February 1, 2008

CA North & South—Kaiser Foundation Health Plan

MMC

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CA North & South—Kaiser Foundation Health Plan

A Health Maintenance Organization (HMO) Plan offers comprehensive health services from participating health care providers. Generally, your care is fully covered after you pay a set COPAYMENT *per visit. You select a* PRIMARY CARE PHYSICIAN *(PCP) who will manage your care and refer you to a specialist or other provider in the network if necessary. Except in an emergency, you do not receive benefits if you receive care outside the network.*

SPD and Plan Document

This section provides a summary of the CA North & South—Kaiser Foundation Health Plan Health Maintenance Organization Plan (the "Plan") as of February 1, 2008.

This section, together with the *Administrative Information* section and the applicable section about participation, forms the Summary Plan Description and plan document of the Plan.

A Note about ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that governs many employer-sponsored plans including this one. Your ERISA rights in connection with this Plan are detailed in the *Administrative Information* section.

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The Plan at a Glance

This Plan helps you and your family pay for medical care. You may pay a COPAYMENT and obtain preauthorization for certain services. The chart below contains some important Plan features and coverage amounts. For more information, see the “Detailed List of Covered Services” on page 10.

Plan feature	Coverage amount
Deductible	Employee: None Family members: None
Out-of-pocket maximum	Employee: $1,500 Family members: $3,000
Copayments	Physician office visits: $25 Emergency Room: $75 waived if admitted to Hospital Out-Patient surgery/procedure: $100 Hospital stay: $250 per admission
Hospital stay	Plan pays 100% after the $250 copayment per admission; preauthorization is required
Retail prescription drugs	You must use a pharmacy in the network ***Generic:*** Plan pays 100% after the $10 copayment for up to a 30 day supply ***Brand-Name:*** Plan pays 100% after the $30 copayment for up to a 30 day supply. Out-of-Network: Not covered
Mail-order prescription drugs	***Generic:*** Plan pays 100% after the $20 copayment for up to a 100 day supply ***Brand-Name:*** Plan pays 100% after the $60 copayment for up to a 100 day supply. Out-of-Network: Not covered
Lifetime maximum	None
Contact Information	Contact for Medical Service and Prescription Drug Coverage: Kaiser Permanente (Claims Administrator and Pharmacy Benefit Manager) Phone: (800) 464 4000 Website: http://www.kaiserpermanente.org MMC does not administer this Plan. Kaiser Permanente’s decisions are final and binding.

Participating in the Plan

You are eligible to participate in the Plan if you meet the eligibility requirements described in the *Participating in Healthcare Benefits* section.

You have the option to cover your family members who meet the eligibility requirements that are described in the *Participating in Healthcare Benefits* section.

Eligibility for this Plan is also based on your resident zip code.

Retiree Eligibility

Certain retirees who are not yet eligible for Medicare may also be eligible for coverage under this plan. For information on the eligibility requirements, how to participate and the cost of coverage, see the Pre-65 Retiree Medical Participation section.

Enrollment

To participate in this plan, you must enroll for coverage. You may enroll only:

- within 30 days of the date you become eligible to participate
- during Annual Enrollment
- within 30 days of a qualifying change in family status that makes you eligible to enroll
- within 30 days of losing other coverage that you had relied upon when you waived your opportunity to enroll in this plan.

Enrollment procedures for you and your eligible family members are described in the *Participating in Healthcare Benefits* section.

Cost of Coverage

You and the Company share the cost of coverage for both you and your eligible family members.

The cost of your coverage depends on the level of coverage you choose.

You can choose from three levels of coverage. Cost for each coverage level for ELIGIBLE MMC EMPLOYEES (OTHER THAN KROLL) is shown below.

	Semi-monthly Cost	Weekly Cost
Employee Only	$50.97	$23.52
Employee + one	$107.05	$49.41
Family	$152.92	$70.58

Important Note for Kroll Employees: Employee contribution rates were provided to Kroll employees in their enrollment guide and are currently available on KrollNet. Questions about employee contributions can also be directed to the MMC Employee Service Center at 1-866-374-2662."

See the *Participating in Healthcare Benefits* section for more information on the cost of your coverage, such as information about taxes.

Imputed Income for Domestic Partner Coverage

If you cover your domestic partner or your domestic partner's children, there may be imputed income for the value of the coverage for those family members. See the *Participating in Healthcare Benefits* section for more information on imputed income for domestic partner coverage.

