Benefits Handbook Date July 1, 2013

Preferred Provider Organization (PPO)

Marsh & McLennan Companies

Preferred Provider Organization (PPO)

The Preferred Provider Organization (PPO) offers comprehensive health services from participating and non-participating providers.

You may select any participating provider in the network to manage your care, or you may choose a non-participating provider. Generally, your costs are lower if you use a participating provider.

Generally, the Plan begins paying benefits for covered care after you pay a ***DEDUCTIBLE****.*

SPD and Plan Document

This section provides a summary of the Preferred Provider Organization Plan (the "Plan") as of January 1, 2013.

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.

Contents

The Plan at a Glance

The Plan helps you and your family pay for medical care. The chart below contains some important Plan features and coverage information. For more information, see the "Detailed List of Covered Services" on page 28.

Plan feature	In-network	Out-of-network
Deductible	Individual: $400 per individual Family: $1,000 maximum	Individual: $800 per individual Family: $2,000 maximum
Out-of-pocket maximum	Individual: $2,500 per individual Family: $6,250 maximum	Individual: $5,000 per individual Family: $12,500 maximum
Coverage levels	80% after DEDUCTIBLE	60% after deductible (Out-of-network benefits are based on reasonable and customary charges)
Prescription drugs	There is a pharmacy network for retail and Express Scripts By Mail for mail order PRESCRIPTION DRUGS	There is a pharmacy network for retail prescription drugs
Contact Information	For Medical Services: Aetna (Claims Administrator) P.O. Box 981109 El Paso, TX 79998-1109 Aetna Customer Service: +1 866 210 7858 Website: www.aetna.com/docfind/custom/mmc For Prescription Drug Coverage: Express Scripts (Pharmacy Benefits Manager) Express Scripts Customer Service: +1 800 987 8360 Website (for members): www.express-scripts.com Express Scripts Group #: MMCRX05 Marsh & McLennan Companies does not administer claims under this Plan. For medical claims, Aetna's decisions are final and binding; for prescription drug services, Express Scripts' 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.

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 *Participating in Pre-65 Retiree Medical Coverage* 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 four levels of coverage. Cost for each coverage level for eligible Marsh & McLennan Companies Employees (other than Insurance Alliance, a Marsh & McLennan Agency LLC company (Insurance Alliance) and Marsh & McLennan Agency LLC – Northeast (MMA-Northeast)) is shown below.

Eligible Marsh & McLennan Companies Employees	Semi-monthly Cost	Weekly Cost
Employee Only	$64.75	$29.89
Employee + Spouse	$155.41	$71.73
Employee + Child(ren)	$134.84	$62.23
Family	$226.64	$104.60

Medical rates are not available for employees of Insurance Alliance and MMA-Northeast. For contribution rates, contact the Employee Service Center at +1 866 374 2662, any business day, from 8:00 a.m. to 8:00 p.m. Eastern time.

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.

The table below shows the imputed income amounts for eligible Marsh & McLennan Companies Employees (other than Insurance Alliance and MMA-Northeast):

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.

Imputed Income for Domestic Partner Coverage in the PPO

Eligible Marsh & McLennan Companies Employees	Semi-monthly	Weekly
Employee + Domestic Partner (non-qualified)	$246.91	$113.96
Employee + Child(ren) (non-qualified)	$171.03	$78.94
Employee + Domestic Partner (non-qualified) & Child(ren)	$269.88	$124.56
Employee + Domestic Partner & Child(ren (Domestic Partner and Child(ren) non-qualified)	$440.92	$203.50

Imputed income rates for domestic partner coverage are not available for employees of Insurance Alliance and MMA-Northeast. For imputed income rates, contact the Employee Service Center at +1 866 374 2662, any business day, from 8:00 a.m. to 8:00 p.m. Eastern time.

ID Cards

If you are enrolled in employee only coverage you will automatically be sent one ID card for your medical coverage and a separate ID card for your prescription drug coverage. You will be sent one additional medical ID card and one additional prescription drug ID card if you enroll one or more family members in the program. Each ID card will list the employee's name and the names of up to five covered family members.

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. As a Preferred Provider Organization (PPO) participant, you may choose, each time you need medical treatment, to use:

- any physician, hospital or lab, or
- a provider who participates in the Aetna Choice POS II network and has agreed to charge reduced fees to Preferred Provider Organization (PPO) members. Using the network is more cost effective than using non-network providers because their fees are typically less than those charged by non-network providers.

If you use an in-network provider, you do not need to submit a claim form. IN-NETWORK PROVIDERS bill the Claims Administrator directly.

Generally, the Plan's reimbursement is 80% for in-network providers and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's DEDUCTIBLE has been met. You pay the remainder of the fee.

See the "Detailed List of Covered Services" on page 28 for more detailed information

Certain expenses not covered or reimbursed by the Plan, such as, any deductible you are required to meet, your share of the amounts above the reasonable and customary charge, 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.

Refer to "What's Not Covered" on page 31 to find out about any services that are not covered under the Plan.

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. It is the plan participant's responsibility (not the provider or facility) to obtain preauthorization for out-of-network services. For more information on the preauthorization process and applicable services, refer to the description under "Utilization Review" on page 7.

Deductibles

The DEDUCTIBLE is the amount that must be paid before the Plan will reimburse any benefits.

What is the individual deductible?

The individual deductible is the amount each family member has to pay before the Plan will reimburse any benefits. The annual individual deductible is:

- In-network: $400 per individual
- Out-of-network: $800 per individual

What is the family deductible?

The family deductible is the maximum amount you have to pay before the Plan will reimburse any benefits. The annual family deductible is:

- In-network: $1,000 maximum ($400 per individual)
- Out-of-network: $2,000 maximum ($800 per individual)

If you are covering two or more family members, each family member's (including a newborn's) covered expenses up to his or her individual deductible count toward the family deductible. Once this family deductible is met, the Plan will begin to pay benefits for all family members. The Plan will also begin to pay applicable benefits for any covered family member who meets the individual deductible, even if the total family deductible is not met.

Do I have to meet a new deductible every year?

You and your family members will have to meet a new deductible each year.

What expenses apply toward the deductible?

Most of your expenses for COINSURANCE amounts apply toward the medical deductible.

Your payments for the following don't apply toward the Plan deductible:

- amounts in excess of a reasonable and customary charge
- preauthorization penalties
- services not covered by the Plan
- PRESCRIPTION DRUGS.

Out-of-Pocket Maximums

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

The annual individual out-of-pocket limit is:

- In-network: $2,500 per individual
- Out-of-network: $5,000 per individual

The out-of-pocket maximum does not apply to:

- amounts exceeding Plan limits
- amounts in excess of a reasonable and customary charge
- preauthorization penalties
- PRESCRIPTION DRUGS
- services not covered by the Plan.

Your DEDUCTIBLE applies towards your out-of-pocket maximum.

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

The annual family out-of-pocket maximum is:

- In-network: $6,250 maximum ($2,500 per individual)
- Out-of-network: $12,500 maximum ($5,000 per individual)

If you are covering two or more family members, the expenses of all family members can be combined to satisfy the family out-of-pocket maximum. Once an individual family member meets the individual out-of-pocket maximum, benefits for this individual will be paid at 100% for IN-NETWORK PROVIDERS and 100% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS.

