pays benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before your coverage begins or after your coverage ends, even if the expenses were incurred as a result of an accident, injury or disease that occurred, commenced or existed while coverage was in effect. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a certain share of the expense. This share will be determined by the Claims Administrator. Rather than processing the total services as one expense and one date of service, the Claims Administrator will break out the charges and dates proportionately for each service rendered. The Claims Administrator assumes no responsibility for the outcome of any covered services or supplies or makes no express or implied warranties concerning the outcome of any covered services or supplies.

CDP Benefits Payable
The CDP medical option pays benefits only for eligible expenses. To receive benefits for an eligible service or supply, you must first pay any applicable deductible or co-payment amount. You can pay this amount using the Health Reimbursement Account (HRA) feature of the CDP. The Plan then pays a percentage of the remaining eligible expenses. This percentage is called the co-payment percentage and depends on the type of expense. The ‘CDP Benefits chart’ reflects typical payment percentages. Different benefit levels may apply to certain services, as described in the following pages.

For non-network care expenses under the CDP, benefits are paid on a Recognized Charge basis (similar to “reasonable and customary” or R&C). Any expenses above the Recognized Charge billed by the provider or facility will be the responsibility of the patient.

The recognized charge for a service or supply is the lowest of:

- The provider’s usual charge for furnishing it;

- The charge that the Claims Administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; or
• The charge that the Claims Administrator determines to be the recognized charge percentage made for that service or supply. The recognized charge percentage is the charge determined by the Claims Administrator on a periodic basis to be in the 90th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished.

(See the Definitions section of this SPD for more information about recognized charges.)

For network care expenses under the CDP, benefits are paid based on a Negotiated Charge basis. This is the maximum charge a Network Provider has agreed to make as to any service or supply for the purpose of the benefits under the Plan.

If any expense is covered under one type of covered medical expense, it cannot be covered under any other type.

Lifetime Maximum Benefit
This is the maximum amount of benefits available while you are covered under the Plan. Under no circumstances does “lifetime” mean during the lifetime of the covered person.

Lifetime Maximum Benefit: $3 million per covered person.

CDP Option Detail

Calendar Year Deductible
This is the amount of covered medical expenses you pay each calendar year before the CDP pays any benefits. There are different deductible levels (in-network/out-of-network) for individuals and families. The chart in the “How the CDP Works” section shows the calendar year deductibles for individuals and families based on your coverage level.

Note: For You + Spouse/Domestic Partner or You + Child(ren) coverage, the in-network deductible is applied at a rate of $3,200 for all covered individuals combined with a $1,700 HRA. For You + Family coverage, the in-network deductible is applied at a rate of $4,900 total for the family with a $2,100 HRA. Also, the in-network and out-of-network deductibles cross-apply.

Once you pay the deductible amount (usually through your HRA), the Comprehensive Medical and Prescription Drug component of the CDP begins. When an individual or family reaches the deductible in a calendar year, benefits are paid based on the coinsurance amounts shown in the chart.

Out-of-Pocket Maximum
The out-of-pocket maximum (in-network/out-of-network) is the maximum amount that an individual or family will have to pay in a calendar year for covered medical expenses. This amount includes the calendar year deductible and coinsurance maximum and applies to each covered individual or family each calendar year. Once an individual or family reaches the out-of-pocket maximum in a calendar year, covered medical expenses incurred in the rest of that calendar year will be paid at 100% by the Plan.

The out-of-pocket maximum applies to all covered medical expenses except expenses that are:

• Applied against any co-payment amount;
• Payable at a rate of 50% or less;

• Paid at a reduced rate because of failure to obtain any necessary certification; and

• Deemed to be more than the recognized charge.

Like the calendar year deductible, the individual and family out-of-pocket maximums are shown in the chart in the ‘How the CDP works’ section and differ based on your coverage level.

**Foreign Claims**
Claims for services rendered while you are out of the country are reimbursed at the in-network level. You should check with the Claims Administrator to see how monetary conversions are handled. In most cases you will need to pay for expenses up front, and submit the bill to your provider. You may be required to submit an itemized invoice and diagnosis. You may be responsible to provide a translation of services. Contact Customer Service for claim filing details.

**Precertification Requirements**
You must obtain precertification (prior notification) for the following types of care prior to seeking the services to avoid a reduction in benefits paid for that care:

• Hospital admissions

• Home health care

• Skilled nursing care

• Hospice care

• Convalescent facility admissions

• Hospital and treatment facility admissions for alcoholism, drug abuse, or mental disorders

• Durable medical equipment (Contact Aetna directly for precertification requirements for durable medical equipment)

• Maternity (inpatient stays greater than 48 or 96 hours)

• Transplant services

• Or certain outpatient procedures.

The **penalty amount for failure to precertify out-of-network services for any of the care listed above is $500.** This penalty amount applies separately to each type of expense listed above. Precertification does not mean that benefits are payable in all cases. Coverage depends on the covered health services that are actually given, your eligibility status and any benefit limitations. See the following charts for Aetna precertification details.
**AETNA CDP Precertification**

<table>
<thead>
<tr>
<th>Service</th>
<th>Certification</th>
<th>Approved/Denied</th>
<th>Medically Necessary</th>
<th>Payment Percentage – CDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions – Hospital, Skilled Nursing Facility or Hospice Facility</td>
<td>Requested</td>
<td>Approved</td>
<td>Yes</td>
<td>90% or 60% of room &amp; board and other Covered Medical Expenses</td>
</tr>
<tr>
<td>Convalescent Facility Admissions, Home Health Care, Outpatient Hospice Care or Skilled Nursing Care</td>
<td>Requested</td>
<td>Denied</td>
<td>No</td>
<td>0% of room and board; 90% or 60% of other covered medical expenses</td>
</tr>
<tr>
<td>Admissions – Hospital, Skilled Nursing Facility or Hospice Facility</td>
<td>Not Requested</td>
<td>—</td>
<td>Yes</td>
<td>$500 penalty applies on out-of-network room and board (room and board expenses in excess of $500 are paid at 90%/60%); all other covered expenses paid at 90%/60%</td>
</tr>
<tr>
<td>Convalescent Facility Admissions, Home Health Care, Outpatient Hospice Care or Skilled Nursing Care</td>
<td>Not Requested</td>
<td>—</td>
<td>No</td>
<td>0% of room and board; for all other covered expenses, a $500 penalty applies out-of-network with benefits in excess of $500 paid at 90%/60%</td>
</tr>
</tbody>
</table>

To obtain certification, you must call the toll-free number on the back of your ID card. **Certification must be obtained before an expense is incurred.**
This requirement does not apply for maternity admissions unless your Physician requests more than the minimum stay for you (see the “Pregnancy Coverage” section).

For hospital confinement as a full-time inpatient:

- If the admission is a non-urgent admission, you verify the length of stay by calling at least 14 days before the scheduled admission date.

- If the admission is an emergency admission or an urgent admission, you, the person’s physician or the hospital must call for certification:
  
  — Before the start of a confinement that requires an urgent admission; or
  
  — No later than 48 hours following the start of a confinement that requires an emergency admission. If the physician cannot request certification within that time, it must be done as soon as reasonably possible. If the confinement starts on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours.

If a person’s physician believes that the person needs a longer confinement or additional services or supplies, you, the physician or the hospital must call to certify additional days or services or supplies. This must be done no later than on the last day that has already been certified.

Prompt written notice will be provided to the hospital, the physician and you of the days of confinement and services or supplies that have been certified.

If services and supplies for hospice care have been certified and the patient later requires a hospital confinement for pain control or acute symptom management, any other certification requirement in this Plan will be waived for such hospital confinement.
What Is Covered

Covered medical expenses are expenses for certain hospital and other medical services and supplies. They must be for the treatment of an injury or disease. Claims are paid based on date of service. If Rockwell Automation or the Claims Administrator terminates the contract, or if an employee changes plans, all claims incurred on or before the date of termination shall be paid by the Claims Administrator (including inpatient hospital stays incurred on or before the date of termination that continue past the date of termination). Following is a list of covered medical expenses.

**Hospital Expenses**

**Inpatient Hospital Expenses**
Charges made by a hospital for giving room and board and other hospital services and supplies to a person who is confined as a full-time inpatient.

Not included is any charge for daily room and board in a private room over the hospital’s semiprivate room rate.

**Outpatient Hospital Expenses**
Charges made by a hospital for hospital services and supplies given to a person who is not confined as a full-time inpatient.

**Convalescent Facility Expenses**
Charges made by a convalescent facility for the following services and supplies (they must be furnished to a person while confined to convalesce from a disease or injury):

- Room and board. This includes charges for services, such as general nursing care, made in connection with room occupancy. Charges for daily room and board in a private room that exceed the institution’s semiprivate rate are not covered.

- Use of special treatment rooms.

- X-ray and lab work.

- Physical, respiratory, occupational or speech therapy.

- Oxygen and other gas therapy.

- Other medical services usually performed by a convalescent facility (this does not include private or special nursing or physician’s services).

- Medical supplies.
Benefits will be paid for no longer than the Convalescent Days during any one calendar year.

**Limitations to Convalescent Facility Expenses**

This section does not cover charges made for treatment of:

- Drug addiction;
- Chronic brain syndrome;
- Alcoholism;
- Senility;
- Mental retardation; or
- Any other mental disorder.

**Emergency Room Treatment**

**Emergency Care**

If emergency treatment is received in the emergency room of a hospital while a person is not a full-time inpatient, covered medical expenses for charges made by the hospital for such treatment will be paid at the percentage shown in the ‘CDP Benefits chart’.

**Non-Emergency Care**

If non-emergency treatment is received in the emergency room of a hospital while a person is not a full-time inpatient, covered medical expenses for charges made by the hospital for such treatment will be paid at a reduced payment percentage of 50%.

**Home Health Care Expenses**

Home health care expenses are covered if: (1) the charge is made by a home health care agency; (2) the care is given under a home health care plan; and (3) the care is given to a person in his or her home. Home health care expenses are charges for:

- Part-time or intermittent care by an R.N., or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational and speech therapy.
- The following, to the extent they would have been covered under this Plan if the person had been confined in a hospital or convalescent facility:
  - Medical supplies;
  - Drugs and medicines prescribed by a physician; and
  - Lab services provided by or for a home health care agency.
The maximum number of visits covered in a calendar year is 120. Each visit by a nurse or therapist is counted as one visit. Each visit of up to four hours by a home health aide is counted as one visit.

**Limitations to Home Health Care Expenses**

Not covered are charges made for:

- Services or supplies that are not a part of the home health care plan;
- Services of a person who usually lives with you or who is a member of your or your wife’s or husband’s family;
- Services of a social worker; and/or
- Transportation.

**Routine Preventive Care Expenses**

In-Network Routine Preventive Care expenses are 100% covered with no annual limit, outside of the HRA. Routine Preventive Care typically includes such services as regular exams, child immunizations, cancer screenings, mammograms and well-woman exams. You should contact the Claims Administrator directly for information about whether a service is considered Routine Preventive Care.

Routine Preventive Care expenses usually include routine physical exams and routine mammograms:

**Routine Physical Exams**

The Plan covers charges made by a physician for a routine physical exam (including a routine hearing exam) given to you, your spouse, your domestic partner or your dependent child. Included as part of the exam are routine immunizations and related lab work and x-rays.

If an exam is given to diagnose or treat a suspected or identified injury or disease, it is not considered a routine physical exam.

You pay no out-of-pocket costs for diagnostic outpatient lab tests when the Lab Card benefit is used.

For routine physical exam guidelines, call the 800# on the back of your ID card or visit the Claims Administrator’s Web site.

**Routine Mammogram**

Even though not incurred in connection with a disease or injury, covered medical expenses include charges incurred by a female for a routine mammogram. For routine mammogram guidelines, call the 800# on the back of your ID card or visit the Claims Administrator’s Web site.
Hearing Aid Benefits
Covered benefits include charges for an audiometric exam and hearing aid evaluation test (no more than once every 36 months for either service) and hearing aid(s), one for each ear if medically necessary. The services must be performed by:

- A physician certified as an otolaryngologist or otologist; or
- An audiologist who either:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Hearing aid benefits include charges for:

- A hearing aid evaluation test to determine the make and model of the hearing aid that will best compensate for the loss of hearing (when performed by a physician or audiologist), but only when the need for such an examination is indicated by the most recent audiometric examination. The test includes one visit by you or your covered dependent after obtaining the hearing aid for an evaluation of its performance and a determination of its conformity to the prescription.

- Hearing aids that are worn in the ear, behind the ear (including air-conduction and bone-conduction types) or on the body, but only if:
  - The hearing aid is prescribed based on the most recent audiometric examination and the most recent hearing aid evaluation test;
  - It is the make and model prescribed by a physician or audiologist and is certified as such by the physician or audiologist; and
  - The hearing aid is obtained from a dealer.

The maximum hearing aid benefit payable in any 36-month period will be $750 per ear.

Charges for a routine hearing exam (or medical examination of the ear) are payable under routine physical exam expenses, but not more than one hearing exam can be given in a consecutive 12-month period.
Limitations to Hearing Aid Benefits
The Plan’s hearing aid benefit does not include charges for:

- Replacement of a hearing aid that is lost, stolen or broken;
- Replacement of a hearing aid installed within the prior 36-month period;
- Replacement parts or repairs of a hearing aid;
- Batteries or cords;
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss;
- Any ear or hearing exam to diagnose or treat a disease or injury;
- Any hearing aid furnished or ordered because of a hearing exam that was done before the date the person became covered under this Plan;
- Any hearing care service or supply that is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your employer;
- Any hearing care service or supply for which a benefit is provided under any workers’ compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- Any hearing care service or supply that does not meet professionally accepted standards;
- Any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government.

Hospice Care Expenses
Charges made for the following furnished to a person for hospice care when given as a part of a hospice care program are included as covered medical expenses.

Facility Expenses
The charges made in its own behalf by a hospice facility, hospital, or convalescent facility for inpatient or outpatient care, as described below.

Inpatient Care
- Room and board and other services and supplies furnished to a person while a full-time inpatient for pain control and other acute and chronic symptom management.
- Not included is any charge for daily room and board in a private room over the institution’s semiprivate rate.
**Outpatient Care**
Services and supplies furnished to a person while not confined as a full-time inpatient.

**Other Expenses for Outpatient Care**
Charges made by a hospice care agency for:

- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours in any one day.
- Medical social services under the direction of a Physician, including:
  - Assessment of the person’s social, emotional, and medical needs;
  - The home and family situation;
  - Identification of the community resources that are available to the person; and
  - Assisting the person to obtain those resources needed to meet the person’s assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services provided by a physician.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to eight hours in any one day. (These services consist mainly of caring for the person.)
- Medical supplies.
- Drugs and medicines prescribed by a physician.

Charges made by the providers below for outpatient care, but only if the provider is not an employee of a hospice care agency and such agency retains responsibility for the care of the person.

- A physician for consultant or case management services.
- A physical or occupational therapist.
- A home health care agency for physical and occupational therapy; part-time or intermittent home health aide services for up to eight hours in any one day (these services consist mainly of caring for the person); medical supplies; drugs and medicines prescribed by a physician; and psychological and dietary counseling.
Limitations to Hospice Care Expenses
The Plan’s recognized hospice care expenses do not include charges for:

- Bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling – This includes estate planning and the drafting of a will.
- Respite care – This is care furnished during a period of time when the person’s family or usual caretaker cannot, or will not, attend to the person’s needs.

Short-Term Rehabilitation Expenses
The charges made by a physician or a licensed or certified physical, occupational or speech therapist for the following services for treatment of acute conditions are covered medical expenses.

Short-term rehabilitation is therapy that is expected to result in the improvement of a bodily function (including the restoration of the level of an existing speech function), which has been lost or impaired due to an injury, a disease or congenital defect.

Short-term rehabilitation services consist of: (1) physical therapy, (2) occupational therapy, or (3) speech therapy furnished to a person who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in significant improvement of the person’s condition within 60 days from the date the therapy begins and is reviewed after 20 visits (or when deemed medically necessary) for medical necessity.

The Plan limits speech therapy benefits to 60 visits per calendar year.

Limitations to Short-Term Rehabilitation Expenses
Not included in short-term rehabilitation expenses are charges for:

- Services covered to any extent under any other part of this Plan.
- Any services that are covered expenses in whole or in part under any other group plan sponsored by an employer.
- Services received while the person is confined in a hospital or other facility for medical care.
- Services not performed by a physician or under his or her direct supervision.
- Services rendered by a physical, occupational or speech therapist who resides in the person’s home, or who is a part of the family of either the person, the person’s spouse or domestic partner.
- Services rendered for the treatment of delays in speech development, unless resulting from disease, injury or congenital defect.
• Special education, including lessons in sign language, to help a person whose ability to speak has been lost or impaired to function without that ability.

To qualify as a covered expense, the service must be provided in accordance with a specific treatment plan that: (1) details the treatment to be rendered and the frequency and duration of the treatment; and (2) provides for ongoing reviews and is renewed only if therapy is still necessary.

**Skilled Nursing Care Expenses**
The charges made by an R.N. or L.P.N. or a nursing agency for “skilled nursing services” are included as covered medical expenses. No other charges made by an R.N. or L.P.N. or a nursing agency are covered.

As used here, “skilled nursing services” means the following services:

• Visiting nursing care by an R.N. or L.P.N. Visiting nursing care means a visit of not more than four hours for the purpose of performing specific skilled nursing tasks.