Section 152 Dependents

If your domestic partner (or his or her child(ren)) qualifies as a dependent under IRS Section 152, imputed income does not apply.

The table below shows the imputed income amounts:

Imputed Income for Domestic Partner Coverage CA North & South—Kaiser Foundation Health Plan

	Semi-monthly	Weekly
Employee + one	$112.55	$51.95
Family (you and two or more eligible family members)	$235.31	$108.60

ID Cards

You will be sent your ID card(s) within two to four weeks of your enrollment.

You may request additional ID cards directly from the Claims Administrator.

How the Plan Works

This Plan helps you and your family pay for medical care. You may pay a COPAYMENT and obtain preauthorization for certain services. Generally, your care is fully covered after you pay a set copayment per visit. You select a PRIMARY CARE PHYSICIAN (PCP) who will manage your care and refer you to a specialist or other provider in the network if necessary. Except in an emergency, you do not receive benefits if you receive care outside the network.

For more information, see the "Detailed List of Covered Services" on page 10.

Certain expenses not covered by the Plan, such as copayments and services that are not covered, may be reimbursed through a Health Care Flexible Spending Account.

Some services have specific limits or restrictions; see individual service for more information.

Benefits are only paid for medically necessary charges or for specified wellness care expenses.

Preauthorization may be required in order to receive coverage for certain services.

Out-of-Pocket Maximums

What is the annual out-of-pocket maximum (limit) for an individual?

The annual out-of-pocket limit for one person is $1,500 per calendar year.

What is the annual out-of-pocket maximum (limit) for family members?

The annual family out-of-pocket limit is $3,000 per calendar year.

Networks

Is there a network of doctors and hospitals that I have to use?

In order to receive benefits you must use a network provider. Except in an emergency, you are covered only when you are treated by providers in the network.

The network includes general practitioners, as well as specialists and hospitals. These network providers are selected by and contracted with the Claims Administrator.

Where can I get a directory that lists all the doctors and hospitals in the network?

The doctors and hospitals in the network are listed in a provider directory. The Claims Administrator provides an online directory of providers on their website. You may also call the Claims Administrator.

It is the member's responsibility to confirm their provider's participating status when calling for an appointment and prior to receiving services.

Is there a separate network of providers for mental health treatment?

There is a network of mental health providers. Providers in the network are listed in a provider directory. The Claims Administrator provides an online directory of providers on its website. You may also call the Claims Administrator.

You receive benefits only when you are treated by providers in the network. Please contact the Claims Administrator to be connected with a behavioral specialist.

Is there a special network of pharmacies?

There is a pharmacy network associated with this Plan. You receive benefits only when you have your prescription filled at a network pharmacy.

The Claims Administrator provides an online directory of pharmacies in the network on its website.

Your Primary Care Physician

A primary care physician is a doctor you choose to manage all of your health care. Your primary care physician provides preventive and routine care office visits and diagnoses, and refers you to specialists and hospitals as needed.

A primary care physician is your family practitioner, general practitioner, gynecologist, internal medicine doctor, obstetrician/gynecologist and pediatrician.

Specialists include, but are not limited to, allergists, cardiologists, dermatologists, neurologists, orthopedists, otolaryngologists, psychologists, podiatrists, surgeons and chiropractors.

What is the role of the primary care physician?

To receive benefits, you have to receive care from doctors in the network. Your primary care physician will provide checkups, diagnoses and treatment, and will refer you to hospitals and specialists as needed.

How do I choose a primary care physician?

After you enroll, you will be sent a 'Welcome New Member' packet which will provide instruction on how to select your physician.

How do I change a primary care physician?

You change your primary care physician by choosing a new doctor from the list in the provider directory and by notifying the HMO directly.

Can each member of my family go to a different primary care physician?

Yes, each family member can have his or her own primary care physician.

How do I get a specialist referral?

Except for routine gynecological exams, behavioral health, and emergencies, your primary care physician has to refer you to a network specialist for you to receive benefits under the Plan.

For mental health, alcohol or drug treatment, you have to contact the Claims Administrator before receiving treatment.

Utilization Review

Which utilization review services are offered?

The Plan offers preauthorization review.

You may obtain more information about these review services by calling the Claims Administrator.

What is preauthorization?

Preauthorization is a utilization review service performed by licensed healthcare professionals. The intent is to determine medical necessity and appropriateness of proposed treatment, level of care assessment, benefits and eligibility and appropriate treatment setting.