The following do not apply to the out-of-pocket maximum:

- amounts exceeding Plan limits
- amounts in excess of a reasonable and customary charge
- preauthorization penalties
- prescription drugs
- services not covered by the Plan.

Your deductible applies toward your out-of-pocket maximum.

Networks

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

In order to receive benefits at the in-network level, you must use a network provider. However, you can still see any provider and be reimbursed 60% of reasonable and customary charges for covered expenses after the Plan's DEDUCTIBLE has been met.

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.

Is there a 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.

Is there a network of pharmacies?

There is a network of participating retail pharmacies associated with this Plan. The Plan generally pays higher benefits if you use an in-network retail pharmacy.

If you use a non-participating pharmacy, in addition to your COINSURANCE/COPAYMENT, you will be responsible for the cost above the Pharmacy Benefits Manager's negotiated price.

The Pharmacy Benefits Manager provides an online directory of participating pharmacies. You may also call the Pharmacy Benefits Manager.

Utilization Review

Which utilization review services are offered?

The Plan offers preauthorization and case management 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?

The following types of medical expenses require preauthorization whether INPATIENT or OUTPATIENT care:

- Hospital
- Skilled Nursing Facility
- Rehabilitation Facility
- Home Health Care

- HOSPICE
- Hospice Care
- Private Duty Nursing Care
- Residential Treatment for treatment of mental disorders and substance abuse
- Partial Hospitalization Programs for mental disorders and substance abuse
- Intensive Outpatient Programs for mental disorders and substance abuse
- Amytal Interview (i.e., Applied Behavioral Analysis, Biofeedback, Electorconvulsive Therapy, Neuropsychological Testing, Outpatient Detoxification, Psychiatric Home Care Services and Psychological Testing)

You must also receive preauthorization for:

- all hospital admissions including
  - mental health
  - alcohol and substance abuse
  - organ transplant
  - all inpatient surgeries
- the purchases and rentals of the following DURABLE MEDICAL EQUIPMENT:
  - electric/motorized wheelchairs and scooters
  - clinitron/electric beds
  - limb and torso prosthetics
  - customized braces
- home health care
- hospice care
- skilled nursing care
- maternity coverage

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

If the procedure or treatment is performed for any condition other than an emergency condition, the call must be made at least 14 days before the date the procedure is to be

performed or the treatment is to start. If it is not possible to make the call during the specified time, it must be made as soon as reasonably possible before the date the procedure or treatment is to be performed.

When do I obtain preauthorization?

You, your family member or health care professional must obtain preauthorization as soon as you know you need a service requiring preauthorization when using an out-of-network provider, but not less than 14 days prior to the procedure or treatment.

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

When using an in-network provider, it is the provider's responsibility to obtain any necessary preauthorization.

How do I obtain preauthorization?

Initiate the preauthorization process by calling the Claims Administrator.

What happens If I fail to obtain preauthorization?

If you fail to obtain preauthorization when using an out-of-network provider, your out-of-network benefits will be reduced by $400. (Preauthorization penalties do not apply towards your DEDUCTIBLE or out-of-pocket maximum.)

You are responsible for preauthorizing out-of-network services only. Your in-network provider will preauthorize all other services.

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

You must obtain preauthorization as soon as possible but at least 14 days before you are admitted for a non-emergency hospital admission or stay.

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

Case Management Review

When the preauthorization service identifies a major medical condition, that condition will be subject to case management review. Case management review aims at identifying major medical conditions early in the treatment plan and makes recommendations regarding the medical necessity of requested health care services.

Case managers with experience in intensive medical treatment and rehabilitation provide case management services. The case manager works with the patient's physician to identify available resources and develop the best treatment plan. Case management review may even recommend services and equipment that the Plan would not ordinarily cover.

The case manager often negotiates lower fees on behalf of the patient from physicians, facilities, pharmacists, equipment suppliers, etc. In addition, the case manager can

coordinate the various caregivers, such as occupational or physical therapists, required by the patient.

Situations that may benefit from case management include severe illnesses and injuries such as:

- head trauma
- organ transplants
- burn cases
- neo-natal high risk infants
- multiple fractures
- HIV-related conditions
- brain injuries
- cancer
- prolonged illnesses
- degenerative neurological disorders (e.g. multiple sclerosis)

To best help the patient, the case manager should be involved from the earliest stages of a major condition. This service gives you access to a knowledgeable case manager who will use his or her expertise to assist you and your physician in considering your treatment options.

If the case manager questions the necessity of the proposed hospital admission or procedure, a physician advisor may contact your physician to discuss your case and suggest other treatment options that are generally utilized for your condition. You, your physician, and the case manager will be informed of the outcome of the review, and the Claims Administrator will determine the level of benefit coverage you will receive. You and your physician will be notified of the utilization reviewer's recommendation by telephone and in writing. You will also be informed of the appeal process if the procedures your physician ultimately recommends are not covered under the Plan (as determined by 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.

Are immunizations for business travel covered under the Plan?

The Plan does not cover immunizations for business travel.

Is acupuncture covered under the Plan?

The Plan covers acupuncture when it is:

- performed by a physician as a form of anesthesia in connection with surgery that is covered under the Plan.
- a form of Alternative Treatment as long as it is rendered by a certified/licensed individual.

Are insulin pump syringes covered under the medical coverage?

Yes. Insulin pump syringes are covered under the medical coverage. Insulin pump syringes are not covered under the prescription drug coverage.

Can a prosthetic device be replaced?

The plan covers the replacement of prosthetic devices when medically necessary.

Are wigs covered?

The plan will pay benefits for wigs when medically necessary. One wig per year is covered.

Preventive/Wellness Care

How is preventive/wellness care covered?

The Plan covers PREVENTIVE/WELLNESS CARE at 100% for IN-NETWORK PROVIDERS with no DEDUCTIBLE and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's deductible has been met. Plan limits apply. Contact the Claims Administrator for specific details.

Hearing exams for children under age 18 are covered when provided as part of a preventive/wellness visit.

What services are considered preventive/wellness care?

The Plan considers physician, testing and diagnostic fees for the following specific wellness expenses:

- blood cell counts
- blood tests for prostate screening
- chest X rays
- cholesterol tests
- EKG's
- mammograms (For details, see "Does the Plan cover mammograms?" on page 13)
- pap smears

- routine physical exams, including one pelvic exam each calendar year
- sigmoidoscopy (Covered if you are 40 and over when recommended by physician or 1 every 5 years if you are considered at average risk.)
- tuberculosis tests
- urinalysis.

The following services are not considered preventative/wellness care:

- Services which are covered to any extent under any other group plan of your employer.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while the person is confined in a hospital or other facility for medical care.
- Services which are not given by a physician or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.
- Vision, hearing, or dental exams.

Does the Plan cover outpatient physician services?

The Plan covers charges for out-patient office visits at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Does the Plan cover gynecology visits?

The Plan covers one routine gynecological exam each calendar year at 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of Preventive/Wellness Care.