• Private-duty nursing by an R.N. or L.P.N. if the person’s condition requires skilled nursing care and visiting nursing care is not adequate.

Benefits will not be paid during a calendar year for private-duty nursing for any shifts in excess of 70 private duty nursing care maximum shifts. Each period of private-duty nursing of up to eight hours will be deemed to be one private-duty nursing shift.

“Skilled nursing services” do not include:

• That part or all of any nursing care that does not require the education, training and technical skills of an R.N. or L.P.N. (such as transportation, meal preparation, charting of vital signs and companionship activities);

• Any private-duty nursing care given while the person is an inpatient in a hospital or other health care facility;

• Care provided to help a person with the activities of daily life (such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting); or

• Care provided solely for skilled observation, except as follows:

  — For no more than one four-hour period per day for a period of no more than 10 consecutive days following the occurrence of any of the following: (1) a change in patient medication; (2) the need for treatment of an emergency condition by a physician; or (3) the onset of symptoms indicating the likely need for such services, surgery, or release from inpatient confinement; or

  — Any service provided solely to administer oral medicines, except where applicable law requires that such medicines be administered by an R.N. or L.P.N.
Spinal Disorder (Chiropractic) Treatment
Benefits are payable for covered medical expenses incurred for manipulative (adjustive) treatment or other physical treatment of any condition caused by or related to biomechanical or nerve-conduction disorders of the spine.

Benefits are limited to a maximum of 25 visits for a person in a calendar year. This maximum does not apply to expenses incurred:

- While the person is a full-time inpatient in a hospital;
- For treatment of scoliosis;
- For fracture care; or
- For surgery – This includes pre- and post-surgical care given or ordered by the operating physician.

Pregnancy Coverage
Benefits are payable for pregnancy-related expenses of female plan participants on the same basis as for any other medical condition.

In the event of an inpatient confinement, such benefits will be payable for inpatient care of the covered person and any newborn child for: (1) a minimum of 48 hours following a vaginal delivery; or (2) a minimum of 96 hours following a cesarean delivery. If a person is discharged earlier, benefits will be payable for two post-delivery home visits by a health care provider.

Benefits for stays longer than 48 hours (or 96 hours, as applicable) will not be reduced.

In addition, a plan may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours).

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to the Claims Administrator that the person has been totally disabled since her coverage terminated.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage
Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for any other illness or disease. Reversal of sterilization is not covered.
**Mastectomy and Breast Reconstruction**
Covered medical expenses include charges incurred by a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductible and coinsurance provisions that apply for the mastectomy.

**Mouth, Jaws and Teeth**
Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for services rendered and supplies needed for the following treatment of or related to conditions of the:

- Teeth, mouth, jaws, jaw joints; or
- Supporting tissues (this includes bones, muscles and nerves).

For these expenses, “physician” includes a dentist.

- Surgery needed to:
  - Treat a fracture, dislocation or wound.
  - Cut out cysts, tumors or other diseased tissues.
  - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

  **Non-surgical treatment of infections or diseases does not include those of or related to the teeth.**

Dental work, surgery and orthodontic treatment needed to remove, repair, replace, restore or reposition natural teeth damaged, lost, or removed, or other body tissues of the mouth fractured or cut, due to injury. Any such teeth must have been free from decay, or in good repair, and firmly attached to the jaw bone at the time of the injury. The treatment must be completed within the calendar year of the accident or the following calendar year.
If crowns (caps), dentures (false teeth), bridgework, or in-mouth appliances are installed due to such injury, Covered Medical Expenses are limited to charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Except as provided for injury, charges for the following services are not covered:

- In-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- Root canal therapy; and
- Tooth removal.

Charges for the following services are not covered under any circumstances:

- Removal, repair, replacement, restoration, or repositioning of teeth lost or damaged in the course of biting or chewing;
- Repair, replacement, or restoration of fillings, crowns, dentures, or bridgework;
- Periodontal treatment;
- Dental cleaning, in-mouth scaling, planing, or scraping; or
- Myofunctional therapy (muscle training therapy or training to correct or control harmful habits).

**Urgent Care**

Benefits are payable for charges made by an urgent care provider to evaluate and treat an urgent condition.

When travel to an in-network urgent care provider for treatment of an urgent condition is not feasible, such treatment may be paid at the in-network level of benefits. If a claim for treatment of an urgent condition is paid at the out-of-network level and you believe that it should have been paid at the in-network level, you should contact Member Services at the toll-free number on your I.D. card.
**Non-Urgent Care**
Covered medical expenses for charges made by an urgent care provider to treat a non-urgent condition will be paid on the same basis as those made by a provider who is not an urgent care provider. Non-urgent care includes, but is not limited to, the following:

- Routine or preventive care (including immunizations);
- Follow-up care;
- Physical therapy;
- Elective surgical procedures; and
- Any lab and radiologic exams that are not related to the treatment of the urgent condition.

**Other Covered Medical Expenses Under The Plan**
Charges made by a physician and/or charges for the following:

- Drugs and medicines that by law need a physician’s prescription and for which no coverage is provided under the prescription drug coverage, including depo-provera injections for contraceptive purposes
- Diagnostic lab work and X-rays. You pay no out-of-pocket costs for diagnostic lab tests in a physician’s office or designated lab when tests are performed using the Lab Card program.
- X-ray, radium and radioactive isotope therapy.
- Anesthetics and oxygen.
- Rental of durable medical and surgical equipment. In lieu of rental, the following may be covered:
  - The initial purchase of such equipment if the Claims Administrator is shown that: (1) long-term care is planned; and (2) such equipment cannot be rented or is likely to cost less to purchase than to rent.
  - Repair of purchased equipment.
  - Replacement of purchased equipment if the Claims Administrator is shown that it is: (1) needed due to a change in the person’s physical condition; or (2) likely to cost less to purchase a replacement than to repair existing equipment or to rent the same equipment. Replacement limitations may apply. Contact the Claims Administrator for specifics.
  - Over-the-counter and custom-made surgical support stockings and garment supports (up to two pairs annually). One pair of custom formed orthopedic shoes or orthotic inserts annually when recommended by a physician. Subject to review for medical necessity.
• Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first hospital where treatment is given.

• Artificial limbs and eyes. Not included are such items as eyeglasses, vision aids and communication aids.

**National Medical Excellence Program® (NME)**
The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that cannot be provided within a patient’s local geographic area. Please contact the Claims Administrator directly at the number listed in the “Administrative Information” section of this SPD for a listing of **approved** transplant centers.

Notification to the Claims Administrator is required for all transplant services as soon as the possibility of a transplant arises. When care is directed to a facility (“medical facility”) more than 100 miles from the person’s home, this Program will pay a benefit for travel and lodging expenses, but only to the extent described below.

**Travel Expenses**
These are expenses incurred by a patient for transportation between his or her home and the medical facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a companion for transportation when traveling to and from a patient’s home and the medical facility to receive such services.

**Lodging Expenses**
These are expenses incurred by a patient for lodging away from home while traveling between his or her home and the medical facility to receive services in connection with a procedure or treatment. The benefit payable for these expenses will not exceed $50 per person per night.

Also included are expenses incurred by a companion for lodging away from home:

• While traveling with a patient between the patient’s home and the medical facility to receive services in connection with any listed procedure or treatment; or

• When the companion’s presence is required to enable a patient to receive such services from the medical facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed $50 per person per night.

For the purpose of determining travel expenses or lodging expenses, a hospital or other temporary residence from which a patient travels in order to begin a period of treatment at the medical facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the patient’s home.
Travel and Lodging Benefit Maximum
For all travel expenses and lodging expenses incurred in connection with any one procedure or treatment type:

• The total benefit payable will not exceed $10,000 per episode of care.

• Benefits will be payable only for such expenses incurred during a period that begins on the day a covered person becomes an organ transplant patient and ends on the earlier of:

  — One year after the day the procedure is performed; or

  — The date the patient ceases to receive any services from the facility in connection with the procedure.

Benefits paid for travel expenses and lodging expenses do not count against any person’s lifetime maximum benefit under this Plan.

Limitations
Travel expenses and lodging expenses do not include, and no benefits are payable for, any charges that are included as covered medical expenses under any other part of this Plan.

Travel expenses do not include expenses incurred by more than one companion who is traveling with the patient.

Lodging expenses do not include expenses incurred by more than one companion per night.
What Is Not Covered

Coverage is not provided for the following charges:

• Those for services and supplies not medically necessary for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended or approved by the person’s attending Physician or Dentist.

• Those for care, treatment, services or supplies that are not prescribed, recommended or approved by the person’s attending Physician or Dentist.

• Those for or in connection with services or supplies that are, as determined by a Claims Administrator, to be experimental or investigational. You should contact the Claims Administrator directly for details on what is considered to be experimental or investigational.

• Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.

• Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person’s disease or injury.

• Those for or related to the following types of treatment: primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training, or carbon dioxide therapy.

• Those for services of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.

• Those for services of a resident physician or intern rendered in that capacity.

• Those for services that are made only because there is health coverage.

• Those for services that a covered person is not legally obligated to pay.

• Those for services, as determined by the Claims Administrator, to be for custodial care.

• Those for services and supplies:
  
  – Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
– Furnished, paid for, or for which benefits are provided or required under any law of a government. This exclusion will not apply to “no fault” auto insurance if (1) required by law; (2) provided on other than a group basis; and (3) included in the definition of “Other Plan” in the section titled “Effect of Benefits Under Other Plans Not Including Medicare.” In addition, this exclusion will not apply to: (1) a plan established by government for its own employees or their dependents; or (2) Medicaid.

• Those for or related to any eye surgery mainly to correct refractive errors.

• Those for services and supplies provided by a person who lives in your home or who is a member of your immediate family.

• Those for services and supplies for injury or illness caused by: (1) the commission or attempted commission of a felony; (2) an illegal occupation; or (3) participation in a civil disturbance or insurrection.

• Those for education or special education or job training, whether or not given in a facility that also provides medical and/or psychiatric treatment.

• Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies that improve, alter or enhance appearance – whether or not for psychological or emotional reasons except to the extent needed to:

  – Improve the function of a part of the body that is not a tooth or structure that supports the teeth – and that is malformed either as a result of a severe birth defect, including harelip, webbed fingers, or toes – or as a direct result of disease or surgery performed to treat a disease or injury.

  – Repair an injury. Surgery must be performed in the calendar year of the accident that causes the injury, or in the next calendar year.

  – Provide breast reconstruction as required under the Women’s Health Protection and Cancer Rights Act.

• Those for therapy, supplies or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

• Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to: sildenafil citrate, phentolamine, apomorphine, alprostadil, or any other drug that is in a similar or identical class, has a similar or identical mode of action, or exhibits similar or identical outcomes. This exclusion applies whether or not the drug is delivered in oral, injectable or topical (including but not limited to gels, creams, ointments and patches) forms.

• Those for performance, athletic-performance or lifestyle-enhancement drugs or supplies.

• Those for or related to sex-change surgery or to any treatment of gender-identity disorders.
• Those for or related to artificial insemination, in vitro fertilization, or embryo-transfer procedures.

• Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations or other preventive services and supplies – except as provided under Covered Expenses.

• Those for or in connection with marriage, family, child, career, social adjustment, pastoral or financial counseling.

• Those for acupuncture therapy. Acupuncture therapy is not excluded when it is performed by a physician as a form of anesthesia in connection with surgery that is covered under this Plan.

• Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (i.e., the ability to express thoughts, speak words and form sentences) as the result of a disease or injury.

• Those to the extent that they are not recognized charges as determined by the Claims Administrator – except that this will not apply if the charge for a service or supply does not exceed the recognized charge for that service or supply by more than $10.

• Those for the reversal of a sterilization procedure.

• Those for services of a midwife

• Those for a service or supply furnished by a network provider in excess of such provider’s negotiated charge for that service or supply. This excess amount will not be the responsibility of the covered person. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

Any exclusion listed above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when determining benefits.

The law of the jurisdiction where a person lives when a claim is incurred may prohibit some benefits. If so, they may not be paid.
Prescription Drug Benefits

The Aetna Consumer Directed Plan (CDP) medical option includes integrated retail and mail-order prescription drug benefits. The Plan pays a benefit equal to the payment percentage applicable to covered prescription drug expenses incurred in a calendar year, which are in excess of the annual Health Reimbursement Account (HRA) amount.

Covered Prescription Drug Expenses
The Plan pays benefits shown below for certain prescription drug expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a prescription drug is dispensed by a pharmacy to a person for treatment of a disease or injury, a benefit will be paid (according to the “Benefit Amount” section below).

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

Benefit Amount
The benefit amount for each covered prescription drug or refill dispensed by a preferred (in-network) pharmacy (90% of negotiated charges in 2006) will be an amount equal to the payment percentage of the total charges. The total charge is determined by:

- The preferred pharmacy; and
- Aetna.

Any amount so determined will be paid to the preferred pharmacy on your behalf.

The benefit amount for each covered prescription drug or refill dispensed by a non-preferred (out-of-network) pharmacy (60%) will be an amount equal to the payment percentage of the non-preferred pharmacy’s charge for the drug except for an emergency condition, in which case the benefit will be payable at the preferred level of coverage.
To obtain estimated price information for maintenance medications, go to Aetna Navigator, Aetna’s online self-service member Web site (www.aetna.com), and use the Estimate the Cost of Care tool, or call the toll-free number on your Aetna member ID card. Aetna’s Rx Home Delivery is Aetna’s mail order prescription drug service. To check the status of an order, place a refill or speak to a pharmacist, or for questions, call 1.866.612.3862 (TDD: 1.800.201.9457) or visit www.AetnaRXHomeDelivery.com. Your physician may fax your prescription(s) and completed order form to 1.800.416.9264. Customer service representatives are available: Monday – Friday, 7 a.m. – 11 p.m.; Saturday from 8 a.m. – 9:30 p.m. and Sunday from 8 a.m. – 6 p.m., Eastern Time. Pharmacists are available 24 hours a day, seven days a week, to answer questions and provide emergency assistance, if needed.

**Limitations**

No prescription drug benefits are paid for the following:

- A device of any type unless specifically included as a prescription drug;
- Any drug entirely consumed at the time and place it is dispensed;
- Less than a 30-day supply of any drug dispensed by a mail order pharmacy;
- More than a 30-day supply per prescription or refill. However, this limitation does not apply to a supply of up to 90 days per prescription or refill for drugs which are provided by a mail order pharmacy;
- The administration or injection of any drug;
- The following injectible drugs:
  - Allergy sera or extracts;
  - Imitrex, if it is more than the 48th such kit or 96th such vial dispensed to the person in any year;
- Any refill of a drug if it is more than the number of refills specified by the prescriber. Before recognizing charges, Aetna may require a new prescription or evidence as to need if the prescriber has not specified the number of refills or if the frequency or number of prescriptions or refills appears excessive under accepted medical practice standards;
- Any refill of a drug dispensed more than one year after the latest prescription for it or as permitted by the law of the jurisdiction in which the drug is dispensed;
- Any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or prescription drug expense benefit plan carried or sponsored by Rockwell Automation;
- Any drugs which do not, by federal or state law, require a prescription order (i.e., an over-the-counter [OTC] drug), even if a prescription is written, including nicotine gum, patches and other smoking deterrents;

- Any prescription drug for which there is an over-the-counter (OTC) product which has the same active ingredient and strength;

- Immunization agents;

- Biological sera and blood products;

- Nutritional supplements;

- Appetite suppressants;

- Performance, athletic performance or lifestyle enhancement drugs or supplies;

- Vitamins (except legend, prenatal and pediatric fluoride vitamins);

- Retin-A for individuals age 26 or older;

- Fertility agents;

- Prescription drugs dispensed by a mail order pharmacy that is not a preferred (in-network) pharmacy.

**Dispensing Limits**

Some prescription drugs may be subject to dispensing limits. To verify whether a prescription drug has dispensing limits, call the toll-free customer service phone number on the back of your ID card.
Mental Health and Substance Abuse Benefits

The Aetna CDP medical option includes integrated benefits for mental disorders and substance abuse.

Treatment of Mental Disorders
Certain expenses for both inpatient and outpatient treatment of mental disorders are covered medical expenses.

Inpatient Treatment
The plan pays for the effective treatment of a mental disorder if the covered person is full-time inpatient at:

- A hospital; or
- A treatment facility (coverage includes necessary services and supplies and room and board up to the private room limit).

Outpatient Treatment
The Plan pays for the effective treatment of a mental disorder:

- At a hospital;
- At a treatment facility; or
- From a physician.

Treatment of Alcoholism or Substance Abuse
Certain expenses for both inpatient and outpatient treatment of alcoholism or substance abuse are covered medical expenses.

Inpatient Treatment
The Plan pays for the effective treatment of alcoholism or substance abuse (including medical complications such as cirrhosis of the liver, delirium tremens or hepatitis) if the covered person is a full-time inpatient at:

- A hospital; or
- A treatment facility (coverage includes necessary services and supplies and room and board up to the private room limit).
Outpatient Treatment
The Plan pays for the effective treatment of alcoholism or substance abuse:

- At a hospital; or
- At a treatment facility.