What services require preauthorization?

Refer to the Kaiser HMO's certificate of coverage for services and procedures requiring preauthorization.

If you have an emergency hospital admission, surgery or specified procedure, you, a family member, your physician or the hospital must precertify within 48 hours of service.

When to obtain preauthorization

You, your family member or health care professional must obtain preauthorization as soon as you know you need a service requiring preauthorization. Refer to the Kaiser HMO's certificate of coverage for additional information.

Note: You are responsible for ensuring your service has been preauthorized.

How to obtain preauthorization

Initiate the preauthorization process by calling the Claims Administrator.

What's Covered

Pre-existing Conditions

There are no exclusions, limitations or waiting periods for pre-existing conditions for you or any covered family members.

Office Visits

Does the Plan cover office visits?

The Plan covers office visits at 100% after the $25 COPAYMENT.

Preventive/Wellness Care

Does the Plan cover routine examinations?

The Plan covers routine examinations at 100% after the $25 copayment.

Are immunizations for business travel covered under the Plan?

The Plan does not cover immunizations for business travel except when a plan physician determines they are medically indicated due to a probable risk of exposure (e.g. foreign travel, occupation).

Maternity

Who is eligible for maternity coverage?

Maternity coverage is available to eligible covered female participants.

Do I need to have my maternity coverage preauthorized?

You do not need a preauthorization for visits to a participating obstetrician. However, you are responsible for obtaining preauthorization from the Claims Administrator after your first visit and for verifying that the necessary approval has been obtained before admission to the hospital.

You must obtain preauthorization if the mother or her newborn stay in the hospital longer than 48 hours after a vaginal delivery or 96 hours after a Cesarean birth. This notification must occur within 24 hours of the determination to extend the stay.

Does the Plan cover prenatal visits?

The Plan covers prenatal visits 100% after the $25 COPAYMENT for the initial obstetrics visit. There is no copayment for subsequent visits.

What will the Plan pay for hospital charges for the mother and the baby?

The Plan covers INPATIENT maternity stays at 100% after the $250 hospital copayment.

A child is covered at birth as long as the baby meets the child eligibility requirements and is enrolled within 60 days of the birth.

The mother and the newly born child are covered for a minimum of 48 hours of care following a vaginal delivery and 96 hours following a Cesarean section. However, the mother's provider may - after consulting with the mother - discharge the mother earlier than 48 hours following a vaginal delivery (96 hours following a Cesarean delivery).

Does the Plan cover midwife services?

The Plan covers midwives at 100% after the $250 hospital.

If my dependent child has a baby does the Plan cover the newborn child?

Unless the newborn meets the definition of an eligible child and is covered under the Plan, medical care for the newborn, whether in or out of the hospital, is not covered.

Inpatient Hospital and Physician Services

What will the Plan pay if I have to go to the hospital?

The Plan pays inpatient hospital charges at 100% after the $250 hospital COPAYMENT per admission.

What approvals do I need if I am going into the hospital?

All non-emergency hospital stays require preauthorization by your PRIMARY CARE PHYSICIAN. Your primary care physician or the PARTICIPATING SPECIALIST referred by your primary care physician coordinates this process with the Plan.

Does the Plan cover hospital visits by a physician?

While you are in the hospital, the Plan covers hospital visits by a physician at 100% after a $250 hospital copayment.

Does the Plan cover ambulance charges?

The Plan covers ambulance charges that are medically necessary in an emergency to transport you to the nearest hospital at 100% with no copayment.

Does the Plan cover hospice care?

The Plan covers charges for hospice care at 100% with no copayment. Preauthorization is required.

Prescription Drugs

Does the Plan cover brand-name prescription drugs?

If you use a pharmacy in the network, the Plan covers brand-name prescription drugs at 100% after the $30 COPAYMENT for up to a 30 day supply.

Does the Plan cover generic drugs?

If you use a pharmacy in the network, the Plan covers generic prescription drugs at 100% after the $10 copayment for up to a 30 day supply.

What happens if I buy a brand-name prescription drug when a generic drug is available?

If you or your physician requests the brand-name prescription drug when a generic prescription drug is available, you pay a brand-name copayment and the cost difference between the generic and the brand name drug.

Is there a mail-order program?

Yes. Plan pays 100% after the $20 copayment for generic drugs and the $60 copayment for brand-name drugs for up to a 100 day supply

Is there a special network of pharmacies?

There is a pharmacy network associated with this Plan. You receive benefits only when you have your prescription filled at a network pharmacy.