If the visit to the gynecologist is for treatment of a medical condition, it is not considered routine care and will be covered at 80% for in-network providers or 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Does the Plan cover mammograms?

The Plan covers one routine or non-routine mammogram per calendar year at 100% with no deductible for in-network providers and 60% of reasonable and customary charges after the Plan's deductible has been met for out-of-network providers. The Plan covers:

- One baseline mammogram for women age 35 - 39.
- One mammogram each calendar year for women age 40 and over.

If your doctor recommends more than one non-routine mammogram as a follow up to a medical diagnosis in a calendar year, it will be covered at 80% of reasonable and customary charges after the Plan's deductible has been met for in-network providers and 60% of reasonable and customary charges after the Plan's deductible has been met for out-of-network providers.

Does the Plan cover Pap smears?

The Plan covers one routine Pap smear each calendar year at 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of Preventive/Wellness Care.

If your doctor recommends a non-routine Pap smear as a follow-up to a medical diagnosis, the Plan covers your Pap smear at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Does the Plan cover prostate specific antigen (PSA) tests and routine Annual Digital Rectal exams?

The Plan covers one routine prostate specific antigen (PSA) test and one routine Annual Digital Rectal Exam (DRE) each calendar year for covered males age 40 and over at 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of Preventive/Wellness Care.

If your doctor recommends a non-routine PSA test as a follow-up to a medical diagnosis, the Plan covers your PSA or DRE test at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

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?

No Preauthorization within 48 hours is not required for the initial hospital admission.

You must notify the preauthorization service 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 in-network at 80% for an in-network provider after the Plan's DEDUCTIBLE has been met. After the first visit, subsequent visits are typically billed as part of doctor's delivery fee, which is also reimbursed at 80% after the Plan's deductible has been met.

The Plan covers prenatal visits out-of-network at 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's deductible has been met.

What will the Plan pay for the doctor's charge for delivering the baby?

The Plan covers charges for delivery of the baby at 80% for IN-NETWORK PROVIDERS and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

What will the Plan pay for the doctor's charge for examining the baby?

The Plan covers the charges for your baby's first examination in the hospital at 80% for In-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

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.

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

The Plan covers hospital charges for maternity admissions at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

The Plan covers newborn nursery care at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

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 section).

You must notify the precertification review service within 24 hours of a determination to extend the stay.

Does the Plan cover midwife services?

The Plan covers midwives who are in practice with a network group at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers in association with a supervising physician after the Plan's deductible has been met.

What is the Healthy Pregnancy Program?

The Healthy Pregnancy Program provides tools and information to help your whole family have a successful pregnancy. Use this program throughout your pregnancy and after your baby is born to:

- Learn what's best for a healthy pregnancy
  - Receive materials on prenatal care, labor and delivery, newborn care and more
  - Get information for the father or domestic partner
  - Take a pregnancy risk survey and find out if you have any issues or risk factors that could affect your pregnancy
- If you have issues or risk factors that need special attention, the program's nurses provide personal case management to determine ways to lower your risks
- Get support to help quit smoking
- Reduce your risk for pre-term labor.

For more information, call the Beginning Right Maternity Program at +1 800 CRADLE 1 (+1 800 272 3531).

Does the Plan offer a maternity wellness program?

The Plan offers the Beginning Right maternity program, which provides information and resources to support you and your family throughout your pregnancy and after your baby is born.

For more information, call the Beginning Right maternity program at +1 800 CRADLE 1 (+1 800 272 3531).

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.

Family Planning

Does the Plan cover infertility treatment?

The Plan covers infertility treatments 80% for IN-NETWORK PROVIDERS and 60% of reasonable and customary charges for out-of-network after the Plan's DEDUCTIBLE has been met.

Infertility treatments are covered as follows:

- assisted reproduction procedures (including facility charges and related expenses) due to infertility
- ovulation induction and monitoring up to a maximum of six attempts per lifetime
- artificial reproductive technology (ART) - limited to a combined maximum of three attempts per lifetime for the following:
  - in vitro fertilization
  - gamete intrafallopian transfer (GIFT)
  - zygote intrafallopian transfer (ZIFT)
  - Cryopreserved embryo transfers
  - Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.

You should obtain a PREDETERMINATION OF BENEFITS to determine your coverage and benefits for these services.

PRESCRIPTION DRUGS related to infertility are covered under the prescription drug benefit.

Does the Plan cover artificial insemination?

Artificial insemination is covered at 80% for in-network providers and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's deductible has been met and up to a maximum benefit of six courses of treatment per lifetime.

Treatment for artificial insemination does not count toward the maximum for other infertility treatments.

You should obtain a predetermination of benefits to determine your coverage and benefits for these services.

Prescription drugs related to infertility treatment are covered under the prescription drug benefit.

Are contraceptive devices covered under the Plan?

The Plan covers contraceptive devices at 80% for in-network providers or 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Oral, transdermal, intravaginal, injectable and implantable contraceptives are covered under the prescription drug plan. Diaphragms and cervical caps are also covered under the prescription drug plan.

Does the Plan cover vasectomy?

The Plan covers vasectomies at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

You must obtain preauthorization before you are admitted to the hospital.

Vasectomy reversals aren't covered.

Does the Plan cover tubal ligation?

The Plan covers out-patient tubal ligation at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

The Plan covers in-patient tubal ligation at 100% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

You must obtain preauthorization before you are admitted to the hospital.

Tubal ligation reversals aren't 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 80% for IN-NETWORK PROVIDERS and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS per admission after the Plan's DEDUCTIBLE has been met.

The Plan will cover the cost of a semi-private room. If you use a private room, the Plan will cover the amount up to the semi-private room rate.

You must obtain preauthorization as soon as possible but at least 14 days before you are admitted for a non-emergency hospital stay.

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

You must obtain preauthorization as soon as possible but at least 14 days before you are admitted for a non-emergency hospital admission or stay.

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

Does the Plan cover hospital visits by a physician?

While you are in the hospital, the Plan covers hospital visits by a physician at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Does the Plan cover ambulance charges?

The Plan covers transportation by ambulance to a medical facility at 80% for in-network providers and 80% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Coverage includes charges for transportation to a hospital by air or water ambulance when:

- Ground ambulance transportation is not available.
- Your condition is unstable and requires medical supervision and rapid transport.
- In a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital and the above two conditions are met.

Does the Plan cover hospice care?

The Plan covers charges for HOSPICE at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

You must obtain preauthorization before you before you receive hospice care.

Mastectomy – Reconstructive Surgery

Does the Plan cover mastectomy-related services?

Yes, the Plan covers mastectomy-related services. Coverage will be provided in a manner determined by the attending physician and the patient. The covered services include:

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

What are the applicable deductibles and coinsurance for mastectomy-related benefits under the Plan?

The mastectomy-related benefits are subject to the same deductibles and COINSURANCE applicable to other medical and surgical benefits provided under this Plan. See the "Detailed List of Covered Services" on page 28 for the applicable Mastectomy – reconstructive surgery coverage.

Obesity Surgery

The plan covers surgical treatment of obesity provided by or under the direction of a physician.