General Exclusions – Mental Health and Substance Abuse
No payment will be made by Aetna for the following care, services or supplies:

- Educational rehabilitation or treatment of learning disabilities, regardless of the setting in which such services are provided.
- Custodial care.
- Treatment for personal or professional growth development, or training for professional certification.
- Evaluations, consultations or therapy for educational or professional training or for investigational purposes relating to employment.
- Therapies that do not meet national standards for mental health professional practice, including but not limited to Erhard/The Forum, primal therapy, rolfing, sensitivity training, bioenergetic therapy, or crystal healing therapy.
- Experimental or investigational therapies.
- Court-ordered psychiatric or substance abuse treatment except when certified by Aetna as medically necessary.
- Psychological testing, except when precertified as medically necessary by Aetna.
- Services, supplies or treatment that are covered for benefits under the medical portion of this Plan.
- Prescription drugs.
- Private-duty nursing, except when precertified by Aetna as medically necessary.
- Services to treat conditions that are identified by the DSM-IV as not being attributable to a mental disorder but are additional conditions that may be a focus of clinical attention (i.e., V Codes).
- Treatment of congenital and/or organic disorders, except for the associated treatable and acute behavioral manifestations.
• Aversion Therapy.

• Treatment for co-dependency.

• Non-abstinence-based or nutritionally based treatment for substance abuse.

• Treatment or consultations provided via telephone.

• Services, treatment or supplies provided as a result of any worker’s compensation law or similar legislation or obtained through, or required by any governmental agency or program – whether federal, state or of any subdivision thereof (exclusive of Medicaid/Medi-Cal) or caused by the conduct or omission of a third-party for which the member has a claim for damages or relief, unless the member provides Aetna with a lien against such claim for damages or relief in a form and manner satisfactory to Aetna.

• Treatment or consultations provided by the member’s parents, siblings, children, or current or former spouse or domestic partner.

• Sexual therapy programs.

• Remedial education beyond evaluation and diagnosis of learning disabilities, education rehabilitation, academic education, and educational therapy for learning disabilities.

• Couples therapy, except when certified as a medically necessary part of the treatment plan of a spouse or domestic partner covered by the Plan who has a DSM-IV Mental Disorder.

• Marriage counseling.

• Conditions resulting from an:
  
  – Act of war (declared or undeclared);
  
  – Insurrection; or
  
  – Atomic explosion or other release of nuclear energy under any conditions (except when used solely as medical treatment).

• Treatment for caffeine or nicotine intoxication, withdrawal or dependence.

• Counseling/Therapy related to a change of sex.
Lab Card Program

This program provides you with free outpatient laboratory testing when you show your Lab Card and verbally request to use the Lab Card benefit. You pay no deductible, no co-payments and no coinsurance. It is up to you to request that your doctor’s office collect your specimens and contact Lab Card Client Services at 1.800.646.7788 for a specimen pickup. Be sure to present your Lab Card when you visit your physician, or go to an approved Lab Card collection facility and request the Lab Card benefit. If the Lab Card benefit is not used, regular plan benefits will apply. This means that you will be responsible for the deductible, co-insurance or co-pay.

How Does the Lab Card Program Work?

- You show your Lab Card and/or health care card with the Lab Card logo when visiting the doctor’s office. Present your Lab Card and verbally request the Lab Card benefit.

- The doctor’s office collects the specimens and calls Lab Card Client Services at 1.800.646.7788 for a pickup.

- Testing is performed and the results are sent directly to the doctor (usually the next day).

- If the doctor’s office is unable to collect the specimens, you can call Lab Card Client Services at 1.800.646.7788 or visit www.labcard.com to locate an approved collection site in your area.

What Is Covered Under the Lab Card Program?

The Lab Card program covers most outpatient laboratory tests, provided that tests have been ordered by a doctor, processed under the Lab Card benefit, and are covered and approved by your current medical plan. This includes:

- Blood testing;
- Urine testing;
- Pathology;
- Routine throat cultures;
- Tissue biopsies; and
- Pap smears.
The Lab Card program does not cover:

- Lab work ordered during inpatient hospitalization;
- Lab work needed on an emergency basis (STAT) and time-sensitive specialized outpatient laboratory testing, such as fertility, bone marrow studies and spinal fluid tests;
- Non-laboratory work such as mammography, X-ray, imaging and dental work;
- Lab work performed when the Lab Card program is not requested; and
- Lab work not approved or covered under the Medical Plan.

For more information, go to the Web site [www.labcard.com](http://www.labcard.com) or call [1.800.646.7788](tel:1.800.646.7788) to locate an approved collection site in your area.
Health Information Line

The Rockwell Automation CDP also provides you with free, fast, and convenient access to telephone or online resources to help you make informed health care decisions.

How the 24-Hour Nurse Line Works
This program gives you and your family members a 24-hour-a-day, seven-day-a-week direct link to a registered nurse and health care library. This service is completely voluntary and provided at no charge as part of your benefits program. It is available to both you and your eligible dependents.

When you or someone in your family has a health-related question, you simply call the Nurse Line number identified in the Health Plan Comparison Chart on the EmployeeConnect Web site. You can speak with a registered nurse who will answer your questions and provide you with health information over the telephone. The nurse line can provide information about specific health conditions, help you understand the possible benefits and risks of treatment options, and assist you with preparing questions for doctor visits. All interactions are kept strictly confidential.

Additionally, if you would like information on a specific health topic, you can select the Health Information Library option, which allows you to listen to recorded information on more than 1,000 topics.

The CDP also includes access to online health information. You can access the online service through the Aetna’s Web site, which is noted in the Health Plan Comparison Chart on EmployeeConnect.

The health information resources support your health care provider’s services and are never intended to be a substitute for evaluation and treatment by your doctor.
As medical care becomes more and more complex and patients are treated by an increasing number of highly specialized physicians, the use of computerized systems to identify opportunities to improve care and prevent errors becomes increasingly important.

The Aetna Plan options turn member data into information that can be used to improve clinical quality and patient safety. This program identifies opportunities for improved care and delivers patient-specific, evidence-based treatment guidelines to physicians.

As opportunities for improved care are identified, your doctor may be contacted by telephone, fax or letter with important medical information that may be helpful in your treatment. While all treatment decisions are ultimately the responsibility of the physician in consultation with his or her patient, this program serves as a valuable resource in prompting a doctor to consider aspects of his or her patient’s care that he or she may have otherwise have overlooked.
Aetna Health Connections℠ Disease Management Program

Not everyone can be perfectly healthy. But, even with an ongoing health condition, you can reach your own health goals. Aetna’s disease management program can help you:

- Know how to get the treatment and preventive care you need
- Understand how to follow your doctor’s treatment plan
- Manage your ongoing conditions well
- Make changes to reach your personal health goals
- Identify and manage your risks for other conditions

You get this program as part of your Aetna health benefits or health insurance plan. There’s nothing extra to pay, and participating is up to you.

Better support for a healthier you
Many health conditions often cause or appear with other conditions. Because of this, our program offers support for more than 30 medical conditions. Our nurses and clinicians can support you even if you have more than one condition — all in one program. You’ll have one person who can help you no matter how many conditions you have.

Plus, you get:
- Educational materials and online resources
- Nurse case management if you’re high risk
- State-of-the-art technology that looks out for your health and safety

The program can make it easier for you to manage your conditions and live your life well.

Getting started is easy
We may identify you for program participation through:

- Your doctor or self-referral
- Your request submitted through the Aetna Navigator™ member website at www.aetna.com
- Our patient management staff or systems
- Medical and pharmacy claims data

If you are an Aetna member and have one of the conditions listed, call us at 1.866.269.4500 to get started. Or, call us if you think you’re at risk for one of the conditions. The more quickly you act, the more in control you can be.
### Added protection for your health

Aetna Health Connections offers more than just disease management. We use state-of-the-art technology to help make sure you’re getting the care you need.

### Smart technology looks out for you

Aetna’s CareEngine® system continuously scans your health data. It also compares it with current, evidence-based guidelines of care. This means you have extra protection. The system can:

- Identify gaps, errors, and duplications in care
- Remind you to get the preventive care you need
- Spot potentially dangerous interactions, such as two drugs that shouldn’t be taken together
- Notify your treating doctor about opportunities to improve care

When you give your disease management nurse new information — like a vitamin you take or foods that you eat — he or she can add it to the CareEngine. This helps create a more complete health view and gives you added protection.

### Support for more than 30 conditions

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<thead>
<tr>
<th>Vascular</th>
<th>Cancer</th>
<th>Renal</th>
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<tbody>
<tr>
<td>• Congestive heart failure</td>
<td>• General cancer</td>
<td>• Chronic kidney disease</td>
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<td>• Diabetes (adult and pediatric)</td>
<td>• Breast cancer</td>
<td>• End-stage renal disease</td>
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<td>• Coronary artery disease</td>
<td>• Lung cancer</td>
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<td>• Peripheral artery disease</td>
<td>• Lymphoma/leukemia</td>
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<td>• Hypertension</td>
<td>• Prostate cancer</td>
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<tr>
<td>• Cerebrovascular disease/stroke</td>
<td>• Colorectal cancer</td>
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<td>• Hyperlipidemia (high cholesterol)</td>
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<td><em>Pulmonary</em></td>
<td><em>Gastrointestinal</em></td>
<td><em>Other</em></td>
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<td>• Asthma (adult and pediatric)</td>
<td>• GERD (gastroesophageal reflux disease)</td>
<td>• Hypercoagulable state (blood clotting)</td>
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<td>• COPD (chronic obstructive pulmonary disease)</td>
<td>• Peptic ulcer disease</td>
<td>• Sickle cell disease (adult and pediatric)</td>
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<td>• IBD (inflammatory bowel disease),</td>
<td>• Cystic fibrosis</td>
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<td>• Crohn’s disease and ulcerative colitis</td>
<td>• HIV (human immunodeficiency virus)</td>
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<td>• Chronic hepatitis</td>
<td>• Chronic low back pain</td>
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<td>• Weight management</td>
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<td><em>Other</em></td>
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Vision

Through Aetna you receive special discounts on eyeglasses, contact lenses and solutions, LASIK and other eye-care services and accessories. And since it’s automatically included with your Aetna health benefits or health insurance plan, you don’t pay anything extra for program access. And that’s not all: your discount covers specialty vision care items not typically covered by insurance, like eyeglass chains, designer frames, sunglasses — even colored contacts. Now, you’ve got everything you need to keep you, and your vision, super-sharp!

There’s no limit to how often you can use the discount. You’ll get on-the-spot savings each and every time you purchase a product or service from our wide selection of participating locations.

It’s easy to find a provider, with a broad range of participating independent locations as well as national chains like LensCrafters®, Target Optical®, and select Sears® Optical and Pearle Vision® locations. Want to find a spot in your hometown? Visit our DocFind® directory at www.aetna.com and follow the standard search prompts to “Places/Eyecare” to find a participating professional in seconds. Or check your paper directory. If you don’t have one, you can call the number on your ID card, or give EyeMed customer service a ring at 1.800.793.8616.

For such a short procedure, a routine eye exam does the eyes — and the body — good. It’s the #1 way to detect eye problems like glaucoma or astigmatism. And it can also spot symptoms of diabetes, hypertension and other medical problems early … before they become a bigger problem.

That’s why most of the participating locations have doctors of optometry practicing right on the premises or at a nearby location. Now, even if you don’t have eye exam coverage through your medical benefits plan, you can still get a great rate on eye exams for eyeglasses or contact lenses through Aetna Vision Discounts. Check the price list on the back of this flyer for details. If you already have eye exam coverage, Aetna Vision Discounts is a great way to supplement your insurance coverage. Covered eye exams are available from most participating locations. But remember — check your plan documents first, since your out-of-pocket expenses could be lower if you follow your plan requirements.

Need eye exams or eyewear?
1.800.793.8616
Monday – Saturday 8 a.m. to 11 p.m.
Sundays 11 a.m. to 8 p.m. Eastern Time
Lost a Lens?
1.800.391.LENS (5367)
Ready for LASIK?
1.800.422.6600
Weekdays 8 a.m to 9 p.m.
Saturdays 9 a.m. to 6 p.m. Eastern Time
Definitions

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Other definitions that apply only to a specific benefit appear in the description of that benefit.

**Brand-Name Drug**
The trademarked name of the drug that appears on the package label.

**Calendar Year**
A period that starts on any January 1st and ends on the next December 31st.

**Claims Administrator**
The company, or its affiliate, that provides certain claim administration services for health care benefits. Aetna is the Claims Administrator for CDP Medical Plan benefits. LabOne (Quest Diagnostics) is the Claims Administrator for Lab Card benefits.

Contact information for each of the Claims Administrators can be found in the “Administrative Information” section of this SPD.

**Companion**
This is a person whose presence as a companion or caregiver is necessary to enable an organ transplant patient to receive services in connection with a transplant procedure or treatment on an inpatient or outpatient basis, or to travel to and from the facility where treatment is given.

**Co-payment**
This can be a percentage or a fixed amount (flat dollar amount) a covered person must pay each time he or she receives benefits from the plan.

**Covered Health Services**
Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, or substance abuse (or their symptoms).

A Covered Health Service is a health care service or supply described in **What Is Covered – Medical Benefits** as a covered health service that is not excluded under **What Is Not Covered**, including experimental or investigational services and unproven services.

Covered health services must be provided:

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

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

**Covered Person**
Either the employee or an enrolled dependent, but this term applies only while the person is enrolled under the Plan. References to “you” and “your” throughout this SPD are references to a covered person.

**Custodial Care**
This means services and supplies furnished to a person mainly to help him or her with the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

• By whom they are prescribed;

• By whom they are recommended; or

• By whom or by which they are performed.

**Dentist**
This means a legally qualified dentist. Also, a physician who is licensed to do the dental work that he or she performs.

**Dependent**
A “dependent” includes:

• Your legal spouse;

• Effective January 1, 2009, your domestic partner;

• Your natural unmarried children or legally adopted unmarried child(ren) under age 21 (a legally adopted child includes a child for whom adoption papers have been filed and who is living with the adopting parents during the period of probation);

• Effective January 1, 2009, your domestic partner’s children under age 21;

• Your unmarried stepchildren under age 21;

• Your or domestic partner’s unmarried child or stepchild who is a full-time student, as defined below; and

• Your or domestic partner’s disabled dependent child, as defined on the next page.
In addition, to qualify as your dependent, any child described above must:

- Permanently reside in the household of which you are the head;
- Be dependent on you for more than half of his or her support; and
- Qualify as a dependent on your tax return or be reported as such on your most recent tax return; or
- Be the subject of a Qualified Medical Child Support Order, as defined in the Qualified Medical Child Support Order section.

The term dependent excludes in any case:

- Any person covered as an employee;
- Any child who is employed on a regular full-time basis;
- Any child covered by another employee;
- Any child age 21 and over who is not a full-time student or disabled dependent child; and

Coverage terminates at the end of the month in which your child reaches age 21 unless he or she qualifies as a full-time student or disabled dependent child.

The eligibility of a dependent child who qualifies as a full-time student will terminate at the end of the month in which the student:

- Graduates or completes the course of study;
- Terminates full-time attendance at the institution; or
- Attains age 24.

**Full-Time Student**  
This means any unmarried child between the ages of 21 and 24 who:

- Otherwise meets the definition of a dependent child as described above;
- Is not covered as an employee by any other employer group insurance or prepayment plan; and
- Is enrolled in a recognized course of study or training and is in active full-time attendance at an institution such as a:

  1. High school or vocational school supported or operated by state or local governments, or by the federal government;
2. State university or college or community college;

3. Licensed private school, college or university; or

4. Licensed technical school, nurse’s training school, automotive school or similar training school.

The eligibility of a dependent child who qualifies as a full-time student will continue during a regularly scheduled vacation period and during between-term periods established by the institution. Employment limited to such periods is not considered to be employment on a regular full-time basis.

**Disabled Dependent Child**

This means any unmarried child age 21 and over, if, in addition to otherwise meeting the definition of a dependent child as provided above, such child is:

- Incapable of self-sustaining support by reason of a handicapped condition that commenced prior to the age of 21; and
- Remains dependent upon you or other care providers for lifetime care and supervision.

For the purpose of this provision, “dependent upon other care providers” means that the dependent child requires:

- A community integrated living arrangement;
- A group home;
- A supervised apartment; or
- Other residential services that are licensed or certified by the appropriate state agencies, such as:
  1. The Department of Mental Health and Developmental Disabilities;
  2. The Department of Mental Public Health; or
  3. The Department of Public Aid.

To continue coverage for a disabled dependent child age 21 and over, proof that the child is and remains unable to work and dependent upon you or other care providers must be received by the company within 31 days after the coverage would otherwise terminate. From time to time, additional proof will be required.

**Qualified Medical Child Support Order**

This is an order by a court for one parent to provide a child or children with health insurance. If the Plan Administrator receives a QMCSO for your child or children, the Plan Administrator will contact you concerning the plan procedures for such an order.
Directory
This is a listing of network providers in the service area covered under this Plan. It is available to any person covered under the Aetna CDP and is provided free of charge at www.aetna.com.

Durable Medical and Surgical Equipment
This means an item of equipment—and the accessories needed to operate it—that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or injury;
- Suited for use in the home;
- Not normally of use to persons who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Only one item of equipment for the same or similar purpose is considered durable medical and surgical equipment. A participant may not receive coverage for two pieces of equipment that serve the same or similar purpose (e.g., two different models of blood glucose meters used for the treatment of diabetes).

Not included is equipment such as: whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, communication aids, vision aids and telephone alert systems.

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This means an item of equipment – and the accessories needed to operate it – that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or injury;
- Suited for use in the home;
- Not normally of use to persons who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
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Not included is equipment such as: whirlpools, portable whirlpool pumps, sauna baths, massage
devices, overbed tables, elevators, communication aids, vision aids and telephone alert systems.