The Claims Administrator provides an online directory of pharmacies in the network on its website.

Emergency Room

Does the Plan cover emergencies?

The Plan covers emergency care in a hospital emergency room at 100% regardless of which hospital you use, whether you have approval from your PRIMARY CARE PHYSICIAN, or whether the hospital is in-network or out-of-network. The Plan also covers emergencies sustained out of the United States.

Emergency room visits are subject to a $75 COPAYMENT (waived if admitted within 24 hours). You must notify the Plan first, if possible. If not, notify your primary care physician as soon as reasonably possible.

Non-emergency services in a hospital emergency room are not covered.

What are some examples of emergency medical conditions?

Some examples of emergency medical conditions are:

- A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the member could reasonably expect the absence of immediate medical attention to result in any of the following: serious jeopardy to the member's health
  - serious impairment to the member's bodily functions
  - serious dysfunction of any bodily organ or part
  - "Active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child

Mental Health

Does the Plan cover inpatient hospitalization for mental health treatment?

The Plan covers expenses for treatment of mental health conditions in a hospital or mental health facility at 100% after the $250 hospital COPAYMENT per admission for up to 30 days per calendar year per year. There is no LIFETIME MAXIMUM benefit. Preauthorization is required.

There is no annual limit for members with a mental health parity diagnosis.

Does the Plan cover outpatient mental health treatment?

The Plan covers outpatient visits for treatment of mental health conditions at 100% after the $25 copayment per visit.

There is a maximum benefit of 40 visits per calendar year for outpatient mental health benefits.

There is no annual limit for members with a mental health parity diagnosis.

How do I get a referral for mental health or alcohol and substance abuse treatment?

You don't need a referral for mental health or alcohol and substance abuse treatment.

Detailed List of Covered Services

The Plan covers medically necessary covered services and supplies for the diagnosis and treatment for an illness or injury. The Claims Administrator determines whether the service or supply is covered. Click on covered service for a description of the covered services, including age and/or other limitations.

Most services and supplies are subject to a COPAYMENT.

You will only receive coverage if you use an in-network provider. Some services require you to obtain preauthorization from the Claims Administrator.

Benefit	Coverage
Alcohol and substance abuse	***Inpatient:*** Detoxification: Plan pays 100% after the $250 hospital copayment per admission and no annual limits or maximum benefits; preauthorization is required Rehabilitation: Plan pays 100% after the $100 copayment and a maximum benefit of 60 days per calendar year, with no more than 120 days in any consecutive 5 calendar year period as long as care is provided in a Transitional Residential Recovery Service (TRRS) ***Outpatient:*** Detoxification: Plan pays 100% after the $25 copayment with no limits or maximum benefits; preauthorization is required Rehabilitation: Plan pays 100% after the $25 copayment for individual visits and the $5 copayment for group visits with no visit limits; preauthorization is required
Allergy tests	Plan pays 100% after the $25 copayment
Allergy treatment	Plan pays 100% after the $25 copayment
Ambulance charges	Plan pays 100% with no copayment for medically necessary emergencies
Artificial insemination	Plan pays 50% of the cost with no copayment (limitations/exclusions apply); preauthorization is required
Chiropractors	Plan pays 100% after the $25 copayment for up to 20 visits per calendar year
Contraceptive devices	Plan pays 100% after the $25 copayment (for the fitting)
Doctor delivery charge for newborns	Plan pays 100% with no copayment
Durable medical equipment	Plan pays 100% with no copayment if prescribed by a physician; precertification is required
Emergency room	Plan pays 100% after the $75(waived if admitted within 24 hours) for an emergency medical condition
Gynecology visits	Plan pays 100% after the $25 copayment The Plan covers routine exams
Hearing care	Plan pays 100% after the $25 copayment
Home health care	Plan pays 100% with no copayment for up to 100 visits per calendar year; preauthorization is required
Hospice care	Plan pays 100% with no copayment; preauthorization is required
Immunizations	Plan pays 100% after the $25 copayment
In-vitro fertilization	In-vitro fertilization is not covered
Inpatient hospital services	Plan pays 100% after the $250 hospital copayment; preauthorization is required
Inpatient physician services	Plan pays 100% after the $250 hospital copayment
Laboratory charges	Plan pays 100% with no copayment