Prior authorization under the condition of meeting the medical definition of morbid obesity is required. Contact the Claims Administrator for specific details.

Occupational Therapy

The plan covers the treatment to:

- learn or re-learn daily living skills (e.g., bathing, dressing and eating) or compensatory techniques to improve the level of independence in the activities of daily living.
- provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease.
- Coverage includes services, treatment, education testing or training related to developmental delays.

Prior authorization for occupational therapy is recommended. Contact the Claims Administrator for specific details.

Orthognathic Coverage

The plan covers the diagnosis or treatment of the jawbones, including orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Prior authorization is required. Contact the Claims Administrator for specific details.

"What's Not Covered" on page 31 for orthognathic coverage exclusion.

Prescription Drugs

Does the Plan cover formulary and non-formulary brand-name prescription drugs?

The Plan covers formulary and non-formulary PRESCRIPTION DRUGS purchased via the Plan's mail order service or a participating retail pharmacy.

Formulary Drugs

If the prescription drug is on the formulary list, you will pay 20% of the negotiated price for up to a 30-day supply at a participating retail pharmacy for the first three fills of each

prescription (the initial fill plus two refills). There is a minimum payment of $20 and a maximum payment of $60 for up to a 30-day supply.

If you purchase prescription drugs via the mail order service, you will pay 20% of the Pharmacy Benefits Manager's negotiated price for up-to a 90-day supply at the Express Scripts Pharmacy. There is a minimum payment of $50 and a maximum payment of $150 per 90-day supply.

For all maintenance prescription drugs, after the first three fills at a retail pharmacy, if you choose to continue to fill the prescription at a retail pharmacy, you will pay 50% of the negotiated price for all subsequent fills.

Non-formulary Drugs

If the prescription drug is not on the formulary list and is not excluded from coverage, you will pay 20% of the negotiated price up to a 30-day supply at a participating retail pharmacy for the first three fills of each prescription (the initial fill plus two refills). There is a minimum payment of $35 and a maximum payment of $85 for up to a 30-day supply.

For all maintenance prescription drugs, after the first three fills at a retail pharmacy, if you choose to continue to fill the prescription at a retail pharmacy, you will pay 50% of the negotiated price for all subsequent fills. If the prescription drug is on the formulary list, you will pay 20% of the negotiated price for up to a 30-day supply at a participating retail pharmacy. There is a minimum payment of $20 and a maximum payment of $60 for up to a 30-day supply.

If you purchase prescription drugs via the mail order service, you will pay 20% of the Pharmacy Benefits Manager's negotiated price for up to a 90-day supply at the Express Scripts Pharmacy. There is a minimum payment of $87.50 and a maximum payment of $212.50 per 90-day supply after the Plan's DEDUCTIBLE has been met.

To price medications and check formulary status, visit www.express-scripts.com.

Unless your physician specifically prescribes a brand-name medication without substitution, prescriptions will be filled with the generic equivalent when allowed by state law.

Your costs for prescription drugs do not apply to your medical deductible and medical out-of-pocket maximum.

Some drugs require prior authorization.

Does the Plan cover generic drugs?

The Plan covers generic prescription drugs purchased via the Plan's mail order service or a participating retail pharmacy.

If you use a participating retail pharmacy, the Plan covers generic prescription drugs at 100% after the $10 COPAYMENT for up to a 30-day supply. For all maintenance prescription drugs, after the first three fills at a retail pharmacy, if you choose to continue

to fill the prescription at a retail pharmacy, you will pay 50% of the negotiated price for all subsequent fills.

If you purchase generic prescription drugs via the mail order service, you will pay a $25 copayment for up to a 90-day supply after the Plan's deductible has been met.

Your costs for prescription drugs do not apply to your medical deductible and medical out-of-pocket maximum.

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

Unless your physician specifically prescribes a brand-name medication without substitution, prescriptions will be filled with the generic equivalent when allowed by state law.

If you or your physician requests the brand-name prescription drug when a generic prescription drug is available and there is no medical reason for the brand-name prescription drug, you pay the generic drug COINSURANCE for the drug in addition to the difference between the brand-name prescription drug and generic prescription drug gross cost.

How does the Plan cover generic and brand-name contraceptive medications with no generic equivalent?

The Plan will cover generic and brand-name contraceptive medications **with no generic equivalent** (single source) at 100% in-network with no copayment for females as long as a valid prescription is submitted.

If I buy more than three fills of a prescription drug at a retail pharmacy, will I have to pay more?

For all maintenance prescription drugs, after purchasing the first three fills of a prescription drug (the initial fill plus two refills) at a participating retail pharmacy, if you choose to continue to fill the prescription at a retail pharmacy, you pay 50% of the negotiated price for up to a 30-day supply for all subsequent refills.

Is there a mail-order program?

The Plan's mail order service allows participants to order up to a 90-day supply of prescription medication by mail for certain medications.

For generic prescription drugs, you will pay a $25 copayment for up to a 90-day supply.

The Plan pays 100% after the $25 copayment for generic drugs. For formulary brand-name drugs you will pay 20% of the negotiated price for up to a 90-day supply at the Express-Scripts Pharmacy. There is a minimum payment of $50 and a maximum payment of $150 for up to a 90-day supply. For non-formulary brand-name drugs you will pay 20% of the negotiated price up to a 90-day supply at the Express-Scripts Pharmacy.

There is a minimum payment of $87.50 and a maximum payment of $212.50 for up to a 90-day supply.

Your costs for prescription drugs do not apply to your medical deductible and medical out-of-pocket limit.

Are any prescription drugs or drug supplies subject to limitations?

You may be subject to several different types of drug management programs. These include quantity management, prior authorization and qualification by history or step therapy.

Quantity Management

To ensure safe and effective drug therapy, certain covered medications may have quantity restrictions. These quantity restrictions are based on manufacturer and/or clinically approved guidelines and are **subject to periodic review and change**.

Select drug categories include:

- Antibiotics
- Anticonvulsant Agents – Lyrica
- Antiemetic Agents
- Antifungal Agents
- Antinarcoleptics
- Cardiovascular Agents – Ranexa
- Dermatologicals – Regranex, Solodyn
- Diabetic Agents – Byetta/Victoza, Symlin
- Fertility Agents
- Hypnotic Agents
- Inhaled Bronchodilators – Spiriva
- Irritable Bowel Syndrome Therapy
- Lipid/Cholesterol Lowering Agent – Lovaza
- Migraine Therapy
- Narcotic Analgesics
- Non-Narcotic Analgesics – Lidoderm Patch, Diclofenac, Vimovo

- Rheumatological Agents
- Smoking Deterrents
- Specialty Medications
- Vaginitis Therapy

The following are additional examples of prescription drugs or supplies that are covered with quantity limitations:

Drug or Supply	Quantity Limit
Erectile dysfunction drugs such as Viagra®, Cialis®, or Caverject®	8 units per month
Inhaler spacers	2 spacers per year
Diabetic devices (blood glucose monitors)	1 monitor per year

Prior Authorization

Certain medical treatments and prescription medicines need prior approval before the Plan will cover them. This requirement is to ensure the treatment or medication is appropriate and effective. If you do not receive approval, you will be responsible for paying the full cost.