**Emergency Admission**
One where the Physician admits the person to the hospital or treatment facility immediately after the
sudden and, at that time, unexpected onset of a change in a person’s physical or mental condition:

- That requires immediate admission as a full-time inpatient; and
- For which, if immediate inpatient care were not given, could, as determined by the Claims
  Administrator, reasonably be expected to result in:
  - Placing the person’s health in serious jeopardy;
  - Loss of life or limb;
  - Significant impairment to bodily function;
  - Serious dysfunction of a body part or organ; or
  - In the case of a pregnant woman, serious jeopardy to the health of the fetus.

**Emergency Care**
This means the treatment given in a hospital’s emergency room to evaluate and treat medical
conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead
a prudent layperson possessing an average knowledge of medicine and health, to believe that his or
her condition, sickness, or injury is of such a nature that failure to get immediate medical care could
result in:

- Placing the person’s health in serious jeopardy;
- Serious impairment to bodily function;
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

**Emergency Condition**
This means a recent and severe medical condition, including, but not limited to, severe pain that
would lead a prudent layperson possessing an average knowledge of medicine and health to believe
that his or her condition, sickness or injury is of such a nature that failure to get immediate medical
care could result in:

- Placing the person’s health in serious jeopardy;
- Serious impairment to bodily function;
- Serious dysfunction of a body part or organ; or
• In the case of a pregnant woman, serious jeopardy to the health of the fetus.

**Employee**
This means a salaried or hourly (non-bargained) person regularly employed on a full-time basis by, and paid from the U.S. payroll of, the employer as defined below at any component of the employer where the benefits of this Plan have been extended. In addition, the term employee may mean a person regularly employed on a part-time basis who works at least 20 hours per week. Eligibility of such part-time employees is determined by Human Resources policy at the component of the employer.

**Employer**
This means Rockwell Automation and any subsidiaries or affiliates that Rockwell Automation designates. For the purpose of this plan, employer does not include Weidmueller/W-Interconnection, Inc., and ICS TriPlex. Employees of these subsidiaries or affiliates are not eligible to participate in the Plan. Special eligibility rules may also apply to employees of acquired companies.

**Family**
You and your dependent who qualify for Rockwell Automation benefits, including a spouse or domestic partner, dependent children, and the dependent children of your domestic partner. When used to describe your coverage tier, the term “family coverage” refers to any employee who enrolls a spouse or partner as well as one or more child.

**Formulary Drugs**
A preferred list (Primary Drug List) of brand-name medications that are determined to be clinically effective – in addition to being cost-effective – when compared to similar-acting drugs.

**Generic Drug**
The common usage of the term used to identify non-brand-name drugs that are sold at a lower cost. Technically, a generic drug is a pharmaceutical equivalent to another drug and is identical in strength, concentration and dosage form.

**Home Health Care Agency**
This is an agency that:

- Mainly provides skilled nursing and other therapeutic services;
- Is associated with a professional group that creates policy; this group must have at least one Physician and one R.N.;
- Has full-time supervision by a physician or an R.N.;
- Keeps complete medical records for each person;
- Has a full-time administrator; and
- Meets licensing standards.
**Home Health Care**
This is care and treatment of a disease or injury. The care and treatment must be prescribed in writing by the attending Physician as an alternative to confinement in a hospital or skilled nursing facility.

**Hospice Care**
This is care given to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

**Hospice Care Agency**
This is an agency or organization that:

- Has hospice care available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction in which it resides.
- Provides skilled nursing services, medical social services, and psychological and dietary counseling.
- Provides or arranges for other services, which will include: (1) services of a physician; (2) physical and occupational therapy; (3) part-time home health aide services that mainly consist of caring for terminally ill persons; and (4) inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel who include at least one physician, one R.N., and one licensed or certified social worker employed by the agency.
- Establishes policies governing the provision of hospice care.
- Assesses the patient’s medical and social needs.
- Develops a hospice care program to meet those needs.
- Provides an ongoing quality-assurance program. This includes reviews by Physicians other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record for each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

**Hospice Care Program**
This is a written plan of hospice care that:
• Is established by and reviewed from time to time by the attending physician and appropriate personnel of a hospice care agency.

• Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families.

• Includes an assessment of the person’s medical and social needs, and a description of the care to be given to meet those needs.

**Hospice Facility**
This is a facility, or distinct part of one, that:

• Mainly provides inpatient hospice care to terminally ill persons;

• Charges its patients;

• Meets any licensing or certification standards set forth by the jurisdiction in which it resides;

• Keeps a medical record for each patient;

• Provides an ongoing quality-assurance program; this includes reviews by physicians other than those who own or direct the facility;

• Is run by a staff of physicians; at least one such physician must be on call at all times;

• Provides, 24 hours a day, nursing services under the direction of an R.N.; and

• Has a full-time administrator.

**Hospital**
This is a place that:

• Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons;

• Is supervised by a staff of physicians;

• Provides 24-hour-a-day R.N. service;

• Is not mainly a nursing home or a place for rest for the aged, for drug addicts or for alcoholics; and

• Makes charges.
**Imputed Income**
Imputed income is added to your total annual compensation reported to the IRS. It appears on your Form W-2 and is taxable at your regular income tax rate.

Imputed income has the following effects on your pay:
- It is divided equally among pay periods and is shown on each paycheck from which deductions are taken;
- It is subject to federal income tax, state income tax (except in Pennsylvania and Mississippi), and FICA; and
- It is not subject to federal and state unemployment taxes.
- You should contact your tax advisor directly for additional information about imputed income.

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

**Jaw Joint Disorder**
This means a temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint or a myofacial pain dysfunction (MPD) or any similar disorder in the relationship between the jaws or joints and muscles and nerves.

**Legend Drug**
A drug that cannot legally be obtained without a physician’s written prescription.

**L.P.N.**
This means a Licensed Practical Nurse.

**Maintenance Drug**
Any prescription drug that is used on a steady, year-round basis to treat a long-term illness.

**Medical Claims Administrator**
A selected vendor responsible for the administration and payment of claims for health care plans on the behalf of an employer. The medical Claims Administrator for the Aetna CDP medical option is Aetna.

**Medically Necessary**
A service or supply furnished by a particular provider is medically necessary/appropriate if the Claims Administrator determines that it is appropriate for the diagnosis, care or treatment of the disease or injury involved, and is considered an eligible expense.

The Claims Administrator will determine whether a treatment or supply is a covered service and how the eligible expense will be covered under the Plan.

To be determined as appropriate, the service or supply must:
• Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person’s overall health condition;

• Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person’s overall health condition; and

• As to diagnosis, care and treatment, they must be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above requirements.

• In determining if a service or supply is appropriate under the circumstances, the Claims Administrator will take into consideration:

  • Information provided on the affected person’s health status;
  • Reports in peer-reviewed medical literature;
  • Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
  • Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
  • The opinion of health professionals in the generally recognized health specialty involved; and
  • Any other relevant information brought to the Claims Administrator’s attention.

• In no event will the following services or supplies be considered to be medically necessary:

  • Those that do not require the technical skills of a medical, mental health or dental professional;
  • Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, and any health care provider or health care facility;
  • Those furnished solely because the person is an inpatient on any day on which the person’s disease or injury could safely and adequately be diagnosed or treated while not confined; or
  • Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician’s or a dentist’s office or other less-costly setting.
Negotiated Charge
This is the maximum charge a network provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Network Care
This is a health care service or supply furnished by:

- A network provider; or

- Any health care provider for an emergency condition when travel to a network provider is not feasible.

Network Provider
This is a health care provider that has contracted to furnish services or supplies for a negotiated charge, but only if the provider is, with the Claims Administrator’s consent, included in the directory as a network provider for:

- The service or supply involved; and

- The class of employee of which you are a participant.

National Medical Excellence (NME) Patient
This is a person who:

- Requires any of the NME procedure and treatment types for organ transplants for which the charges are a covered medical expense;

- Contacts Aetna and is approved by Aetna as an NME patient; and

- Agrees to have the procedure or treatment performed in a hospital designated by Aetna as the most appropriate facility.

Non-Network Care
This is a health care service or supply furnished by a health care provider that is out of network.

Non-Network Provider
This is a health care provider that has not contracted to furnish services or supplies at a negotiated charge.

Non-Occupational Disease
A non-occupational disease is a disease that does not:

- Arise out of (or in the course of) any work for pay or profit; or

- Result in any way from a disease that does.
A disease will be deemed to be non-occupational – regardless of cause – if proof is furnished that the person:

- Is covered under any type of workers’ compensation law; and
- Is not covered for that disease under such law.

**Non-Occupational Injury**
A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

**Non-Urgent Admission**
One that is not an emergency admission or an urgent admission.

**Orthodontic Treatment**
This is any medical or dental service or supply furnished to prevent, diagnose, or correct a misalignment of the teeth, of the bite, or of the jaws or jaw joint relationship, whether or not it is for the purpose of relieving pain.

Not included is the installation of a space maintainer or a surgical procedure to correct malocclusion.

**Physician**
This means a legally qualified and properly licensed physician.

**Plan**
This means the Rockwell Automation Employee Health Plan, which includes the medical benefits described in this plan document and SPD, along with additional documents that describe the terms of benefits offered hereunder and which documents are incorporated herein – all as may be amended from time to time.

**Primary Care Physician**
This is the network provider who is responsible for the person’s ongoing health care.

**Prescribed Drug**
A drug prescribed by an authorized physician for a patient. The prescription must be taken to a pharmacy to be filled by a licensed pharmacist.

**R.N.**
This means a Registered Nurse.
Reasonable and/or Recognized Charge
Only that part of a charge that is reasonable and/or recognized is covered. The reasonable and/or recognized charge for a service or supply is the lowest of:

- The provider’s usual charge for furnishing it;
- The charge the Claims Administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made;
- The charge the Claims Administrator determines to be the Recognized Charge Percentage* made for that service or supply.

In determining the reasonable and/or recognized charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, the Claims Administrator may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

In some circumstances, the Claims Administrator may have an agreement with a provider (either directly or indirectly through a third party) that sets the rate that the Claims Administrator will pay for a service or supply. In these instances, in spite of the methodology described above, the reasonable/recognized charge is the rate established by such an agreement.

Room and Board Charges
Charges made by an institution for room and board and other medically necessary services and supplies. They must be regularly made at a daily or weekly rate.

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* The Recognized Charge Percentage is the charge determined by the Claims Administrator on a semiannual basis to be in the 90th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished.
Routine Preventive Care
These are preventive screenings done in the absence of signs or symptoms of a disease. The Claims Administrator will determine which services qualify as routine preventive care based on the diagnosis and procedure code used on the claim in conjunction with recommendations of nationally-recognized prevention entities, including the Centers for Disease Control and Prevention (CDC), the United States Preventive Services Task Force (USPSTF), and the American Cancer Society. These coverage guidelines are age and gender specific and are updated periodically based on clinical research and outcomes.

Once an illness or injury has been diagnosed, subsequent services and supplies may no longer be deemed routine preventive care and the deductible and coinsurance provisions of the plan apply. Except to the extent a service qualifies as Routine Preventive Care, this plan covers only Medically Necessary services and supplies.

Semiprivate Rate
This is the charge for room and board that an institution applies to the most beds in its semiprivate rooms with two or more beds. If there are no such rooms, the Claims Administrator will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service Area
This is the geographic area, as determined by the Claims Administrator, in which network providers for this Plan are located.

Skilled Nursing Facility
This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - Professional nursing care by an R.N., or by an L.P.N. directed by a full-time R.N.; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.

- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time R.N.

- Is supervised on a full-time basis by a physician or R.N.

- Keeps a complete medical record for each patient.

- Has a utilization review plan.

- Is not mainly a place for rest for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental health disorders.

- Makes charges.
**Terminally Ill**
This is a medical prognosis of six months or less to live.

**Treatment Facility (Mental Disorder)**
This is an institution that:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of mental disorders.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time R.N.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician.
- Makes charges.
- Meets licensing standards.

**Treatment Facility (Alcoholism or Drug Abuse)**
This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a physician.
- Provides, on the premises, 24 hours a day:
— Detoxification services needed with its effective treatment program.

— Infirmary-level medical services. Also, it provides or arranges with a hospital in the area for any other medical services that may be required; supervised by a staff of physicians.

— Skilled nursing care by licensed nurses who are directed by a full-time R.N.

Urgent Admission
One where the Physician admits the person to the hospital due to:

• The onset of or change in a disease;

• The diagnosis of a disease; or

• An injury caused by an accident that, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within two weeks from the date the need for the confinement becomes apparent.

Urgent Care Center
A facility, other than a hospital, that provides covered health services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen sickness or injury, or the onset of acute or severe symptoms.
**Urgent Care Provider**

This is a freestanding medical facility that:

- Provides unscheduled medical services to treat an urgent condition if the person’s physician is not reasonably available.
- Routinely provides ongoing unscheduled medical services for more than eight consecutive hours.
- Makes charges, is licensed and is certified as required by any state or federal law or regulation.
- Keeps a medical record for each patient.
- Provides an ongoing quality-assurance program. This includes reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians. At least one physician must be on call at all times.
- Has a full-time administrator who is a licensed physician, a physician’s office (but only one that has contracted with the Claims Administrator to provide urgent care), and is, with the Claims Administrator’s consent, included in the directory as a preferred urgent care provider.

**Note:** It is not the emergency room or outpatient department of a hospital.
How to Claim a Benefit

Reporting of Claims
A claim must be submitted to the Claims Administrator in writing. It must also provide proof of the nature and extent of the loss. (Your employer has claim forms available.) Generally, if you use network providers, claims will be filed on your behalf.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss that resulted in the filing of the claim.

If, through no fault of your own, you are unable to meet the deadline for filing the claim, your claim will still be accepted if you file it as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 12 months after the deadline.

Payment of Benefits
Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you; however, this Plan has the right to pay any health benefits to the service provider. This will be done unless you have told the Claims Administrator otherwise by the time you file the claim.

This Plan may pay up to $1,000 of any benefit to any of your relatives whom it believes to be fairly entitled to it. This can be done if the benefit is payable to you, you are a minor, or you are unable to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses
Keep complete records of the expenses of each person. They will be required when a claim is made.

The most important records to keep are:

- Names of physicians, dentists and others who furnish services;
- Dates expenses are incurred; and
- Copies of all itemized bills and receipts.
Recovery of Benefits Paid (Subrogation Provision)

In the event that the Plan provides an employee or dependent covered under this Plan (referred to herein as a “covered individual”) with any benefits as a result of any accident, injury or sickness and the covered individual recovers any monies (whether from settlement, judgment or otherwise) from any source because of or in any way related to the accident, injury or sickness, the covered individual shall first reimburse the Plan out of such recovery before the covered individual is entitled to any portion of the recovery without regard to the sufficiency of the recovery – to the extent of the plan benefits that have been or will be provided to the covered individual – and the Plan shall have a lien upon any such recovery to the extent of the plan benefits provided to the covered individual. The covered individual shall be obligated to hold any funds that he or she obtains in constructive trust for the benefit of the Plan. Failure to do so shall be considered a breach of the covered individual’s fiduciary obligation to the Plan.

In no event, however, shall the covered individual be required to reimburse the Plan for any amount exceeding the amount recovered from the third party or any other source. Any amount of any recovery remaining after full reimbursement from the Plan shall belong to the covered individual, but such amount shall be reduced by any attorney’s fees and other costs and expenses related to the recovery that are the obligation of the covered individual. The Plan shall not pay for nor shall the Plan be responsible for the covered individual’s attorney’s fees and related costs and expenses. Attorney’s fees and all other costs and expenses related to any recovery from a third party or any other source are to be paid solely by the covered individual and not by the Plan.

The Plan’s right of recovery shall not be defeated or reduced by the application of the “Made-Whole Doctrine,” the “Common Fund Doctrine” or any other doctrines purporting to limit, reduce or defeat the Plan’s recovery rights. The Plan’s rights of subrogation and reimbursement set forth in this section shall apply regardless of whether the amount of health care expenses is agreed upon or defined in any settlement, compromise or judgment – and even if health care expenses are excluded from the settlement, compromise or judgment.

In addition to the rights prescribed by the preceding paragraph and without derogation thereof, a covered individual who receives Plan benefits as a result of any accident, injury or sickness that might serve as a basis for a possible recovery from a third party or any other source, automatically assigns to the Plan, by virtue of receiving the plan benefits and without any necessity for further documentation thereof, the right to make a claim against the third party or other source to the extent of the amount of the plan benefits. A covered individual must not do anything at any time to prejudice the Plan’s rights of recovery against any third party or other source. A covered individual will promptly advise the Plan Administrator in writing whenever a claim against a third party or other source is made by or on behalf of the covered individual with respect to any accident, injury or sickness for which plan benefits were, or are being, provided.

Any covered individual who is provided with plan benefits has an obligation to furnish the Plan or its designee with the names and addresses of all potential sources of recovery and their insurers, adjusters and claim numbers, as well as accident reports and any other relevant information the Plan requests. If the information requested is not furnished, the Plan, in its sole discretion, may withhold future plan benefits pending receipt of the requested information.
Either the covered individual or the Plan may make a claim against a third party or other source of recovery, or commence an action against a third party or other source of recovery, and shall join the other as provided under applicable state or federal law. Both the covered individual and the Plan shall have an equal voice in the prosecution of any claim or action against a third-party or other source of recovery. The proceeds from any settlement or judgment in any claim made against a third party shall be applied in accordance with the provisions of the first paragraph of this section.