Benefit	Coverage
Mail-order prescription drugs	Plan pays 100% after the $20 copayment for generic drugs and the $60 copayment for brand-name drugs for up to a 100 day supply
Mammograms	Plan pays 100% with no copayment
Mastectomy - reconstructive surgery	Inpatient: Plan pays 100% after $250 hospital copayment Outpatient: Plan pays 100% after $100 copayment
Maternity hospital stay	Plan pays 100% after the $250 hospital copayment
Mental health	There is a separate network for mental health treatment providers ***Inpatient:*** Plan covers inpatient treatment at 100% after the $250 hospital copayment per admission and a maximum benefit of 30 days per calendar year* with no maximum lifetime benefit; preauthorization is required ***Outpatient:*** Plan covers outpatient treatment at 100% after the $25 copayment per visit with a maximum benefit of 40 visits per calendar year*; preauthorization is required *There is no annual limit for members with a mental health parity diagnosis
Occupational therapy	Plan pays 100% after the $25 copayment per visit with no maximum lifetime benefit
Outpatient physician services	Plan pays 100% after the $25 copayment
Pap smears	Plan pays 100% after the $25 copayment
Physical exams for adults	Plan pays 100% after the $25 copayment
Physical exams for children	Plan pays 100% after the ($0 for children up to 24 months of age) copayment
Physical therapy	Plan pays 100% after the $25 copayment per visit
Pregnancy termination	Plan pays 100% after the $250 hospital copayment or the $30 copayment if performed in a physician's office
Prenatal visits	Plan pays 100% after the $25 copayment for the initial obstetrics visit. There is no copayment for subsequent visits
Preventive/Wellness care	Plan pays 100% after the $25 copayment
Retail prescription drugs	***Generic:*** Plan pays 100% after the $10 copayment for up to a 30 day supply **Brand Name:** Plan pays 100% after the $30 copayment for up to a 30 day supply.
Skilled nursing facility	Plan pays 100% with no copayment for up to 100 days per benefit period
Speech therapy	Plan pays 100% after the $25 copayment per visit

Benefit	Coverage
Surgery	**Inpatient:** Plan pays 100% after the $250 hospital copayment **Outpatient:** Plan pays 100% after the $100 copayment
Tubal ligation	**Inpatient:** Plan pays 100% after the $250 hospital copayment **Outpatient:** Plan pays 100% after the $100 copayment
Urgent services (non-emergency room)	Plan pays 100% after the $25 (facility) copayment
Vasectomy	**Inpatient:** Plan pays 100% after the $250 hospital copayment **Outpatient:** Plan pays 100% after the $100 copayment
X-rays	Plan pays 100% with no copayment

Filing a Claim

If you use an in-network provider, in almost all cases, you do not have to file a claim form. Nearly all routine services require you to provide an ID card for services and a COPAYMENT for some services. The providers will file a claim directly with the Claims Administrator. You will rarely need to file a claim with an HMO (one exception may be approved emergency care obtained out-of-network). In the very rare cases that you might need to file a claim, contact the Claims Administrator.

If you receive services from a provider who does not participate in the network, those services will not be covered. Out-of network benefits are not covered under the HMO Plan except in an emergency.

For Flexible Spending Account Reimbursement

If you participate in the Health Care Flexible Spending Account, you must complete a Flexible Spending Account (FSA) Claim Form and return it as the form instructs for reimbursement.

Appealing a Claim

There are special rules, procedures and deadlines that apply to appeals of benefit determinations and denied claims and you have special legal rights under ERISA. Please refer to the *Administrative Information* section for a description of the appeal process.

Glossary

ACTIVE WORK STATUS

You must be actively-at-work during your approved scheduled work week and not on any type of leave.

ACTIVELY AT WORK

You are "actively at work" if you are fulfilling your job responsibilities at a Company-approved location on the day coverage is supposed to begin (e.g., you are not out ill or on a leave of absence).

AFTER-TAX (POST-TAX) CONTRIBUTIONS

Contributions taken from your paycheck after taxes are withheld.

APPROVED SPOUSE AND DOMESTIC PARTNER

Adding a spouse or same gender or opposite gender domestic partner to certain benefits coverage is permitted upon employment or during the Annual Enrollment period for coverage effective the following January 1st if you satisfy the plans' criteria, or immediately upon satisfying the plans' criteria if you previously did not qualify. To obtain spousal or domestic partner coverage, you will need to complete an Affidavit of Eligible Family Membership via MMC Benefits Online declaring that:

Spouse / Domestic Partner

- You have already received a marriage license from a U.S. state or local authority, or registered your domestic partnership with a U.S. state or local authority; or

Spouse Only

- Although not registered with a U.S. state or local authority, your relationship constitutes a marriage under U.S. state or local law (e.g. common law marriage or a marriage outside the U.S. that is honored under U.S. state or local law).