Select drug categories include:

- Androgens & Anabolic Steroids
- Anorexiants
- Antinarcoleptics – Nuvigil, Provigil
- Cancer Therapy
- Dermatologicals – Panretin, Regranex, Targretin, Tretinoins/Tazorac
- Specialty Medications – require prior authorization under the Plan and are subject to quantity limitations as well.
  - Examples of drug categories include: Botulinum Toxins (Botox), Erythroid Stimulants, Fertility Agents, Growth Hormones, Hepatitis Treatment, Immune Globulins, Multiple Sclerosis Therapy, Myeloid Stimulants, Psoriasis Agents, Pulmonary Arterial Hypertension (PAH) Therapy, Rheumatoid Arthritis Therapy, RSV Agents.

As new drugs become available or new indications are approved for already available drugs, the drugs that require prior authorization may be modified. To obtain prior authorization for coverage ask your doctor to call Express Scripts at +1 800 753 2851.

After they receive the necessary information, you and your doctor will be notified confirming whether or not coverage has been approved.

Qualification by History (Step Therapy)

Some medications are covered only for certain uses and/or require certain criteria such as age, sex, or condition (determined by previous claims history) to receive coverage. In these cases, a coverage review will be required if certain if criteria cannot be determined from past history.

Select drug categories include:

- Antimalariais
- Antinarcoleptics
- Atypical Antipsychotics
- CNS Stimulant & Amphetamines
- COX-II Inhibitors
- Dermatologicals – Protopic & Elidel, Solodyn, Ziana
- Diabetic Agents – Victoza
- HIV Agents – Selzentry
- Narcotic Analgesics
- Non-Narcotic Analgesics – Cambia

As new drugs become available or new indications are approved for already available drugs, the drugs that may become subject to qualification by history rules may be modified.

Contact the Pharmacy Benefits Manager at +1 800 987 8360 for more information about any of these programs.

Are there any limitations on specialty prescription drugs?

The Accredo Recommended Days Supply Program maintains quantity limitations for certain specialty prescription drugs in accordance with FDA approval limits and to help reduce drug waste and prescription drug costs.

The first time you submit a claim for a specialty medication on this list, you will be limited to a 30-day supply for four months, even if your physician prescribed a 90-day supply. Your copayment will be prorated, so you will not be penalized for filling the prescription in 30-day supply increments instead of a 90-day supply.

An Accredo Representative will contact both you and your physician to explain why the prescription has been limited to a 30-day supply, discuss therapy and the disease state and discuss the importance of compliance.

In addition, specialty medications require prior authorization under the Plan and are subject to quantity limitations. These limits are subject to change and are discussed above. Contact the Pharmacy Benefits Manager at +1 800 987 8360 for more information about any of these programs.

What prescription drugs and drug supplies are excluded from prescription drug coverage?

The following drugs and drug supplies are excluded from prescription drug coverage:

- Over-the-counter drugs (including topical contraceptives, nicotine products, vitamins and minerals, nutritional products including enteral products and infant formulas, homeopathic products and herbal remedies)
- Medical equipment and devices – insulin pumps, insulin pump syringes
- Home diagnostic kits
- All injectables (other than self-administered injectables and injectable drugs in connection with approved infertility treatment)
- Vaccines (except for zoster vaccine for shingles)
- Allergy serums
- Plasma and blood products
- Drugs for cosmetic use
- Prescription products with an over the counter equivalent
- Investigational drugs, experimental use drugs, non-FDA approved drugs.

Note: you can obtain non-covered prescription drugs through Express Scripts By Mail at a discounted price. You will pay 100% of the discounted price.

Is there a network of pharmacies?

There is a network of participating retail pharmacies associated with this Plan. The Plan generally pays higher benefits if you use an in-network retail pharmacy.

If you use a non-participating pharmacy, in addition to your coinsurance/copayment, you will be responsible for the cost above the Pharmacy Benefits Manager's negotiated price.

The Pharmacy Benefits Manager provides an online directory of participating pharmacies. You may also call the Pharmacy Benefits Manager.

How do I file a claim for benefits for prescription drugs?

All prescriptions filled at a participating retail pharmacy require you to provide an ID card for coverage under the Plan. You are responsible for the applicable copayment or coinsurance. Rarely will you need to file a claim with the Pharmacy Benefits Manager (one example may be a prescription filled at retail before you have received your ID card). Should you need to file a claim, contact the Pharmacy Benefits Manager.

Claim forms are also available on the Pharmacy Benefits Manager's website. If you file a claim within 60 days of your effective date with the plan, you will be reimbursed 100% of your out of pocket expense minus the appropriate coinsurance. After your 60 day grace period, you have 12 months from the date the prescription is filled to submit a claim. You are responsible for the difference between the discounted in-network price and the out-of-network price and the appropriate coinsurance.

Is there a separate ID card for the prescription drug program?

There is a separate ID card for the prescription drug program. If you are enrolled in medical coverage, you will automatically be sent a prescription drug ID card in addition to your medical plan ID card. You will be sent one additional prescription ID card if you enroll one or more family members in the program. Each ID card will list the names of all covered family members.

You may request additional ID cards directly from the Pharmacy Benefits Manager.

Mental Health/Substance Abuse

Does the Plan cover mental health/substance abuse services?

The Plan covers residential mental health/substance abuse treatment services, including residential treatment.

Does the Plan cover services in connection with autism?

The Plan covers treatments provided in connection with autism, except for education and experimental and investigational treatments.

Speech Therapy

The plan covers the treatment of:

- a speech impediment or speech dysfunction that results from injury, stroke or a congenital anomaly.
- delays in speech development.

Prior authorization for speech therapy is recommended. Contact the Claims Administrator for specific details.

Gender Reassignment Surgery

Does the Plan cover transgender surgery?

Transgender surgery is covered for persons that meet all of the following conditions:

- You are at least 18 years old.
- You have been diagnosed with “true” transsexualism.
- You have completed a recognized program at a specialized gender identity treatment center.

What transgender surgery benefits will the Plan pay?

The Plan will provide medically necessary benefits in connection with transgender surgery including transgender surgery travel expenses. The maximum individual limit is $75,000.

Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan.

Temporomandibular Joint (TMJ) Coverage

The plan covers services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by and under the direction of a physician. Coverage includes the diagnostic or surgical treatment required as a result of an accident, trauma, congenital defect, developmental defect or pathology.

- Diagnostic coverage includes examination, radiographs and applicable imaging studies, and consultation.
- Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.
- Surgical treatment* includes arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations and TMJ implants.

  *Surgical treatment if provided if the following criteria are met:

  - There is clearly demonstrated radiographic evidence of significant joint abnormality.
  - Non-surgical treatment has failed to adequately resolve the symptoms.
  - Pain or dysfunction is moderate or severe.

See “What’s Not Covered” on page 31 for TMJ exclusions.

Detailed List of Covered Services

The Plan reimburses 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 and determines the amount to be reimbursed.

Most services and supplies are subject to a DEDUCTIBLE and COINSURANCE.