The foregoing rights, obligations and other provisions of this section shall apply equally to a covered individual’s estate (if the covered individual is deceased), and to a covered individual’s legal guardian (if the covered individual is incapacitated).

Recovery of Overpayment
If a benefit payment is made by the Claims Administrator – to or on behalf of any person – that exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right to:

- Require the return of the overpayment on request; or
- Reduce, by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

Additional Provisions
The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

Type of Coverage
Coverage under this Plan is non-occupational. Only non-occupational accidental injuries and non-occupational diseases are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Assignments
Coverage may be assigned only with the written consent of the Claims Administrator.

Physical Examinations
The Claims Administrator will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.
Legal Action
No legal action can be brought to recover any benefit after two years from the deadline for filing claims.

The Claims Administrator will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person’s coverage went into effect if the loss occurs more than two years after the date on which coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Adjustment Rule
If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

Unclaimed Amounts
Amounts that are not claimed within two years of the date they are initially made available shall result in:

- The underlying benefit claim being deemed as extinguished and void for all purposes; and
- Any amount that was made available (e.g., via a check) shall be deemed void, and the amount shall be automatically returned to the Plan or the Employer.

Filing Health Claims Under the Plan
You may file claims for plan benefits and appeal adverse claim decisions, either by yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from the Claims Administrator. The notice will explain the reason for the denial and the review procedures.

An “authorized representative” means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order that gives a person authority to submit claims on your behalf – except that, in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Urgent Care Claims
If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision no later than 36 hours after the claim is received.

“Urgent Care” means services received for a sudden illness, injury or condition that is not an emergency condition, but requires immediate outpatient medical care that cannot be postponed. An urgent situation is one that is severe enough to require prompt medical attention to avoid serious deterioration of a person’s health; this includes a condition that would subject a person to severe pain that could not be adequately managed without prompt treatment.
If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

**Other Claims (Pre-Service and Post-Service)**

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision no later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan’s control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan’s claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan’s procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

**Ongoing Course of Treatment**

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.
Effect of Other Benefit Plans

Other Plans Not Including Medicare
This Plan has a “non-duplication of benefits” provision to avoid payment of duplicate benefits from more than one plan. It applies if you are covered by another health plan in addition to the Rockwell Automation Plan.

Under the non-duplication of benefits provision of this Plan, the amount normally paid under this Plan is reduced to take into account payments made by “other plans.” To understand how non-duplication works, the first step is to determine which plan pays benefits first – in other words, which is the primary plan and which is the secondary plan. These are the guidelines used:

• A plan with no rules for coordination with other benefits will be considered the primary plan.

• If all plans have a non-duplication of benefits provision, then additional rules apply. A plan that covers a person other than as a dependent (employee or retiree plan) is primary to a plan that also covers such person as a dependent. However, if the person is also receiving Medicare benefits, the following order of payment applies:

  1. Benefits are determined and paid from the active employee plan, if any, which covers the individual – including as a dependent.

  2. Benefits are determined and paid from Medicare. If the individual is not covered by any active employee plan, including as a dependent, then Medicare is primary.

  3. Benefits are determined and paid from the retiree plan, if any, that covers the individual – including as a dependent.

• Except in the case of a dependent child whose parents are divorced or separated, if a child is covered under both parents’ plans:

  – The benefits of the plan of the parent whose birthday occurs first in a calendar year will be primary to those of the plan of the parent whose birthday occurs later in that calendar year.

  – If both parents have the same birthday, the benefits of a plan that covered one parent longer are determined before those of a plan that covered the other parent for a shorter period of time.

If the other plan does not have the “birthday rule” described in provision 3 above, but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
• In the case of a dependent child whose parents are divorced or separated:
  
  – If there is a court decree that states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in provision 3 on the previous page above will apply.

  – If there is a court decree that makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan that covers the child as a dependent of such parent will be determined before the benefits of any other plan that covers the child as a dependent child.

  – If there is not such a court decree:

    - If the parent who has custody of the child has not remarried, the benefits of a plan that covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.

    - If the parent who has custody of the child has remarried, the benefits of a plan that covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan that covers that child as a dependent of the stepparent. The benefits of a plan that covers that child as a dependent of the stepparent will be determined before the benefits of a plan that covers that child as a dependent of the parent without custody.

  • If an order of payment is not established by the bullets above, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

  – The benefits of a plan that covers a person as an active employee or as that person’s dependent shall be determined before the benefits of any other plan that covers a person as a laid-off or retired employee or that person’s dependent.

  – If the other plan does not have a provision regarding laid-off or retired employees – and, as a result, each plan determines its benefits after the other then the above paragraph will not apply.

  – The benefits of a plan that covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

  – If the other plan does not have a provision regarding right of continuation pursuant to federal or state law – and, as a result, each plan determines its benefits after the other – then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a calendar year will be reduced by all “other plan” benefits payable for those expenses. When the non-duplication of benefits rules of this Plan and any “other plan” both agree that
this Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, the claims payor can release or obtain data. The claims payor can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan
This means any other plan of health expense coverage under:

- Group insurance;
- Any other type of coverage for persons in a group (this includes plans that are insured and those that are not); and
- No-fault automobile insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Effect of Medicare
Your health care benefits may be affected if you or a dependent becomes eligible for Medicare, as the following paragraphs explain.

Medicare is a health care program provided by the federal government through Social Security taxes. There are two parts to Medicare:

- Part A covers hospital expenses. There is generally no cost to you for Part A coverage.
- Part B covers other medical expenses such as doctor bills. You pay a monthly premium for Part B coverage.

You generally become eligible for Medicare when you reach age 65. Your spouse or domestic partner also becomes eligible for Medicare when he or she reaches age 65. Medicare is also available for certain persons who are receiving Social Security disability benefits or who suffer end-stage renal (kidney) disease. So it is possible that you, your spouse, your domestic partner, or a dependent may become eligible for Medicare benefits before age 65.

Health care benefits under this Plan will be changed for any person while eligible for Medicare. A person is “eligible for Medicare” if he or she:

- Is already covered by Medicare;
- Is not covered by Medicare because he or she:
  — Refused it;
— Dropped it; or
— Failed to make proper request for it.

These are the changes:

- The total amount of “regular benefits” under all health care benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount that Medicare provides for the expenses involved, this Plan will pay the difference. Otherwise, this Plan will pay no benefits. This will be done for each claim.

- Charges used to satisfy a person’s Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.

- Any rule for coordinating “other plan” benefits with those under this Plan will be applied after this Plan’s benefits have been figured under the above rules. Any benefits under Medicare will not be deemed to be an allowable expense.

Coverage will not be changed at any time when your Employer’s compliance with federal law requires this Plan’s benefits for a person to be figured before benefits are figured under Medicare.

**Medicare Entitlement Based on Age**

You enroll in Medicare through your local Social Security Administration office. Your first opportunity to enroll begins three months before the month you turn age 65. You have three months after your 65th birthday to enroll. If you enroll after this six-month period, your Medicare coverage may be delayed. Also, your Part B premium will be higher if you do not enroll when you are first eligible.

If you, your spouse or domestic partner is age 65 or older and you are still actively working, you may continue your coverage under this Plan, and Medicare will be your secondary coverage. You do not have to enroll in Part B until you stop working, and there will be no penalty.

However, you, your spouse or domestic partner can elect Medicare as your only coverage for medical care expenses. If you make that choice, you must notify the Company in writing. The Company cannot be secondary in this case.

**Medicare Entitlement Based on Disability**

After you or a dependent has been entitled to Social Security disability benefits for 24 months or if you or a dependent has end-stage renal disease (kidney failure), Medicare benefits will be available to the disabled individual.
**Disabled Employees and Dependents**
If you become eligible for Medicare through receipt of Social Security disability benefits for 24 months due to a disability other than end-stage renal disease, Medicare will become the primary payor of medical benefits and this Plan will become secondary. This Plan would remain the primary payor of medical benefits only if the disabled Medicare beneficiary is a dependent of a currently working employee.

**Individuals With End-Stage Renal Disease**
If you or your dependent becomes eligible for Medicare due to end-stage renal disease, benefits for covered expenses are payable under this Plan during the first 30 months. After that, Medicare is primary and this Plan is secondary. The 30-month period begins when you or your dependent is first eligible to enroll in Medicare.

If Medicare becomes the primary payor of a covered person’s benefits, the Rockwell Automation Plan will reduce its benefits (on a “carve-out” basis) by any benefits available under Medicare. As soon as you or your dependent becomes eligible for Medicare, the Plan will assume that you are covered by both Parts A and B. **This means that if you or your dependent does not enroll for Medicare Parts A and B when eligible, you must pay the amounts that would have been paid by Medicare had you enrolled.**

**Effect of Prior Coverage – Transferred Business**
If this plan coverage is replacing the health care plan coverage of a business entity acquired by Rockwell Automation, the rules below apply to the persons covered under that prior plan:

- “Prior coverage” is any group health care plan of the entity being acquired that is being replaced by part or all of this Plan. Prior coverage must have been sponsored by your employer (i.e., the entity being acquired).

- Any benefits provided by this Plan will be in exchange for the benefits provided under the “prior coverage” plan. Any benefits paid under the “prior coverage” plan may reduce any benefits payable under this Plan.
When Coverage Ends

During Approved Medical Leave
An employee who is on a medical leave of absence will be permitted to continue participation under the Medical Plan for the duration of the leave, or one year, whichever is less. The Company will continue paying its usual portion of the premium during this period. After one year, coverage can be continued under COBRA by paying the full premium cost up to the maximum allowed under COBRA.

During Approved Personal Leave of Absence
(Includes Military Reserve Training)
An employee who is granted a personal leave will be permitted to continue participation under the Medical plan for the duration of the leave. If the personal leave is longer than one month in duration, coverage can be continued under COBRA by paying the full premium cost.

During Educational Leave of Absence
An employee who is granted an educational leave of absence will be permitted to continue participation under the Medical Plan through COBRA for the duration of the leave by paying the full premium cost, up to the maximum allowed under COBRA.

During Family Leave of Absence
In accordance with the Family and Medical Leave Act of 1993 (FMLA), the following provisions apply to employees who have been employed for at least 12 months. Other conditions may apply, depending on the state where you are employed. Contact the Rockwell Automation Service Center for details.

An employee who is granted an FMLA leave and who is already covered under the Company’s group health insurance plan shall continue coverage with the same terms and conditions that existed prior to his or her leave. The company will continue to contribute its portion of the premium payment during the leave of absence, and the employee will be required to pay his or her portion of the monthly premiums as instructed by the company. If an employee fails to return from leave, the company may seek reimbursement for premiums paid by the company during the leave.

During Uniformed Services Leave of Absence
An employee already covered under the company’s group health plan may continue coverage, including dependent coverage when applicable, with the same terms and conditions that existed prior to his or her leave. The company will continue to contribute its portion of the premium payment during the leave of absence, and the employee is required to pay his or her portion of the monthly premium as required by the company. An employee who discontinues his or her insurance(s) and returns to employment will be able to immediately participate in any plan(s) available to other similarly situated employees at that time.
Early or Normal Retirement
Depending on your age and years of service at the time you retire, you may be eligible to continue your medical coverage during retirement. Retiree benefits will be described in an Appendix to this SPD.

Voluntary Termination of Employment
Coverage ceases at the end of the month in which your employment terminates, and then COBRA coverage is offered.

Employee Death
COBRA continuation of coverage will be available to eligible surviving dependents for 36 months. The first six months is company-paid. If you had been eligible for retiree medical at the time of your death, retiree medical benefits will be available to your eligible surviving dependents after the first six months of Company-paid coverage.

In General
• If the Group Benefits Plan were to be discontinued, all coverage would then end.

• If the employee should discontinue any required contributions, the coverage for which such contribution is required will end as of the expiration of the period for which the last contribution was made.

• Dependent coverage will end for a covered dependent when the dependent is no longer eligible under the terms of the Plan.

• Claims are paid based on the date of service. If Rockwell Automation or the Claims Administrator terminates the contract or a covered person changes plans, all claims incurred on or before the date of termination shall be paid by the Claims Administrator (including inpatient hospital stays incurred on or before the date of termination that continue past the date of termination).
COBRA Continuation of Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (a federal law commonly known as COBRA), participants in health care plans (and their eligible dependents) may choose to continue coverage for specific periods of time. Individuals entitled to COBRA continuation coverage ("qualified beneficiaries") are you and your dependents who are covered at the time of a qualifying event that would normally cause coverage to end. In addition, a child born to you or placed for adoption with you during the COBRA continuation period is also a qualified beneficiary. The COBRA provisions in this section also apply to any HMO offered through the company.

Qualifying Events
If your employment is terminated for any reason other than your gross misconduct or if your hours worked are reduced so that your plan coverage ends, you and your covered dependents may continue coverage under the Plan for up to 18 months.

If you (the employee) should die, become divorced, dissolve your domestic partnership, or become eligible for Medicare, your covered dependents whose medical coverage under the Plan would be reduced or terminated may continue coverage under this Plan for up to 36 months. Also, your covered children may continue coverage for up to 36 months after they no longer meet the definition of dependent under the terms of the Plan.

Certain events may extend the 18-month COBRA continuation period:

- If your dependent(s) experiences a second qualifying event within the original 18-month period, he or she (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).

- If you (the employee) became entitled to Medicare while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost or reduced) and then a second qualifying event (such as your termination of employment) occurs within 18 months, your dependents may elect COBRA continuation coverage for up to 36 months from the date you became eligible for Medicare.

- If you or a dependent is disabled (as determined by the Social Security Administration) on the date of the qualifying event or within the first 60 days of COBRA continuation coverage, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months). To qualify for this disability extension, the Plan Administrator must be notified of the person’s disability status within 60 days after the Social Security disability determination is issued and before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the Plan Administrator within 30 days after this determination. Important Note: If a second qualifying event occurs at any time
during this 29-month disability continuation period, then each qualified beneficiary (whether or not disabled) may further extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

The law requires that continuation of coverage rights similar to those described above may be applied to retirees, spouses, domestic partners and dependents if the company begins a bankruptcy proceeding and these individuals lose coverage.

Giving Notice That a COBRA Event Has Occurred
To qualify for COBRA continuation upon divorce or loss of a child’s dependent status under the Plan, you are required to notify the Rockwell Automation Service Center within 60 days of the later of: 1) the event; or 2) the date the individual would lose coverage under the Plan. You will then be contacted with instructions for continuing your medical coverage.

For other qualifying events (if your employment ends, your work hours are reduced, or you become entitled to Medicare), you will be contacted with instructions for continuing your medical coverage. In the event of your death, the company will notify your covered dependents regarding how to continue coverage under the Plan.

You must also notify the Rockwell Automation Service Center if a divorce or loss of a child’s dependent status occurs that would extend your period of COBRA coverage.

Electing and Paying for COBRA Continuation Coverage
You and/or your covered dependents must choose to continue coverage within 60 days after the later of the following dates:

• The date of the qualifying event; or

• The date the company notifies you and/or your covered dependents of your right to choose to continue coverage as a result of the qualifying event.

If you elect continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days of your election. Thereafter, COBRA premiums must be paid within 30 days of each due date. The cost of COBRA coverage is 102% of the full cost of plan coverage. For the 19th through 29th months of coverage under the disability extension, the cost of coverage will remain 102% of the full cost.

If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual is disabled. If a second qualifying event occurs during the otherwise applicable disability extension period (i.e., the 19th through the 29th month), the 102% rate also applies to the 19th through 36th months of the COBRA continuation period.

Coverage During the Continuation Period
If coverage under the Plan is changed for active employees, the same changes will be provided to individuals on COBRA continuation. Qualified beneficiaries also may change their coverage elections during the annual enrollment periods or if a change in status occurs.
Trade Act Assistance
If you are eligible for Trade Act Assistance (TAA) or alternative Trade Act Assistance (ATAA) and did not elect COBRA continuation coverage during the COBRA election period that applied to your loss of medical coverage due to your separation from employment, you may have an additional COBRA election period available to you. You may elect COBRA continuation coverage during the 60-day period that starts on the first day of the month that you become a TAA- or ATAA-eligible individual. Your election for COBRA continuation coverage must not be made later than six months after the date of the TAA/ATAA-related loss of coverage (the date on which you lost coverage due to your separation from employment that gives rise to your being a TAA- or ATAA-eligible individual).

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (eligible individuals). Under the new tax provisions, eligible individuals can either receive a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1.866.628.4282. TTD/TTY callers may call toll-free at 1.866.626.4282.

When Trade Act Assistance-Related COBRA Continuation Coverage Begins and Ends
Continued coverage under this special TAA or ATAA section is not retroactive to the date your employment terminated. Instead, the continuation coverage begins on the day the special second election period begins. Continued coverage for any person will end when the first of the following occurs:

- The applicable continuation period expires or otherwise may be terminated under COBRA;
- Any required premium for continued coverage is not paid within 30 days after it is due;
- After the date COBRA is elected, the person becomes covered under another group medical plan (as an employee or otherwise) that does not contain an exclusion or limitation affecting the person’s pre-existing condition, or the other plan’s pre-existing condition limit exclusion or limit does not apply or is satisfied because of HIPAA rules;
- After the date COBRA is elected, the qualified beneficiary enrolls in Medicare;
- In the case of the 11-month extended coverage period due to disability, there has been a final determination, under the Social Security Act, that you are no longer disabled; or
- The company terminates medical coverage for all employees.