Domestic Partner Only

- Although not registered with a U.S. state or local authority, your relationship constitutes an eligible domestic partnership. To establish that your relationship constitutes an eligible domestic partnership you and your domestic partner must:
  - be at least 18 years old
  - not be legally married, under federal law, to each other or anyone else or part of another domestic partnership during the previous 12 months
  - currently be in an exclusive, committed relationship with each other that has existed for at least 12 months and is intended to be permanent
  - not be MEDICARE eligible
  - currently reside together, and have resided together for at least the previous 12 months, and intend to do so permanently, and
  - have agreed to share responsibility for each other's common welfare and basic financial obligations
  - not related by blood to a degree of closeness that would prohibit marriage under applicable state law.

- MMC reserves the right to require documentary proof of your domestic partnership at any time, for the purpose of determining benefits eligibility. If requested, you must provide documents verifying either the registration of your domestic partnership with a state or local authority or your cohabitation and/or mutual commitment.

Once your Affidavit of Eligible Family Membership is completed and processed, you may cover the dependent child(ren) of your spouse or domestic partner.

Before-Tax (Pre-Tax) Contributions

Contributions taken from your paycheck generally before Social Security (FICA and Medicare) and federal unemployment insurance (FUTA) taxes and other applicable federal, state, and other income taxes are withheld.

Claims Administrator/Pharmacy Benefit Manager

Vendor that administers the Plan and processes claims; the vendor's decisions are final and binding.

Coinsurance

The percentage of expenses you are responsible for paying after you meet your deductible.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A Federal law that lets you and your eligible family members covered by a group health plan extend group health coverage temporarily, at their own expense, at group rates plus an administrative fee, in certain circumstances when their coverage would otherwise end due to a "qualifying event", as defined under COBRA.

- A "qualifying event" under COBRA includes loss of coverage as a result of your leaving the Company (other than for gross misconduct); a reduction in hours, your death, divorce or legal separation; your eligibility for Medicare, or a dependent child's loss of dependent status; or, if you are a retiree, loss of coverage due to the Company filing for bankruptcy.

Coordination of Benefits

You or a covered family member may be entitled to benefits under another group health plan (such as a plan sponsored by your spouse's employer) that pays part or all of your health treatment costs. If this is the case, benefits from this plan will be "coordinated" with the benefits from the other plan. In addition to having your benefits coordinated with other group health plans, benefits from this plan are coordinated with "no fault" automobile insurance and any payments recoverable under any workers' compensation law, occupational disease law or similar legislation.

Copayment

The flat dollar amount you pay for a certain type of health care expense.

Covered Service(s)

Medically necessary health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

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
- 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 group studies.

The Claims Administrator determines only the extent to which a service or supply is covered under the plan and not whether the service or supply should be rendered. The coverage determination is made using the descriptions of covered charges included in this section and the Claims Administrator's own internal guidelines. The decision to accept a service or obtain a supply is yours.

Deductible

The amount of out-of-pocket expenses you must pay for covered services before the plan pays any expenses.

Disability

A physical or mental impairment that substantially limits one or more of an individual's major life activities.

Durable Medical Equipment

Durable medical equipment is equipment that is:

- for repeated use and is not a consumable or disposable item
- used primarily for a medical purpose, and
- appropriate for use in the home

Eligible Family Members

Child/Dependent Child means:

- your natural child
- a child for whom you are the legally appointed guardian with full financial responsibility
- the child of an approved domestic partner
- your stepchild
- your unmarried child over the limiting age, who is incapable of self support by reason of a total physical or mental disability as determined by the Claims Administrator
- your legally adopted child or a child or child placed with you for adoption

For your child to be covered, your child must be:

- dependent on you for maintenance and support, and
- under 19 years of age or
- under 25 years of age if a full-time student in a college or other accredited institution (generally those with 12 or more accredited hours of course work per semester, or full-time as determined by the school) and not employed on a full-time basis and
- unmarried

The Company has the right to require documentation to verify dependency (such as a copy of the court order appointing legal guardianship). Company medical coverage does not cover foster children or other children living with you, including your grandchildren, unless you are their legal guardian with full financial responsibility - that is, you or your spouse claims them as a dependent on your annual tax return.