Maximum benefit limits are combined for in-network and out-of-network services.

Some services require you to obtain preauthorization from the Claims Administrator.

Services	In-network Coverage	Out-of-network Coverage
Alcohol and substance abuse	***Inpatient and Residential Treatment Facility:*** 80% after deductible Preauthorization is required ***Outpatient:*** 80% after deductible	***Inpatient and Residential Treatment Facility:*** 60% of R&C after deductible Preauthorization is required ***Outpatient:*** 60% after deductible
Allergy tests	80% after deductible	60% of R&C after deductible
Allergy treatment	80% after deductible	60% of R&C after deductible
Alternative medicine	Not covered	Not covered
Ambulance charges	80% after deductible	80% of R&C after deductible
Artificial insemination	80% after deductible Subject to Plan limits	60% of R&C after deductible Subject to Plan limits
CAT / PET scans	80% after deductible CAT scans of the spine subject to preauthorization	60% of R&C after deductible CAT scans of the spine subject to preauthorization
Chiropractors	80% after deductible for up to 20 visits per calendar year	60% of R&C after deductible for up to 20 visits per calendar year
Contraceptive devices	80% after deductible	60% of R&C after deductible
Cosmetic surgery	Not covered	Not covered
Dental treatment (covered only for accidental injury to sound teeth)	80% after deductible	60% of R&C after deductible
Doctor delivery charge for newborns	80% after deductible	60% of R&C after deductible
Durable medical equipment (DME)	80% after deductible Preauthorization is required for purchase or rentals of certain DME	60% of R&C after deductible Preauthorization is required for purchase or rentals of certain DME
Emergency room	80% after deductible for life-threatening injury or illness	80% of R&C after deductible for life-threatening injury or illness

Services	In-network Coverage	Out-of-network Coverage
Gynecology visits	100% (not subject to deductible) for one routine exam each calendar year Subsequent visits - 80% after deductible	60% of R&C after deductible
Hearing care	80% after deductible Hearing exams are covered when provided as part of a preventive/wellness visit. Hearing aids are covered once every 36 months; per ear.	60% of R&C after deductible Hearing exams are covered when provided as part of a preventive/wellness visit. Hearing aids are covered once every 36 months; per ear.
Home health care	80% after deductible for up to 120 visits per calendar year for homebound patients (Maximum of 120 visits per calendar year, with a nurse shift of 4 hours or less equal to 1 visit, and a nurse shift of more than 4 hours and up to 8 hours equal to 2 visits) Preauthorization is required	60% of R&C after deductible for up to 120 visits per calendar year for homebound patients (Maximum of 120 visits per calendar year, with a nurse shift of 4 hours or less equal to 1 visit, and a nurse shift of more than 4 hours and up to 8 hours equal to 2 visits) Preauthorization is required
Hospice care	80% after deductible Preauthorization is required	60% of R&C after deductible Preauthorization is required
Immunizations (routine)	100% (not subject to deductible) Immunizations for travel are not covered	60% of R&C after deductible Immunizations for travel are not covered
Infertility treatment	80% after deductible You should obtain a PREDETERMINATION OF BENEFITS Subject to Plan limits	60% of R&C after deductible You should obtain a predetermination of benefits Subject to Plan limits
Inpatient hospital services	80% after deductible Preauthorization is required	60% of R&C after deductible Preauthorization is required
Laboratory charges	80% after deductible	60% of R&C after deductible
Magnetic resonance imaging - MRI	80% after deductible Preauthorization is required for MRIs of spine and knee	60% of R&C after deductible Preauthorization is required for MRIs of spine and knee
Mammograms	100% (not subject to deductible) for one routine exam each calendar year for covered females age 40 and over 100% for one baseline mammogram performed between ages 35 and 39	60% of R&C for one routine exam each calendar year for covered females age 40 and over 60% of R&C for one baseline mammogram performed between ages 35 and 39
Mastectomy - reconstructive surgery	80% after deductible	60% of R&C after deductible

Services	In-network Coverage	Out-of-network Coverage
Maternity hospital stay	80% after deductible	60% of R&C after deductible
Mental health	***Inpatient and Residential Treatment Facility:*** 80% after deductible Subject to preauthorization ***Outpatient:*** 80% after deductible	***Inpatient and Residential Treatment Facility:*** 60% after deductible Subject to preauthorization ***Outpatient:*** 60% after deductible
Occupational therapy	80% after deductible up to 60 visits per calendar year combined with physical and speech therapy	60% of R&C after deductible up to 60 visits per calendar year combined with physical and speech therapy
Organ transplant	80% after deductible Preauthorization is required	60% of R&C after deductible Preauthorization is required
Outpatient physician services	80% after deductible	60% of R&C after deductible
Physical exams for adults (routine)	100% (not subject to deductible) for one physical exam each calendar year	60% of R&C after deductible for one physical exam each calendar year
Physical exams for children (routine)	100% (not subject to deductible) Subject to Plan limits	60% of R&C after deductible Subject to Plan limits
Physical therapy	80% after deductible up to 60 visits per calendar year combined with occupational and speech therapy	60% of R&C after deductible 60 visits per calendar year combined with occupational and speech therapy
Pregnancy termination	80% after deductible	60% of R&C after deductible
Prenatal visits	80% after deductible	60% of R&C after deductible
Prostate specific antigen test - PSA (routine)	100% (not subject to deductible) for one exam each calendar year for males age 40 or over	60% of R&C after deductible for one exam each calendar year for males age 40 or over
Prescription drugs	There is a pharmacy network for retail and Express Scripts By Mail for mail order PRESCRIPTION DRUGS.	There is a pharmacy network for retail prescription drugs
Sex transformation operation (and related costs)	80% after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits	60% of R&C after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits
Skilled nursing facility	80% after deductible up to 120 days per calendar year Preauthorization is required	60% of R&C after deductible up to 120 days per calendar year Preauthorization is required

Services	In-network Coverage	Out-of-network Coverage
Speech therapy	80% after deductible up to 60 visits per calendar year combined with occupational and physical therapy	60% of R&C after deductible up to 60 visits per calendar year combined with occupational and physical therapy
Surgery	80% after deductible Preauthorization is required predetermination of benefits is recommended for multiple surgical procedures	60% of R&C after deductible Preauthorization is required predetermination of benefits is recommended for multiple surgical procedures
Tubal ligation	80% after deductible	60% of R&C after deductible
Vasectomy	80% after deductible	60% of R&C after deductible
Vision Exam	80% after deductible Covered when provided as part of a preventive/wellness visit.	60% of R&C after deductible Covered when provided as part of a preventive/wellness visit..
X-rays	80% after deductible	60% of R&C after deductible

What's Not Covered

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

- It is recommended or prescribed by a physician.
- It is the only available treatment for your condition.

The Claims Administrator may modify this list at their discretion, and you will be notified of any such change.