American Recovery and Reinvestment Act of 2009
Effective as of February 17, 2009, the Health Benefits Plan has been modified to reflect the COBRA changes implemented by the American Recovery and Reinvestment Act of 2009 (ARRA). Under the ARRA, assistance eligible individuals pay a reduced COBRA premium for up to 9 months. The reduced premium is 35% of the COBRA premium assistance the eligible individual would otherwise have to pay. No premium reduction is available for periods of coverage beginning prior to February 17, 2009.
Under the ARRA, an assistance eligible individual is an individual who:

1. Is a qualified beneficiary as the result of an involuntary termination between September 1, 2008, and December 31, 2009;

2. is eligible for COBRA continuation coverage at any time during that period; and

3. elects COBRA continuation coverage.

If you have already elected COBRA continuation coverage, you must apply for the premium reduction. You will receive a separate notice that describes the premium reduction and how to apply for it.

If you were terminated between September 1, 2008 and February 16, 2009, and do not have a COBRA election in effect on February 17, 2009, you will have a 60-day extended election period in which you will have a second chance to elect COBRA continuation coverage. You will receive a notice that describes your extended election period. The extended election period begins on the date you receive the COBRA notice explaining the extended election period. If you elect COBRA continuation coverage during your extended election period, any gap in coverage will be disregarded for determining any pre-existing limitations that may apply.

In addition, assistance eligible individuals may elect to enroll in a different medical benefit option under this Plan, if the premium for medical benefit option is less than the premium for the medical benefit option in which the associate was enrolled at the time of the qualifying event. The election must be made not later than 90 days after the date the associate receives notice of their COBRA continuation rights.

You are ineligible for the premium reduction if you are eligible for coverage under another group health plan (such as a plan offered through a spouse’s employer) or for Medicare. If you are receiving the premium reduction and you become eligible for coverage under another group health plan or Medicare, you must notify the Company of your eligibility for other coverage. If you fail to do so, you may have to pay 110% of the premium reduction you received as a tax penalty.
HIPAA Medical Privacy and Security

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These modifications have or will become effective as required by applicable provisions of the Privacy and Security Regulations.

First, under HIPAA Privacy Regulations, this Plan has been modified to allow the Disclosure of Protected Health Information (PHI), as defined under HIPAA, to the Plan Sponsor. The “Use and Disclosure of Protected Health Information Under HIPAA Privacy and Security Regulations” section of this document specifies the terms under which the Plan may share PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of your PHI.

This Plan agrees that it will only disclose your PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in the “Use and Disclosure of Protected Health Information Under HIPAA Privacy and Security Regulations” section below have been adopted and the Plan Sponsor agrees to abide by these terms.

Second, under HIPAA Security Regulations, this Plan has been modified to require the Plan Sponsor to reasonably and appropriately safeguard Electronic Protected Health Information (Electronic PHI), as defined under HIPAA, created, received, maintained or transmitted to or by the Plan Sponsor on behalf of this Plan.

Use and Disclosure of Protected Health Information Under HIPAA Privacy and Security Regulations

This Plan will use your PHI to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will use and disclose your PHI for purposes related to health care treatment, payment for health care, and health care operations. Additionally, this Plan will use and disclose your PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share your PHI with the Plan Sponsor, and limits the uses and disclosures that the Plan Sponsor may make of your PHI.

This Plan shall disclose your PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of health care treatment, payment for health care, and health care operations.

The Plan Sponsor shall use and/or disclose your PHI only to the extent necessary for the administrative functions of health care treatment, payment for health care, and health care operations that it performs on behalf of this Plan.
This Plan agrees that it will only disclose your PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the use and disclosure of your PHI:

- The Plan Sponsor will only use and disclose your PHI (including Electronic PHI) for plan administrative functions, as required by law or as permitted under HIPAA regulations. Your Plan’s Notice of Privacy Practices also contains more information about permitted uses and disclosures of PHI under HIPAA.

- The Plan Sponsor will 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.

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide your PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor regarding your PHI.

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI.

- The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions, or in connection with any other of the Plan Sponsor’s benefits or employee benefit plans.

- The Plan Sponsor will promptly report to this Plan any impermissible or improper use or disclosure of PHI not authorized by the plan documents.

- The Plan Sponsor will report to the Plan any security incident (with respect to Electronic PHI) of which the Plan Sponsor becomes aware.

- The Plan Sponsor will allow you or the Plan to inspect and copy any PHI about you contained in the Designated Record Set that is in the Plan Sponsor’s custody or control. The HIPAA Privacy Regulations set forth the rules that you and the Plan must follow, and also set forth exceptions.

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of your PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations.

- The Plan Sponsor will keep a disclosure log for certain types of disclosures set forth in the HIPAA regulations. You have a right to see the disclosure log. The Plan Sponsor does not have to maintain a log if disclosures are for certain plan-related purposes such as payment of benefits or health care operations.
The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of your PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan’s compliance with HIPAA.

The Plan Sponsor must, if feasible, return to this Plan or destroy all your PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs your PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that your PHI (including Electronic PHI) will be used only for the purpose of plan administration.

The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of your PHI to carry out functions for which the information is requested.

Certain employees, classes of employees, or other workforce members under the control of the Plan Sponsor may be given access to your PHI for plan administrative functions that the Plan Sponsor performs on behalf of the Plan. You can obtain a list of such individuals from the Plan Sponsor upon request.

If any of the employees or workforce members who have access to PHI use or disclose your PHI in violation of the terms set forth in this section, the employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to you.

Definitions

**Administrative Simplification** is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

— Improve the efficiency and effectiveness of the health care system;

— Standardize electronic data interchange of certain administrative transactions;

— Safeguard security and privacy of PHI;

— Improve efficiency to compile/analyze data audit, and detect fraud; and

— Improve the Medicare and Medicaid programs.
• **Business Associate (BA)** in relationship to a **Covered Entity (CE)** means that a BA is a person to whom the CE discloses PHI so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third-Party Administrators, health care clearinghouses, data processing firms, billing firms and other CEs. This excludes persons who are within the CE’s workforce.

• **Covered Entity (CE)** is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

• **Designated Record Set** means a set of records maintained by or for a CE that includes a covered person’s PHI. This includes medical records, billing records, enrollment, payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about covered persons. This record set must be maintained for a minimum of six years.

• **Disclose or Disclosure** is the release or divulgence of information by an entity to persons or organizations outside that entity.

• **Electronic Protected Health Information (Electronic PHI)** is individually identifiable health information that is transmitted by electronic media or maintained in electronic media. It is a subset of PHI.

• **Health Care Operations** are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

  — Conducting quality assessment and improvement activities;

  — Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;

  — Evaluating health care professional and health plan performance;

  — Training future health care professionals;

  — Insurance activities relating to the renewal of a contract for insurance;

  — Conducting or arranging for medical review and auditing services;

  — Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;

  — Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;

— Contacting health care providers and patients with information about treatment alternatives and related functions that do not entail direct patient care; and

— Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess-of-loss insurance).

• **Individually Identifiable Health Information** is information that is a subset of health information, including demographic information collected from a covered person, and that:

  — Is created by or received from a CE;

  — Relates to the past, present, or future physical or mental health or condition of a covered person; the provision of health care; or the past, present, or future payment for the provision of health care; and

  — Identifies the covered person or with respect to which there is reasonable basis to believe the information can be used to identify the covered person.

• **Payment** means the activities of the health plan or a BA, including the actual payment under the policy or contract; and a health care provider or its BA that obtains reimbursement for the provision of health care.

• **Plan Sponsor** means your employer.

• **Plan Administrative Functions** mean administrative functions of payment or health care operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing and monitoring.

• **Privacy Official** is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a covered person’s privacy.

• **Protected Health Information (PHI)** is individually identifiable health information transmitted or maintained by a CE in written, electronic or oral form. PHI includes Electronic PHI.

• **Treatment** is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

• **Use** means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.
Your Rights Under the Law

As a participant in the Group Benefits Plan for eligible Rockwell Automation Employees, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

**Receive Information About Your Plan and Benefits**
You are free to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, 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, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may assess a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**
You can:

- Continue health care coverage for yourself, your spouse, your domestic partner or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and all the documents governing the Plan regarding the rules governing your COBRA continuation coverage rights.

- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance insurer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases (if you request it before losing coverage, or if you request it up to 24 months after losing coverage). Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan – called “fiduciaries” of the Plan – have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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 rights above. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file a 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. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. 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. 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 (i.e., if it finds your claim is frivolous).

Assistance With Your Questions
If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in the 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.
Eligibility Claims

There are two types of claims: eligibility claims and benefit claims. The appeals process differs depending on whether you’re appealing your (or your eligible dependent’s) eligibility to participate in the Plan (an eligibility claim) or whether you’re appealing a denied benefit under the Plan (benefit claims).

Benefit claim appeals are handled by Aetna, which is the claims fiduciary for your CDP medical benefits. See the “Benefit Claims” section for information on how to appeal a benefit claim.

This section details the process and timing around filing an eligibility claim with the Rockwell Automation Benefit Review Team. The Rockwell Automation Employee Benefits Appeals Committee has final authority in deciding all eligibility claims appeals.

Definition of an Eligibility Claim
An eligibility claim is a claim to participate in a plan option or to change an election to participate during the year. It may be a claim to start, add or stop participation in the Plan (i.e., it could be a claim related to enrollment in a plan or eligibility for coverage in a plan). For instance, you may feel an error was made during annual enrollment that resulted in you being assigned incorrect coverage. In these situations, you should contact the Rockwell Automation Service Center at 1.877.OUR.RASC (1.877.687.7272) to discuss your concerns.

Procedure for Filing a Claim
If the Rockwell Automation Service Center does not resolve the issue to your satisfaction, you may file a claim. Upon request, the Rockwell Automation Service Center will send you a Claim Initiation Form.

In order for a communication from you to constitute a valid claim, it must be in writing on the appropriate Claim Initiation Form and delivered, along with any supporting comments, documents, records and other information, by first-class mail postage paid, to:

Rockwell Automation Benefit Review Team
100 Half Day Road
P.O. Box 1407
Lincolnshire, IL 60069-1407

Claims and appeals of denied claims may be pursued by you or your duly authorized representative.
Defective Claims
In the case of your failure to follow the Plan’s procedures for filing a valid claim, you will be notified of the failure and the proper procedures to be followed to file a claim. This notice will be provided to you as soon as possible.

Initial Claim Review—Level I Claims
The initial claim review will be conducted by the Rockwell Automation Benefit Review Team, who will consider the applicable terms and provisions of the Plan and amendments to the Plan, information and evidence that is presented by you and any other information it deems relevant.

Initial Benefit Determination

Claim Involving Urgent Care
To file an eligibility claim involving urgent care, contact the Rockwell Automation Service Center at 1.877.OUR.RASC (1.877.687.7272). In the case of a claim involving urgent care, you will be notified of the benefit determination (whether adverse or not) no later than 72 hours after receipt of the claim, provided that you supply sufficient information to determine whether and to what extent benefits are payable under the Plan.

If you fail to provide sufficient information to determine whether and to what extent you are eligible for coverage by the Plan, the Rockwell Automation Benefit Review Team will notify you within 24 hours after receipt of the urgent care eligibility claim of the specific information necessary to complete the claim. You will be given a reasonable amount of time, taking into account the circumstances (but in no event less than 48 hours), to provide the specified information. You will be notified of the benefit determination no later than 48 hours following the earlier of:

- The Rockwell Automation Benefit Review Team’s receipt of the specified information; or
- The end of the period afforded to you to provide the specified additional information.

Concurrent Care Decision
In the case of a denial of coverage involving a course of treatment (other than by amendment or termination of the Plan) before the end of such period of time or number of treatments, you will be notified of the denial in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that denial before the benefit is reduced or terminated.

When you want to extend the course of treatment beyond the period of time or number of treatments and it is an eligibility claim that involves urgent care, you will be notified of the benefit determination (whether adverse or not) within 24 hours after receipt of the claim by the Rockwell Automation Benefit Determination Review Team (provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments).
Pre-Service Claim
In the case of an eligibility claim that involves prior authorization, you will be notified of the benefit determination (whether adverse or not) within 15 days of receipt of the claim. The Rockwell Automation Benefit Determination Review Team may extend the period for making the benefit determination by 15 days if they determine that such an extension is due to matters beyond the control of the Plan, and if they notify you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which they expect to render a decision.

If an extension is necessary due to your failure to submit the information necessary to decide the eligibility claim, the notice of extension will describe the required information, you will be given at least 45 days from receipt of the notice within which to provide the specified information, and the 15-day extension in which the decision is required to be made will be suspended from the date on which the notification is sent to you until the earlier of: (1) the date you respond to the request for additional information; or (2) the due date established by the Rockwell Automation Benefit Determination Review Team for furnishing the requested information.

Post-Service Claim
In the case of an eligibility claim filed after the medical care has been delivered, you will be notified of the determination within 30 days after receipt of the claim. The Rockwell Automation Benefit Determination Review Team may extend the period for making the benefit determination by 15 days if it determines that such an extension is due to matters beyond the control of the Plan and if it notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the it expects to render a decision.

If an extension is necessary due to your failure to submit the information necessary to decide the eligibility claim, the notice of extension will describe the required information, you will be given at least 45 days from receipt of the notice within which to provide the specified information, and the 30-day extension period in which the decision is required to be made will be suspended from the date on which the notification is sent to you until the earlier of: (1) the date you respond to the request for additional information; or (2) the due date established by the Rockwell Automation Benefit Determination Review Team for furnishing the requested information.

Manner and Content of Notification of Denied Claim
You will be provided with written notice of any denial, in accordance with applicable U.S. Department of Labor regulations. The notification will include:

- The specific reason or reasons for the denial.
- Reference to the specific provision(s) of the Plan on which the determination is based.
- A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary.
• If an internal rule, guideline, protocol or other similar criterion was relied upon in making the denial, the notice will either: (1) include the specific rule, guideline, protocol or other similar criterion of the Plan that was relied upon; or (2) provide a statement that such rule, guideline, protocol or similar criterion was relied upon. A copy of the notice will be provided to you free of charge upon request.

• If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will provide either: (1) an explanation of the scientific or clinical judgment relied upon for the determination; or (2) a statement that such explanation will be provided to you free of charge upon request.

• A description of the Plan’s review procedures and the time limits applicable to such procedures, and, if the claim involves urgent care, of the expedited review process.

Review of Initial Benefit Denial
Procedure for Filing an Appeal of a Denial – Level II Claims
Any appeal of a denial must be presented to the Rockwell Automation Employee Benefits Appeals Committee (Employee Benefits Appeals Committee) within 180 days after receipt of the notice of denial. Failure to appeal within the 180-day period will be considered a failure to exhaust all administrative remedies under the Plan. The request for an appeal must be in writing, utilizing the appropriate form provided by the Employee Benefits Appeals Committee (or in such other manner acceptable to the Committee). The request for an appeal must be filed with the Committee by first-class mail postage prepaid to the following address:

Rockwell Automation Employee Benefits Appeals Committee
100 Half Day Road
P.O. Box 1407
Lincolnshire, IL 60069-1407

Review Procedures for Denials
• The Committee will provide a review that takes into account all comments, documents, records and other information submitted by you without regard to whether such information was submitted or considered in the initial benefit determination.

• You will have the opportunity to submit written comments, documents, records and other information relating to the claim.

• You will be provided, upon request and free of charge, with reasonable access to and copies of all relevant documents.

• The review of a denial will not defer to the initial determination made by the Committee.

• The individual who will conduct the review process will not be the individual who made the initial denial nor the subordinate of such individual.
• In deciding an appeal of any denial that is based in whole or in part on a medical judgment (including determinations as to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate), a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted. The health care professional will be an individual who was neither consulted in connection with the denial nor the subordinate of any such individual.

• The Committee will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your denial, without regard as to whether the advice was relied upon in making the benefit determination.

• In the case of a claim that involves urgent care, an expedited review process will be provided. You may request an expedited appeal orally or in writing, and all necessary information may be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review
• Claim Involving Urgent or Concurrent Care. In the case of a claim involving urgent care, you will be notified of the benefit determination on review within 72 hours after receipt of your request for review.

• Pre-Service Claim. You will be notified of the benefit determination on review within 30 days after receipt of the request for review.

• Post-Service Claim. You will be notified of the benefit determination on review within 60 days after receipt of the request for review.

Manner and Content of Notification of Benefit Determination on Review
You will be provided with a written notice of the Plan’s benefit determination on review, in accordance with applicable U.S. Department of Labor regulations. If your appeal is denied, the notification will provide:

• The specific reason or reasons for the denial.

• Reference to the specific provision(s) of the Plan on which the determination is based.

• A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all relevant documents.

• If an internal rule, guideline, protocol or other similar criterion was relied upon in making the denial, the notice will either: (1) include the specific rule, guideline, protocol or other similar criterion of the Plan that was relied upon; or (2) provide a statement that such rule, guideline, protocol or similar criterion was relied upon. A copy will be provided to you free of charge upon request; and
• If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either: (1) an explanation of the scientific or clinical judgment relied upon for the determination; or (2) a statement that such explanation will be provided to you free of charge upon request.