Eligible Kroll Employees

As used throughout this document, “Kroll Employees” are defined as employees classified on payroll as U.S. full-time regular employees of Kroll, Inc. or any of its subsidiaries.

Eligible MMC Employees (other than Kroll)

As used throughout this document, “MMC Employees (other than Kroll)” are defined as employees classified on payroll as U.S. salaried employees of MMC or any subsidiary or affiliate of MMC (other than Kroll Inc., and any of its subsidiaries).

Eligible Retiree

An employee is eligible for coverage under this plan if he/she is a U.S. salaried employee of MMC or any subsidiary or affiliate of MMC (other than Kroll, Inc., and any of its subsidiaries) who terminates employment with five or more years of vesting service at age 55 or later, or at age 65 and eligible for active employee medical coverage at retirement or is a current retiree under age 65 enrolled in retiree medical coverage.

When you or a covered family member reach age 65 or become eligible for Medicare, you and your covered family members are no longer eligible for coverage under this plan.

Explanation of Benefits (EOB)

A summary of benefits processed by the Claims Administrator.

Global Benefits Department

Refers to MMC’s Global Benefits Department, located at 121 River Street, Hoboken, NJ 07030.

Health Insurance Portability and Accountability Act (HIPAA)

A Federal law, HIPAA imposes requirements on employer health plans concerning the use and disclosure of individual health information.

HOSPICE

A hospice is an institution that provides counseling and medical services that could include room and board to terminally ill individuals. The hospice must have required state or governmental Certificate of Need approval and must provide 24 hour-a-day service under the direct supervision of a physician. The staff must include a registered nurse, a licensed social service worker and a full-time claims administrator. If state licensing exists, the hospice must be licensed.

IN-NETWORK PROVIDERS

Preferred health care providers who have agreed to charge reduced fees to members.

INPATIENT

A covered individual who is admitted to a covered facility for an overnight stay, either by a physician or from the emergency room.

LIFE THREATENING ILLNESS OR INJURY - EMERGENCY ROOM COVERAGE

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part

Some examples of emergencies:

- heart attack, suspected heart attack or stroke
- suspected overdose of medication
- poisoning
- severe burns
- severe shortness of breath
- high fever (103 degrees or higher), especially in infants
- uncontrolled or severe bleeding
- loss of consciousness
- severe abdominal pain
- persistent vomiting
- severe allergic reactions

The plan covers emergency services necessary to screen and stabilize a member when:

- a primary care physician or specialist physician directs the member to the emergency room
- a plan representative (employee or contractor) directs the member to the emergency room
- the member acting as a prudent layperson and a reasonable person would reasonably have believed that an emergency condition existed

Lifetime Maximum

The maximum amount of benefits payable during a person's lifetime for such person covered under the plan.

MMC Benefits On-Line

MMC's PeopleLink Website which contains access to your personalized home page. Go to the Enterprise Menu (upper left) and click on the MMC Benefits Online heading; then click the MMC Benefits Online link. Next, follow the appropriate path to this transaction.

MMC Medical Plans and Medicare Prescription Drug Coverage for Retirees and Disabled Employees

MMC newsletter that provides an overview of how Medicare Part D could affect your MMC prescription drug coverage. It highlights issues you'll want to think about as you consider your prescription drug options.

The U.S. Federal government's health insurance program, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those who are over age 65 or under age 65 and are totally and permanently disabled. Medicare coverage is available regardless of income level. The program is government subsidized and operated.

Medicare

The U.S. Federal government's health insurance program, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those who are over age 65 or under age 65 and are totally and permanently disabled. Medicare coverage is available regardless of income level. The program is government subsidized and operated.

Non-Custodial Care

Non-custodial care is skilled nursing care or physical, occupational, or speech therapy visits rendered by an agency or organization licensed or certified as a home health care agency in the state where the health care is given.

Notice of Creditable Coverage

The Medicare Modernization Act (MMA) requires all group health plan sponsors that offer prescription drug coverage to provide notices to covered employees, retirees, and their dependents who are eligible for Medicare's new prescription drug benefit (Part D). A link to this Notice is contained in the summary plan description.

Out-of-Network Providers

Health care providers who are not in-network providers and do not charge reduced fees.

Outpatient

Treatment/care received by a covered individual at a clinic, emergency room or health facility without being admitted as an overnight patient.