Alternative Treatments

- Acupressure
- Aroma therapy
- Hypnotism
- Massage therapy
- Rolfing
- Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Comfort or Convenience

- Television
- Telephone

- Beauty/barber service
- Guest service
- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners
  - Air purifiers and filters
  - Batteries and battery charges
  - Dehumidifiers
  - Humidifiers
  - Devices and computers to assist communication and speech
- Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools)

Dental

- Dental care except when necessary because of accidental damage to an unrestored tooth. Such services must be performed by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD). Dental services for final treatment to repair the damage must be started within three months of the accident and completed in the calendar year or within the following calendar year.
- Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
  - Extraction, restoration and replacement of teeth
  - Medical or surgical treatments of dental conditions
  - Services to improve dental clinical outcomes
- Dental implants
- Dental braces
- Dental X-rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia. The only exceptions to this are for any of the following:
  - Transplant preparation
  - Initiation of immunosuppressives
  - The direct treatment of acute traumatic injury, cancer or cleft palate
- Treatment of congenitally missing, malpositioned or super numerary teeth, even if part of a congenital anomaly

Drugs

- Over-the-counter drugs and treatments

Experimental or Investigational Services or Unproven Services

Medical, surgical, diagnostic, psychiatric, substance abuse or health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

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

Foot Care

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

Medical Supplies and Appliances

- Devices used specifically as safety items or to affect performance in sports-related activities

- Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Elastic stockings
  - Ace bandages
  - Gauze and dressings
  - Ostomy supplies
- Orthotic appliances that straighten or re-shape a body part (including some types of braces)

Tubings, nasal cannulas, connectors and masks are not covered except when used with DURABLE MEDICAL EQUIPMENT

Mental Health/Substance Abuse

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Services for mental health and substance abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention
- Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Plan's preauthorization review service
- Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents
- Treatment provided in connection with or to comply with commitments, police detentions and other similar arrangements, unless authorized by the Plan's preauthorization review service
- Services incurred for behavioral health treatment in a residential facility, which are paid the same as behavioral health INPATIENT benefits
- Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance disorders that, in reasonable judgment of the Plan's preauthorization review service, are any of the following:
  - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions
  - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome

  - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective
  - Not consistent with the Plan's preauthorization review service's guidelines or best practices as modified from time to time

The Plan's preauthorization review service may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria

- Pastoral counselors
- Education and experimental investigational treatments provided in connection with autism
- Treatment provided in connection with tobacco dependency in excess of 8 visits per 12 months
- Routine use of psychological testing without specific authorization

Nutrition

- Megavitamin and nutrition based therapy
- Nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs, health clubs and spa programs except when necessary in treating chronic disease states in which dietary adjustment has a therapeutic role and is prescribed by a physician and furnished by a provider (e.g., a registered dietician, licensed nutritionist or other qualified licensed health provision) recognized under the plan.
- Nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism.

Orthognathic Coverage Exclusion

- The plan does not cover orthognathic services for the treatment of obstructive sleep apnea.

Physical Appearance

- Cosmetic procedures. Examples include:
  - Pharmacological regimens (e.g., systematic course of drugs), nutritional procedures or treatments
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)

  - Skin abrasion procedures performed as a treatment for acne
  - Orthognathic surgery, for cosmetic reasons
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded

Wigs are generally excluded except in cases of hair loss due a severe medical condition or treatment

Providers

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself
- Services performed by a provider with your same legal residence
- Services provided at a free-standing or hospital-based diagnostic facility without an order written by a physician or other provider. Services that are self-directed to a free-standing or hospital-based diagnostic facility. Services ordered by a physician or other provider who is an employee or representative of a free-standing or hospital-based diagnostic facility, when that physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received

This exclusion does not apply to mammography testing

Reproduction

- Health services and associated expenses for infertility treatments (except those described under Infertility Treatment)
- Surrogate parenting
- The reversal of voluntary sterilization
- Fees or direct payment to a donor for sperm or ovum donations
- Monthly fees for maintenance and / or storage of frozen embryos

Services Provided under Another Plan

- Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you
- Health services while on active military duty

TMJ

- Surface electromyography
- Doppler analysis
- Vibration analysis
- Computerized mandibular scan or jaw tracking
- Craniosacral therapy
- Orthodontics
- Occlusal adjustment
- Dental restorations
- Any charges for services that are dental in nature.

Transplants

- Health services for organ and tissue transplants, except those described under Organ Transplants
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the Plan)
- Health services for transplants involving mechanical or animal organs
- Any solid organ transplant (e.g. heart, lung, etc.; not blood, bone marrow, etc.) that is performed as a treatment for cancer
- Any multiple organ transplant not listed as a covered service

Travel

- Health services provided in a foreign country, unless required as emergency health services
- Travel or transportation expenses to and from your home, even though prescribed by a physician.

Vision and Hearing

- Purchase cost of eye glasses, contact lenses, or hearing aids
- Fitting charge for hearing aids, eye glasses or contact lenses
- Surgery that is intended to allow you to see better without glasses or other vision correction, including radial keratotomy, laser, and other refractive eye surgery

Work-Related Accident and Illness

The Plan does not cover work-related accidents or illnesses. Work-related accidents and illnesses should be reported as soon as they occur to your Human Resources representative for consideration under the Worker's Compensation program.

All Other Exclusions

- Health services and supplies that do not meet the definition of a Covered Service
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type
- Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders without a known physical basis
- Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan
- In the event that a non-network provider waives copayments and/or the annual DEDUCTIBLE for a particular health service, no benefits are provided for the health service for which the copayments and/or annual deductible are waived

- Charges in excess of eligible expense or in excess of any specified limitation
- Custodial care
- Domiciliary care (e.g., group living arrangements)
- Private duty nursing
- Respite care
- Rest cures
- Psychosurgery (brain surgery to treat psychiatric symptoms)
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Medical and surgical treatment of excessive sweating (hyperhidrosis)
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing
- Any charges higher than the reasonable and customary charge
- Any charge for services, supplies or equipment advertised by the provider as free
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency
- Any charges prohibited by federal anti-kickback or self-referral statues
- Any additional charges submitted after payment has been made and your account balance is zero
- Any charges by a resident in a teaching hospital where a faculty physician did not supervise services
- OUTPATIENT rehabilitation services, spinal treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies
- Speech therapy to treat stuttering, stammering, or other articulation disorders

Filing a Claim

How do I file a claim for benefits?

If you use an in-network provider you do not have to file a claim form. The provider will file a claim directly with the Claims Administrator. Once the claim is processed you will be billed for the appropriate COINSURANCE amount.

If you receive services from a provider who does not participate in the network, you need to file a claim to receive benefits.

You can obtain a Preferred Provider Organization Claim Form (Aetna Medical Claim Form) on PeopleLink (www.mmcpeoplelink.com). Select the **Health** tab and under **Medical Plans**, click **PPO**. Then go to **Forms and Documents** in the right navigation bar and select **Medical/Dental/Flexible Spending Accounts**.

Read and follow the form's instructions. Be sure to file a separate claim form for each member of your family. Make copies of all itemized bills, and attach the originals to the claim form. You will also need to indicate whether you want the payment to go to the provider or to you.

Mail the completed claim form and all relevant documentation as the form instructs. You may include more than one bill with a claim, even if the bills are for different medical services.

You have 12 months following the date the expense was incurred to file a medical claim.