Limitations on Legal Action
You cannot take legal action to recover any benefit under the plan if you do not file a valid claim for a benefit and seek timely review of a denial of that claim. In addition, no legal action may be taken more than two years after the earlier of: (a) your request for an appeal has been denied; or (b) the date your claim was first received by the Rockwell Automation Benefit Review Team.
Benefit Claims

Benefit claims and appeals under the CDP are handled by Aetna. As the claims fiduciary and Claims Administrator, Aetna has its own process for appealing adverse or denied benefit claim decisions. The Claims Administrator has final authority in deciding all benefit claims appeals.

**Filing an Appeal of an Adverse Benefit Determination**
Aetna will send you written notice of an adverse benefit determination. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made in writing within 180 days from the date of the notice.

The Plan provides for two levels of appeal, plus an option to seek external review of the adverse benefit determination. You must complete the two levels of appeal before any legal action can be brought to recover a benefit under the Plan. The following chart summarizes some information about how appeals are handled and time frames on decisions for the different types of claims. In certain situations, the time frames shown may be extended. **Note that Level II appeals must be filed within 60 days of the Level I appeal decision.**

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Level I Appeal</th>
<th>Level II Appeal*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care Claim:</strong> a claim for medical care or treatment where delay could: -Seriously jeopardize your life or health, or your ability to regain maximum function; or -Subject you to severe pain that cannot be adequately managed without the requested care or treatment.</td>
<td>36 hours Review provided by Aetna personnel not involved in making the adverse benefit determination.</td>
<td>36 hours Review provided by Aetna.</td>
</tr>
<tr>
<td><strong>Pre-Service Claim:</strong> A claim for a benefit that requires Aetna’s approval of the benefit in advance of obtaining medical care.</td>
<td>15 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.</td>
<td>15 calendar days Review provided by Aetna.</td>
</tr>
<tr>
<td><strong>Concurrent Care Claim Extension:</strong> A request to extend a previously approved course of treatment.</td>
<td>Treated like an urgent care claim or a pre-service claim depending on the circumstances.</td>
<td>Treated like an urgent care claim or a pre-service claim depending on the circumstances.</td>
</tr>
<tr>
<td><strong>Post-Service Claim:</strong> A claim for a benefit that is not a pre-service claim.</td>
<td>30 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.</td>
<td>30 calendar days Review provided by Aetna.</td>
</tr>
</tbody>
</table>

* Must be filed within 60 days of the Level I appeal decision.
You may also choose to have another person (i.e., an authorized representative) make the appeal on your behalf by providing written consent to Aetna. However, in case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

You and/or an **authorized representative** may attend the Level II appeal hearing, question the representative of Aetna (and any other witnesses), and present your case. The hearing will be informal. You may bring your physician or other experts to testify. Aetna also has the right to present witnesses.

If the Level I and Level II appeals uphold the original adverse benefit determination, you may have the right to pursue an external review of your claim.

**External Review**
An external review is a review by an independent physician who has appropriate expertise in the area at issue, of claim denials and denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment. You may request a review by an external review organization (ERO) if:

- You have received notice of the denial of a claim by Aetna;
- Your claim was denied because Aetna determined that the care was not medically necessary or was experimental or investigational;
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable plan appeals process.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, and will include a copy of the Request for External Review Form.

**You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter.** The form must be accompanied by a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the ERO that will conduct the review of your claim. The ERO will select an independent physician who has appropriate expertise to perform the review. In rendering a decision, the external reviewer may consider any appropriate and credible information submitted by you with the Request for External Review Form, and will follow the applicable plan’s contractual documents and plan criteria governing benefits. You will generally be notified of the decision of the ERO within 30 days of Aetna’s receipt of your request form and all necessary information. An expedited review is available if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would jeopardize your health. Expedited reviews are decided within three to five calendar days after Aetna receives the request.

Aetna will abide by the decision of the ERO, except when Aetna can show conflict of interest, bias or fraud.
You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to Aetna. Aetna is responsible for the cost of sending this information to the ERO.

**Additional Information**  
**Retrospective Record Review**  
The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of health care services. Aetna’s effort to manage the services provided to members includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

**Concurrent Review and Discharge Planning**  
The following items apply if the Plan requires certification of any confinement, services, supplies, procedures or treatments:

- Concurrent Review – The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.

- Discharge Planning – Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of postdischarge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

**Provider Networks**  
If plan benefits differ depending on whether care is given by or accessed through a network provider, you may obtain, free of charge, a listing of network providers from your Plan Administrator, or by calling the toll-free Member Services number on your ID card. A current list of providers in the Aetna network is available through DocFind® at [www.aetna.com](http://www.aetna.com).
Administrative Information

Formal Name of the Plan
The Plan described in this SPD and plan document is the Rockwell Automation Employee Health Plan Number 800.

Identification Numbers of the Plan
Rockwell Automation is identified by Employer Identification Number (EIN) 25-1797617. The Plan Number (PN) is 800. You should include these numbers in all correspondence concerning this program.

Type of Plan, Type of Administration
The Plan described in this SPD and plan document is a health and welfare plan.

Rockwell Automation provides the group benefits through its Trust for Employee Welfare Benefit Programs and is liable for the benefits described herein. The claim administrator is responsible for determining benefits and paying the claims.

Plan Sponsor
Rockwell Automation
1201 Second Street
Milwaukee, WI 53204

Plan Administrator
Director—Global Benefits
Rockwell Automation
1201 Second Street
Milwaukee, WI 53204

The Plan Administrator is a named fiduciary of the Plan and acts in the sole interest of the Plan participants and their beneficiaries. The Plan Administrator has designated the claim administrator as its agent to administer the Plan, to process all claims and appeals and to provide other administrative services.

Any errors of the Plan Administrator or the delegates in collecting contributions, paying benefits, or communicating and recording such contributions and benefits shall be corrected upon discovery by the Plan Administrator in whatever manner the Plan Administrator determines is consistent with his or her responsibilities in administering the Plan.
**Plan Administrator Discretion**
The Plan Administrator or his or her designee (which, in the case of benefits claims, is the Claims Administrator) has full and complete discretion and authority to determine eligibility for benefits, to construe the terms of the Plan, and to decide any matter presented through the claims procedure. Benefits under the Plan will be paid to a party only if the Plan Administrator or his or her designee, including the Claims Administrator, decides in his or her discretion that the claimant is entitled to them. Any final determination by the Plan Administrator or its designee, including the Claims Administrator, will be binding upon all parties. If challenged in court, such determination shall not be overturned unless proven to be arbitrary and capricious based upon the evidence considered by the Plan Administrator or his or her designee, including the Claims Administrator, at the time of the determination.

**Claims Administrator**
**For the Aetna CDP Medical Option**
Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

Member Services telephone number: 1.866.547.2665  
Web site: [www.aetna.com](http://www.aetna.com)

**For the Lab Card Program**
Member Services telephone number: 1.800.646.7788  
Web site: [www.labcard.com](http://www.labcard.com)

**Agent for Service of Legal Process**
Corporate Secretary  
Rockwell Automation  
1201 Second Street  
Milwaukee, WI 53204

Legal Process may also be served on the Plan Administrator or Trustee with respect to disputes arising under the Plan.

**Plan Trustee**
Mellon Bank, N.A.  
One Mellon Bank Center  
Pittsburgh, PA 15258-0001

**Plan Records**  
The Plan’s records are kept on a fiscal year basis, beginning October 1st of each year and ending on the following September 30th.
How the Costs of the Benefits Program Are Paid
You contribute toward the cost of the Medical Plan benefits for yourself and your Dependents.

Your contributions generally are made under a “cafeteria” plan, a plan that is designed to comply with Section 125 of the Internal Revenue Code. The Internal Revenue Service (IRS) limits changes during the year to those that are related to and consistent with a qualified change in status (see the “Changing Your Benefits” section).

Rockwell Automation pays the difference between the full cost and any amounts contributed by Employees. All contributions to the Plan are paid to the Trust for Employee Welfare Benefit Programs of Rockwell Automation. This Trust is governed by an agreement between Rockwell Automation and the Trustee. The Trust invests the contributions, pending payment of benefits from the Trust, in order to foster the continued growth and stability of the Trust.

Plan Continuance
Rockwell Automation fully intends to maintain the Plan indefinitely. However (subject to any restrictions contained in collective bargaining agreements with respect to union employees), Rockwell Automation reserves the right to terminate, suspend or amend this Plan with respect to any or all employees or retirees at any time and for any reason without prior notice or consent of any participant or of any person entitled to receive payment of benefits under the Plan. No person or entity has any authority to make oral changes or amendments to this Plan. The Plan Sponsor will establish the effective date of the amendment, modification, change or termination of the Plan.

If this Plan is amended, your rights are limited to eligible claims incurred before you received written notice from the Plan Administrator that the Plan had been amended.

If this Plan is terminated, your rights are limited to eligible claims incurred before you received notice of termination.

No person will become entitled to any vested rights under this Plan, and nothing in this Plan or SPD will be construed as creating any vested rights to plan benefits.

In no event shall Rockwell Automation cause any portion of the Trust to be used for purposes other than for the exclusive benefit of participants and their beneficiaries (including payment of reasonable expenses for administering the Plan), nor may any portion of the Trust become the property of Rockwell Automation, except:

• If trust assets consist of both employee and employer contributions, the employer will determine which portion of the remaining assets is from the employer contributions and which portion is from employee contributions. The assets that are from employee contributions will be used to cover the costs of incurred claims and reasonable expenses to administer the Plan. The assets that are from employer contributions can be reverted to the employer.

• If trust assets are from employer contributions, the assets at the time of termination can revert to the employer, once any incurred plan expenses have been paid.
No Contract of Employment
This plan document and SPD is not intended to be, and may not be construed as, a contract of or a right to employment between you and Rockwell Automation. Appendix B
Appendix A

to the

Rockwell Automation Employee Health Plan

Summary Plan Description

For Employees Retiring
After December 31, 2005

Effective January 1, 2010
Appendix A Index

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>112</td>
</tr>
<tr>
<td>Eligible Dependents</td>
<td>113</td>
</tr>
<tr>
<td>When Benefits Begin</td>
<td>113</td>
</tr>
<tr>
<td>Electing Coverage</td>
<td>114</td>
</tr>
<tr>
<td>Declining Coverage</td>
<td>115</td>
</tr>
<tr>
<td>Retiree Coverage Options</td>
<td>115</td>
</tr>
<tr>
<td>Coverage before age 65</td>
<td>115</td>
</tr>
<tr>
<td>Coverage after Age 65</td>
<td>116</td>
</tr>
<tr>
<td>When Humana Group Medicare Plan Coverage Begins</td>
<td>116</td>
</tr>
<tr>
<td>Disqualification for Coverage due to Enrollment in Medicare Part D</td>
<td>117</td>
</tr>
<tr>
<td>Health Reimbursement Account Balances</td>
<td>117</td>
</tr>
<tr>
<td>Health Savings Account (HSA) Contributions</td>
<td>117</td>
</tr>
<tr>
<td>Enrolling in Medicare</td>
<td>117</td>
</tr>
<tr>
<td>Medicare Parts A, B</td>
<td>117</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>118</td>
</tr>
<tr>
<td>Paying for Coverage</td>
<td>120</td>
</tr>
<tr>
<td>Delinquent Payments</td>
<td>120</td>
</tr>
<tr>
<td>Changing your Payment Method</td>
<td>120</td>
</tr>
<tr>
<td>Annual Enrollment</td>
<td>120</td>
</tr>
<tr>
<td>Change in Status</td>
<td>121</td>
</tr>
<tr>
<td>When Coverage Ends</td>
<td>122</td>
</tr>
<tr>
<td>Amendment or Termination</td>
<td>122</td>
</tr>
</tbody>
</table>
Retired Employee Health Plan

This Appendix is a supplement to the preceding Summary Plan Description (SPD) and Plan document for the medical, prescription drug and mental health and substance abuse benefits available to you and your family as a retired employee of Rockwell Automation under the Rockwell Automation Employee Health Plan (the "Plan"). This Appendix is intended to provide information on eligibility criteria and coverage options, among other things. Except to the extent this Appendix provides otherwise, the SPD and plan document for the coverage option that you have selected more fully describes your benefits. No person will become entitled to any vested rights under the Plan, and nothing in the Plan or SPD or in this Appendix will be construed as creating any vested rights to Plan benefits.

Eligibility

You are eligible for retiree medical coverage if:

At the time of your termination you have 75 age-service points, at least 10 years of service with Rockwell Automation, and are at least age 55. One “point” is given for each of the following:

- Each year of your age.
- Each year of credited service under the Rockwell Automation Pension Plan, if you participate.
- If you are otherwise eligible for retiree medical benefits, but do not participate in the Rockwell Automation Pension Plan, you will receive one point for each year of employment with Rockwell Automation.
- Partial years are counted as 1/12 year for each calendar month. A calendar month is included for each calendar month prior to your termination, whether you work one day of that month or the entire month.

At the time of your termination you are on the U.S. payroll and are:

- A regular full-time or part-time employee of Rockwell Automation or one of its divisions or affiliates that participates in the Plan, or
- An expatriate who is paid from U.S. payroll and otherwise meet the requirements set forth above.

If you are paid from a foreign payroll, you are not eligible to participate in the Plan, even if you transferred from a position on the U.S. payroll and were previously eligible to participate.

You are not covered by benefits provided pursuant to a collective bargaining agreement with Rockwell Automation.
For employees from acquired companies, the company acquisition date is typically your Rockwell Automation date of hire for Retired Employee Health Plan eligibility unless the acquisition terms provide otherwise.

Employees of Rockwell Automation Puerto Rico hired after February 1, 2006, and employees of Weidmueller/W-Interconnection, Inc., Sprecher & Schuh, ICS TriPlex, are not eligible to participate in the Plan. Special eligibility rules may also apply to employees of acquired companies.

Only individuals who are classified by the Company as common law employees are eligible to participate in the Plan. This is true even if such individuals are later determined to be employees for any purpose. Individuals who are not classified as common law employees, and thus are not eligible to participate, include: members of Rockwell Automation's board of directors, leased employees, contract workers or individuals with other similar classifications.

**Eligible Dependents**

**Current Dependents**
Except as described below, if you are eligible for retiree coverage your dependents who are eligible for coverage at the time your employment terminates will also be eligible for coverage. Domestic partners, the child(ren) of a domestic partner, and dependents acquired after retirement are not eligible for coverage.

**Late Entrant Eligible Dependents**
If your dependent is eligible for, but not covered under, the Plan at the time your employment terminates because he or she has other group health plan coverage, and he or she later loses that coverage, your dependent may enroll in the Plan as long as you are enrolled for medical coverage and you notify the Company within 31 days after the loss of that dependent's coverage. At the time of dependent enrollment you must also provide proof of loss of coverage. If you wait beyond the 31 days, you can enroll at the next annual enrollment period (October – December).

**Change in Dependent Status**
If you divorce after retirement, your former spouse will lose eligibility for retiree medical benefits. COBRA continuation may be provided for up to 36 months.

If you remarry after retirement, your new spouse will not be not eligible for coverage under the Plan. Your newborn children are eligible for coverage only if both parents are covered under the Plan.

**When Benefits Begin**
If you meet the above eligibility requirements, you may commence retiree medical benefits as follows:

- The first of the month following your termination of employment; or
- The first of the month following termination of severance benefits, or
• The date you lose other group coverage, provided you apply for coverage within 31 days of such loss and show proof of loss of coverage, or

• January 1 following your election of benefits during an annual enrollment period, or

• In the case of post-Medicare coverage, the later of the date you become eligible for Medicare Parts A and B or the date your application is approved by the Plan.

• If you retire from a terminated status and had met eligibility requirements prior to termination, on the first of the month that coincides with the start of your retirement benefits.

Electing Coverage
Active employee medical and dental coverage ends at the end of the month in which your last workday occurs. For example, if November 15 is your last day of work, your coverage will end as of November 30. Retired employees are not eligible for dental or vision care benefits.

If you are eligible for the Plan and your employment ends, you will receive notification from the Rockwell Automation Service Center regarding your eligibility for the Retiree Medical Plan. If you do not want Retiree Medical Plan coverage at the time your employment ends, you must take action to decline coverage. Follow the instructions in your notification letter.

Important: Refer to “Declining Coverage” below for more information if you don’t enroll when you retire or if you enroll when you retire but later drop your coverage.

Severance
If you are eligible for retiree medical benefits at termination, and are also eligible to continue your employee medical coverage with an employer subsidy due to a severance agreement, you may delay the start of your retiree medical until the first of the month following the end of your severance period.

You must apply for retiree medical coverage before the end of your severance period so there is no gap in coverage after COBRA ends. However, if you are covered by another group medical plan you may postpone retiree medical coverage under this Plan until you lose other group medical plan coverage. You are not required to commence your pension benefits at the same time you begin retiree medical coverage.

COBRA
If you are not eligible for retiree medical benefits, or if you are eligible for retiree medical benefits and decide not to enroll in the plan, you may elect to continue your employee medical coverage under COBRA. You will receive COBRA enrollment materials in the mail. You need to decide if you want COBRA coverage, and if you do, you should enroll in the manner described in the enrollment packet. You should have your bank or other account information available to set up direct debit. Call your retirement specialist at 1.877.OUR.RASC (1.877.687.7272) or visit EmployeeConnect at http://employeeconnect.rockwellautomation.com for more information.
Declining Coverage
If your employment ends, but you do not elect to start receiving your retiree medical benefit, you will receive notification from the Rockwell Automation Service Center regarding your eligibility for retiree medical coverage. If you do not want coverage at the time your employment ends, you must take action to decline coverage. Follow the instructions in your notification letter.