Out-of-Pocket Maximum

The maximum amount you have to pay (excluding your contributions to participate in the plan) toward the cost of your medical care in the course of one year. There are some services and charges that do not count towards the out-of-pocket maximum, such as amounts exceeding plan limits, amounts exceeding the network negotiated price for prescription drugs, amounts your physician or health care provider may charge above the reasonable and customary charge, speech therapy for a child, outpatient mental health treatment and outpatient alcohol and substance abuse treatment.

Participating Specialist

A physician who practices in a certain area of medicine like surgery or cardiology, rather than dealing with all aspects of your health.

Preauthorization/Precertification/Utilization Review

A review service that helps ensure you receive proper treatment and services and that these services are provided in the appropriate setting.

Predetermination of Benefits

This feature helps you estimate how much the Plan may pay (subject to your deductible and Plan maximum at the time the estimate is provided) before you begin treatment.. It is intended to avoid any misunderstanding about coverage or reimbursement, and it is not intended to interfere with your course of treatment.

Pre-Existing Condition

A health problem you had and received treatment for before your current benefit elections took effect.

Prescription Drugs

- **Brand Name Prescription Drugs.** A comprehensive list of preferred brand-name drug products that are covered under the plan. Preferred drugs are selected based on safety, effectiveness, and cost.
- **Generic Prescription Drugs.** Prescription drugs, whether identified by chemicals, proprietary or non-proprietary name, that are accepted by the FDA as therapeutically effective and interchangeable with drugs having an identical amount of the same active ingredient as its brand name equivalent.
- **Brand Name When Generic Prescription Drugs Are Available.** When you or your physician asks for brand-name prescription drugs and there are generic prescription drugs available, you pay a brand-name co-payment and the cost difference between the generic and the brand name drug for the drug.

Preventive/Wellness Care

Annual examinations or routine care covered under the plan; care that prevents or slows the course of an illness or disease or care that maintains good health.

Primary Care Physician

A primary care physician is a doctor you choose to manage all of your health care. Your primary care physician provides preventive and routine care office visits and diagnoses, and refers you to specialists and hospitals as needed.

A primary care physician is your family practitioner, general practitioner, gynecologist, internal medicine doctor, obstetrician/gynecologist and pediatrician.

Specialists include, but are not limited to, allergists, cardiologists, dermatologists, neurologists, orthopedists, otolarygologists, psychologists, podiatrists, surgeons and chiropractors.

Qualified Family Status Change (Status Change, Qualified Change in Family Status)

An event that changes your benefit eligibility. For example, getting married and having a child or your spouse or dependent lose other coverage. You can make certain changes to your before-tax benefit elections that are due to and consistent with the change in family status.

Qualified Medical Child Support Order (QMCSO)

A court order, judgment or decree that (1) provides for child support relating to health benefits under a plan with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan and is ordered under state domestic relations law or (2) is made pursuant to a state medical child support law enacted under Section 1908 of the Social Security Act. A QMCSO is usually issued requiring you to cover your child under your health care plan when a parent receiving post-divorce custody of the child is not an employee.

Qualifying Event

A "qualifying event" under COBRA includes loss of coverage as a result of your leaving the Company (other than for gross misconduct); a reduction in hours, your death, divorce or legal separation; your eligibility for Medicare, or a dependent child's loss of dependent status; or, if you are a retiree, loss of coverage due to the Company filing for bankruptcy.

Reasonable & Customary (R&C) Charges/Fees

Charges/fees that do not exceed the prevailing charges for comparable services in your provider's area. The Claims Administrator determines these limits based on the complexity of the service, the range of services provided and the prevailing charge level in the geographic area where the provider is located. The plan's reasonable and customary guidelines include up to the 90th percentile of providers' charges in the area.

The plan does not cover amounts charged by providers in excess of the reasonable and customary charge for any service or supply. The Claims Administrator regularly reviews the reasonable and customary charge schedule. To confirm whether your provider's charges are within the reasonable and customary limit, obtain a Predetermination of Benefits.

Urgent Care Services

Urgent care is non-preventive or non-routine health care services which are required in order to prevent serious deterioration of a member's health following an unforeseen illness, injury or condition. Urgent care includes conditions that could not be adequately managed without immediate care or treatment, but do not require the level of care provided in the emergency room.

The services must be a covered service under the contract to be subject to reimbursement. Routine care, including follow-up care, is not covered as urgent care.

Waiting Period/Elimination Period

The amount of time you must wait before being able to participate in a plan.