How long does it normally take to process a claim for benefits?

Most claims are normally processed within 10 business days after the claim is received by the Claims Administrator.

You can find out the status of your claims by visiting the Claims Administrator's website.

How do I file a prescription drug claim form?

All prescriptions filled at a participating retail pharmacy require you to provide an ID card for coverage under the Plan. You are responsible for the applicable COPAYMENT or coinsurance. Rarely will you need to file a claim with the Pharmacy Benefits Manager (one example may be a prescription filled at retail before you have received your ID card). Should you need to file a claim, contact the Pharmacy Benefits Manager.

Claim forms are available on the Pharmacy Benefits Manager's website. If you file a claim after 60 days from the date of service you are responsible for the difference between the discounted and undiscounted price. Otherwise, you have 12 months from the date the expense was incurred to submit a claim.

How do I file a claim for hospital charges?

Hospitals will submit a claim from your hospital stay directly to the Claims Administrator. After receiving reimbursement from the Claims Administrator, the hospital will then bill you for any coinsurance or amount not eligible for reimbursement.

Be sure to review the hospital bill and to request an explanation of any charges that you question or do not understand. You should let the Claims Administrator know if you have a concern about the charges on your hospital bill.

You have up to 12 months following the date the expense was incurred to file a claim.

Can I be reimbursed for claims incurred outside the United States?

No, you cannot be reimbursed for services incurred outside the U.S. unless they are considered emergency services. If you incur eligible emergency medical or prescription drug expenses while living or traveling outside of the U.S., your claim's processing will be expedited if the receipts are in English or if the person providing the services gives you a letter in English explaining the treatment. The Claims Administrator will convert the bill for eligible emergency medical expenses to U.S. dollars using an exchange rate on the day the services were performed. Eligible prescription drug expenses will be processed using an equivalent NDC and will be subject to the standard prescription drug claim processing rules.

You have 12 months following the date the expense was incurred to file a claim.

What is an Explanation of Benefits (EOB)?

An Explanation of Benefits statement outlines how the amount of benefit, if any, was calculated. The statement also shows your year-to-date DEDUCTIBLE and OUT-OF-POCKET EXPENSES. If you are due reimbursement, a check will be mailed to you with an explanation of benefits statement, or to the provider if you assigned payment.

An Explanation of Benefits statement lets you verify that the claim was processed correctly. Always read your statement carefully, checking to make sure that you were billed only for:

- services you received, on the day(s) you received them, only from the provider of care
- the exact type of services you received (e.g., if you participated in a group therapy session, make sure that you are not billed for individual treatment)
- the amount you were told the treatment would cost
- the type of medication you received (e.g., if you receive generic medication, check that you are not billed for brand name medication)

If your statement lists services you did not receive, please notify the Claims Administrator.

If you authorize that reimbursement be made directly to your provider, both you and the provider will receive an Explanation of Benefits statement, and the provider receives payment.

What happens if I am overpaid for a claim?

If the Plan overpays benefits to you (or a covered family member), you are required to refund any benefit you receive from the Plan that:

- was for an expense that you (or a covered family member) did not pay or were not legally required to pay
- exceeded the benefit payable under the Plan
- is not covered by the Plan

If a benefit payment is made to you (or a covered family member), which exceeds the benefit amount, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of you or a covered family member.

For Flexible Spending Account Reimbursement

If you participate in the Health Care Flexible Spending Account and do not have a covered domestic partner, once your medical claim is processed, the Claims Administrator will automatically process your claim for reimbursement under your Health Care Flexible Spending Account.

If you cover a domestic partner or you receive services that are not covered under the Plan, your claims cannot be automatically reimbursed. Rather, you must submit a Flexible Spending Account (FSA) Claim Form.

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

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 PeopleLink (www.mmcpeoplelink.com), 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.

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
  - currently reside together, and have resided together for at least the previous 12 months, and intend to do so permanently
  - have agreed to share responsibility for each other’s common welfare and basic financial obligations
  - not be related by blood to a degree of closeness that would prohibit marriage under applicable state law.

Marsh & McLennan Companies reserves the right to require documentary proof of your domestic partnership or marriage at any time, for the purpose of determining benefits eligibility. If requested, you must provide documents verifying the registration of your domestic partnership with a state or local authority, your cohabitation and/or mutual commitment, or a marriage license that has been approved by a state or local government authority.

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

Complete your affidavit, via PeopleLink (www.mmcpeoplelink.com). Select the **Health** tab and under **Medical Plans**, click **PPO**. Then go to **Take Action** in the right navigation bar and select **Enroll, view, change benefits.**

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 Benefits 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 biological child
- a child for whom you or your spouse are the legally appointed guardian with full financial responsibility
- the child of an approved domestic partner
- your stepchild
- your legally adopted child or a child or child placed with you for adoption.

Note: Any child that meets one of these eligibility requirements and who is incapable of self support by reason of a total physical or mental disability as determined by the Claims Administrator, may be covered beyond the end of the calendar year in which the child attains age 26.

Dependent children are eligible for healthcare coverage until the end of the calendar year in which they attain age 26. This eligibility provision applies even if your child is married, has access to coverage through his or her employer, doesn't attend school full-time or live with you, and is not your tax dependent.

Note: While married children are eligible for healthcare coverage under your plan until the end of the calendar year in which they attain age 26, this provision does not apply to your child's spouse and/or child(ren), unless you or your spouse is the child's legally appointed guardian with full financial responsibility.

The Company has the right to require documentation to verify the relationship (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 MMA Employees

As used throughout this document, "MMA Employees" are defined as employees classified on payroll as U.S. regular employees of MMA-Corporate, Insurance Alliance, MMA-Northeast or MMA-Alaska.

Eligible Marsh & McLennan Companies Employees (other than MMA)

As used throughout this document, "Marsh & McLennan Companies Employees (other than MMA)" are defined as employees classified on payroll as U.S. regular employees of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other than MMA and any of its subsidiaries).

Eligible Retiree

An employee is eligible for coverage under this plan if he/she is a U.S. regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other than MMA 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 are deemed to be eligible for Medicare, you and your covered family members are no longer eligible for coverage under the Pre-65 Retiree Medical Plan.

Evidence of Insurability (EOI)

Evidence of Insurability (EOI) is proof of good health and is generally required if you do not enroll for coverage when you first become eligible. If the coverage level you are requesting requires such evidence or if you are increasing coverage. Establishing EOI may require a physical examination at the employee's expense. The EOI must be provided to and approved by the insurer/vendor before coverage can go into effect.

Explanation of Benefits (EOB)

A summary of benefits processed by the Claims Administrator.

Global Benefits Department

Refers to the 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 include:

- 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.

Marsh & McLennan Companies Medical Plans and Medicare Prescription Drug Coverage for Retirees and Disabled Employees

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

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).

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 Expenses

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, and speech therapy for a child.

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

- **Formulary/Brand Name (Preferred) 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.
- **Non-Formulary (Non-Preferred) Prescription Drugs.** Prescription drugs that do not appear on the formulary list are considered non-formulary or non-preferred; these drugs may either be excluded from coverage or may cost more.

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.

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 85th 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.