If You Decline Medical Coverage
If you decline coverage under the Plan because you have coverage under another employer-sponsored group health plan, you will not be able to enroll in the Plan unless you can show loss of such other coverage. Coverage under another employer-sponsored group health plan includes coverage as an active employee, coverage as a dependent or coverage as a retiree. If you lose coverage mid-year, you may apply for coverage under the Plan option that you are eligible for within 31 days of losing your other coverage. If you wait beyond 31 days, you can enroll by contacting the Rockwell Automation Service Center during the next annual enrollment period (October – December).

Retiree Coverage Options

Retirement Options Available by Medicare-Eligibility Status
If you are under age 65 and not Medicare-eligible, your choices are:

- Preferred Provider Organization Plan (PPO)
- Consumer-Directed Plan (CDP)
- High-Deductible Plan (HDP)

If you are age 65 or older, or Medicare-eligible, your only option is:
- Humana Group Medicare Plan

HMOs are not offered to retirees

Coverage before age 65
If you are younger than age 65 when you retire and not Medicare eligible due to permanent disability, your Rockwell Automation plan will remain your primary plan until you reach age 65 or become eligible for Medicare.

Available Options
As a retiree or dependent not yet eligible for Medicare, you can choose from the following options:

- Preferred Provider Organization Plan (PPO)
- Consumer-Directed Plan (CDP)
- High-Deductible Plan (HDP)
You have the opportunity each year during annual enrollment to change your retiree medical election.

**Preferred Provider Organization Plan (PPO)**

**Deductible, Coinsurance and Out-of-Pocket Maximum**

The PPO deductible and out-of-pocket maximum for retirees is as follows. Please note that the PPO plan offers only “You Only” and “Family” coverage tiers to retirees:

<table>
<thead>
<tr>
<th></th>
<th>You Only</th>
<th>You + Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$350</td>
<td>$1,050</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$1,400</td>
<td>$2,700</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket</strong></td>
<td>$1,750</td>
<td>$3,750</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The out-of-pocket maximum is the sum of the deductible and the coinsurance maximum.

Deductible, Coinsurance and Out-of-Pocket Maximum provisions for the CDP and HDP plans are described in the Summary Plan Descriptions for those options.

**Coverage after Age 65**

If you or your dependent has reached Medicare eligibility due to age or disability, you can choose coverage under the Humana Group Medicare Plan option. (The pre-Medicare spouse or retiree, if applicable, remains covered under the option described above.) This plan works in conjunction with Medicare. **This is the only coverage option available to Medicare-eligible retirees and Medicare-eligible dependents.** To be eligible for the Humana Group Medicare Plan option, you must be enrolled in Medicare Parts A and B, but not enrolled in a private Medicare Part D drug plan. You also will be required to complete a Humana Group Medicare Plan application. The specifics of the benefits under the Humana Group Medicare Plan option are found in the Certificate of Coverage for that option.

**Notification of Humana Group Medicare Plan Eligibility**

When you, or your dependent, become eligible for the Humana Group Medicare Plan, you will receive an application form from the Rockwell Automation Service Center. This form is usually sent 30 to 60 days before you become age 65. Complete and return the application form to the RASC by the due date on your notice. Once your completed application form is received, Humana will file the required paperwork with the Centers for Medicare and Medicaid Services (CMS).

If your application is denied for any reason, Humana will reach out to you for the additional needed information. If you do not hear back from Humana, your application is being processed as expected, and you will receive a statement from the Rockwell Automation Service Center that will confirm your enrollment.

**When Humana Group Medicare Plan Coverage Begins**

Coverage generally begins the first of the month in which you and/or your spouse turn 65 provided you have returned a signed Humana Group Medicare Plan application before that date. Pursuant to CMS rules, coverage cannot begin before the date you sign and return your application.
Disqualification for Coverage due to Enrollment in Medicare Part D
If you enroll in another private Medicare Part D plan, your Rockwell Automation Humana Group Medicare Plan coverage will be cancelled for you and your eligible spouse for the remainder of the plan year.

Health Reimbursement Account Balances
When you attain Medicare eligibility, you are no longer eligible for the Consumer-Directed Plan with Health Reimbursement Account (HRA). If your dependent remains covered by the CDP plan, any HRA balance is available for his or her expenses. If participation for you and your dependents ends for any reason, any balance in your HRA will be forfeited back to Rockwell Automation.

Health Savings Account (HSA) Contributions
When you attain Medicare eligibility, you are no longer eligible for the High-Deductible Plan and you will no longer be eligible to contribute to an HSA. However, you will be able to access your HSA account balance. Expenses are deemed eligible according to the rules set by the Internal Revenue Service (IRS). For information on eligible expenses, go to www.irs.gov and search “Medical Expenses” or “Publication 502.”

Enrolling in Medicare

Medicare Parts A, B
You are automatically enrolled in Medicare Part A (at age 65) when you sign up for Social Security benefits, unless you elect otherwise. Part A covers hospital stays, care in skilled nursing facilities, home health care, hospice care, and blood transfusions. Everyone who’s eligible for Medicare gets Part A. There is no charge for it.

You may also sign up for Medicare Part B at the same time you enroll in Medicare Part A. Part B covers doctors’ services, outpatient hospital care, and some medical supplies and equipment. It also covers some services that Part A doesn’t cover, such as certain physical and occupational therapy and home health care services. Part B has a monthly premium that’s deducted from your monthly Social Security benefits.

You need to enroll in Part B three months before you reach age 65. If you wait, you may have to pay a premium penalty. You can delay enrolling in Part B and not pay a premium penalty if you continue active employment after you reach age 65. If you delay Part B enrollment due to working beyond age 65, you may need a Social Security form completed by the Rockwell Automation Service Center when you stop working. Contact your local Social Security office for the applicable form.

Important: The Rockwell Automation Humana Group Medicare Plan requires you to enroll in Medicare Part A and Part B. For more information, visit www.socialsecurity.gov or call 1.800.772.1213. For information about Medicare, visit www.medicare.gov or call 1.800.MEDICARE (1.800.633.4227). If you do not enroll, you will not be eligible for coverage after age 65.
**Disabled Employees and Dependents**
**Medicare Entitlement Based on Disability**
After you or your dependent has been entitled to Social Security disability benefits for 24 months, or if you or a your dependent has end-stage renal disease (kidney failure), Medicare benefits become available.

**Individuals with End-Stage Renal Disease**
If you or your dependent becomes eligible for Medicare due to end-stage renal disease, benefits for Covered Expenses are payable under this Plan during the first 30 months. The 30 months begin when you or your dependent is first eligible to enroll in Medicare. After that, and immediately upon Medicare eligibility for other disabled dependents, Medicare is primary and this Plan is secondary.

**Medicare Part D**
You do not need to enroll in Medicare Part D if you enroll in the Humana Group Medicare Plan. Part D covers prescription drugs. Prescription drug coverage is part of the Humana Group Medicare Plan.

Rockwell Automation’s prescription drug coverage has been certified to be comparable to or better than Medicare Part D drug coverage. As a result, you do not need to enroll in Medicare Part D. You cannot have both Medicare Part D coverage and Rockwell Automation prescription drug coverage. If you enroll in Medicare Part D coverage, you will not be eligible for medical or prescription coverage from Rockwell Automation.

**Company Contribution**
The following table represents the company contributions to the coverage cost for retirees eligible for this benefit. Your cost for retiree coverage under the Plan depends on your Rockwell Automation date of hire and the coverage selected.

If your most recent Rockwell Automation hire date is after December 31, 2004, you pay the full cost of retiree coverage. However, if you were previously employed by Rockwell Automation and qualified for company contributions for retiree medical benefits at termination, that company contribution may commence upon re-enrollment in retiree medical coverage (see “Electing Coverage” for additional information). Service due to your rehire after December 31, 2004 will not increase the amount of your company contribution.

If you were hired on or before December 31, 2004, Rockwell Automation pays a capped contribution/ fixed dollar amount, depending on your years of service at retirement and the coverage selected. You pay the cost of coverage above the Rockwell Automation capped contribution. For employees from acquired companies your acquisition date is your Rockwell Automation date of hire.

If you were hired on or before December 31, 2004, the following chart outlines Rockwell Automation’s portion of your cost. You pay the difference between the Company capped contribution and the total cost. Thus, you pay the full amount of any future cost increases that exceed the capped contribution.
Employer Contributions

Under Age 65 - Rockwell Automation Monthly Contributions

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>You Only</th>
<th>Spouse Only</th>
<th>You &amp; Spouse</th>
<th>You &amp; Child(ren)</th>
<th>Spouse &amp; Child(ren)</th>
<th>You, Spouse &amp; Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 or more</td>
<td>$564.76</td>
<td>$564.76</td>
<td>$1,129.52</td>
<td>$751.13</td>
<td>$751.13</td>
<td>$1,315.89</td>
</tr>
<tr>
<td>20 to 24</td>
<td>$557.02</td>
<td>$557.02</td>
<td>$1,114.04</td>
<td>$740.84</td>
<td>$740.84</td>
<td>$1,297.86</td>
</tr>
<tr>
<td>15 to 19</td>
<td>$518.00</td>
<td>$518.00</td>
<td>$1,036.00</td>
<td>$688.94</td>
<td>$688.94</td>
<td>$1,206.94</td>
</tr>
<tr>
<td>10 to 14</td>
<td>$479.08</td>
<td>$479.08</td>
<td>$958.16</td>
<td>$637.18</td>
<td>$637.18</td>
<td>$1,116.26</td>
</tr>
</tbody>
</table>

Age 65 and Over - Rockwell Automation Monthly Contributions

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>You Only</th>
<th>Spouse Only</th>
<th>You &amp; Spouse</th>
<th>You &amp; Child(ren)</th>
<th>Spouse &amp; Child(ren)</th>
<th>You, Spouse &amp; Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 or more</td>
<td>$75.00</td>
<td>$75.00</td>
<td>$150.00</td>
<td>$150.00</td>
<td>$225.00</td>
<td>$300.00</td>
</tr>
<tr>
<td>20 to 24</td>
<td>$73.16</td>
<td>$73.16</td>
<td>$146.32</td>
<td>$146.32</td>
<td>$219.48</td>
<td>$292.64</td>
</tr>
<tr>
<td>15 to 19</td>
<td>$63.75</td>
<td>$63.75</td>
<td>$127.50</td>
<td>$127.50</td>
<td>$191.25</td>
<td>$255.00</td>
</tr>
<tr>
<td>10 to 14</td>
<td>$54.39</td>
<td>$54.39</td>
<td>$108.78</td>
<td>$108.78</td>
<td>$163.17</td>
<td>$217.56</td>
</tr>
</tbody>
</table>

Your monthly contribution will be subject to annual adjustments, based on the cost of health care coverage to the Company.

Your Cost
Your cost for Retiree Medical will depend on your service with Rockwell Automation and the plan options in effect at the time of your retirement and thereafter. Actual costs will be provided to you at the time you initiate retirement. However, you can call the Rockwell Automation Service Center at any time to find out what the current rates are for retirees.

Health Management Program and Incentive
Retired employees are not eligible to participate in the Health Management program and do not receive the Health Management Incentive. Any credit you receive as an active employee ends when you become a participant in a retiree medical plan.

Working Spouse Adjustment
Retired employees are not subject to the working spouse adjustment. If you cover a spouse who has access to coverage through his or her own employer, at the same time you elect Retiree medical coverage for both yourself and your spouse, you will not be subjected to a Working Spouse Adjustment. If your current premium cost is increased by a Working Spouse Adjustment, the Adjustment will end when you become a participant in a Retiree medical plan.

Coverage Tiers
Your cost for coverage and the amount of the Rockwell Automation capped contribution varies depending on your coverage tier. Your coverage tier reflects the number of people that you enroll in the Plan. For example, if you elect CDP coverage for yourself and your spouse, you are enrolled in
the “You & Spouse” coverage tier for the CDP plan. On the other hand, if you are over age 65 and select the Humana Group Medicare plan, while your spouse is under 65 and selects the CDP plan, you will have “You Only” coverage in Humana Group Medicare and your spouse will have “Spouse Only” coverage in the CDP plan.

In the PPO Plan, the coverage tier also determines your annual deductible and out-of-pocket amounts. Please note that the PPO plan offers only “You Only” and “Family” coverage tiers to retirees.

**Paying for Coverage**
You have the choice to pay for your coverage through a variety of payment methods:

- **Pension Check Deduction.** If your pension check will cover your monthly deductions you may elect this option. Your contribution will be deducted after tax. Contact the Rockwell Automation Service Center at 1.877.OUR.RASC (1.877.687.7272) to sign up to be directly billed for coverage.

- **Direct Bill with Automatic Debit.** If you sign up to pay for your coverage through a direct bill method you can elect to have your checking, savings, or investment account debited on a monthly basis. You will receive a bill around the fifteenth of each month for your coverage for the next month.

- **Direct Bill.** If you sign up to be direct billed for coverage, your payment is due on the first of each of each month. A thirty day grace period applies.

- **Default Option.** If at the time of retirement, you do not specify your payment method, you will pay the amount you owe for your coverage through monthly after-tax deductions from your pension check, if possible. If your pension check is not large enough to cover the entire amount that you owe, you will be billed for the entire amount and no deduction will be taken from your pension check.

**Delinquent Payments**
If you or your dependent should discontinue any required contributions (pension check deduction, direct bill with automatic debit or direct bill), the coverage for which such contribution is required will cancel as of the expiration of the period for which the last contribution was made.

**Changing your Payment Method**
You may change your payment method at any time. Contact the Rockwell Automation Service Center at 1.877.OUR.RASC (1.877.687.7272) to update your payment election. The time to implement the election change depends on when the request is received in relation to the billing cycle.

**Changing Your Enrollment**
**Annual Enrollment**
Each year you will have the opportunity to change coverage for yourself and any eligible dependents to any available option during the Annual Enrollment. Annual Enrollment generally takes place in October or November with a January 1 effective date.

If you need to make a change to covered dependents (as outlined in the Dependent Eligibility section), you may contact the Rockwell Automation Service Center during annual enrollment (October – December) to adjust your coverage.
Before your revised contributions go into effect, you will receive a confirmation of enrollment statement from the Rockwell Automation Service Center that reflects your coverage and the new rates.

**Change in Status**
If you have a change in status, you may make mid-year changes to your coverage that are consistent with your status change. Changes must be reported to the Rockwell Automation Service Center within 31 days of your change in status.

You may elect to discontinue coverage at anytime by contacting the Rockwell Automation Service Center. You may re-enroll in Rockwell Automation coverage only if proof of loss of other coverage is provided within 31 days, or you can re-enroll during a future annual enrollment period (October – December) by contacting the Rockwell Automation Service Center.

**Permanent Change in address**
**Under 65**
The CDP and PPO plan may be administered by one of several vendors depending on where an employee or retiree lives. The HDP is administered by the same vendor regardless of home address. If you move out of your current health provider’s service area, you will lose eligibility for that option, and will have the opportunity to select a different plan option. A change in address is treated as a Qualified Change in Status which allows you to make a mid-year change in coverage. You must provide notification within 31 days of your move. To report your change in address visit the Your Benefits tab on the EmployeeConnect Web site or call the Rockwell Automation Service Center at 1.877.OUR.RASC (1.877.687.7272).

**Temporary Address Changes**
Contact your vendor at the number on the back of your ID card to update your record and to learn more about your network options.

**Over age 65**
Humana Group Medicare Plan members may obtain care from any certified provider in the U.S. who is willing to accept Humana Group Medicare Plan terms and conditions of payment, whether or not these providers are located in the geographic service area and whether or not these providers directly contract with the Humana Group Medicare Plan.

Keep your membership record up-to-date by calling Humana Customer Service at the number on the back of your ID card right away. Changes include: name change, address, phone number or if you go into a nursing home.
When Coverage Ends
Coverage under the Plan ends in the following circumstances.

- **Re-employment.** If you are re-employed by Rockwell Automation as an employee, you will then receive medical benefits as an active employee.

- **Your death.** The remaining coverage for your spouse following your death depends on how long you had been retired at the time of your death. If you die prior to being retired for 10 years, your spouse will continue to have coverage for the remainder of the 10 years. If you die after being retired for 10 years or more, your spouse will continue to have coverage until other coverage is obtained but to a maximum of 6 months.

  Your surviving spouse must be enrolled in the Plan at the time of your death in order to continue medical coverage. Dependents of your surviving spouse must also be enrolled at the time of your death in order to be eligible to continue coverage. If your surviving spouse remarries, his or her new spouse is not eligible for coverage under the Plan. Coverage for a surviving spouse and dependent children will end as described above or on the date the surviving spouse dies, if earlier.

**General Provisions.**
- If the Plan is discontinued, all coverage would then cancel.
- If your or your surviving spouse should discontinue any required contributions, coverage will cancel as of the expiration of the period for which the last contribution was made.
- Dependent coverage will end for a covered dependent when the dependent is no longer eligible under the terms of the Plan.

**Amendment or Termination**
Rockwell Automation fully intends to maintain the Plan indefinitely. However, Rockwell Automation reserves the right to terminate, suspend or amend this Plan with respect to any or all employees or retirees at any time and for any reason without prior notice to or consent of any participant or of any person entitled to receive payment of benefits under the Plan. The Company will establish the effective date of the amendment, modification, change or termination of the Plan.

No person will become entitled to any vested rights under the Plan, and nothing in the Plan or SPD or in this Appendix will be construed as creating any vested rights to Plan benefits.