Benefits Handbook Date November 1, 2013

Aetna Exclusive Provider Organization

Marsh & McLennan Companies

Aetna Exclusive Provider Organization

An Exclusive Provider Organization (EPO) Plan offers comprehensive health services from participating health care providers. Generally, your care is fully covered after you pay a copayment. You may select any participating provider in the network to manage your care. You may visit a specialist or other provider in the network without a referral. Except in an emergency, you do not receive benefits if you receive care outside the network.

This Summary Plan Description is for residents of Connecticut, the District of Columbia (Washington D.C.), Georgia, Kansas, Maine, New Jersey, New York, Ohio, and West Virginia.

Plan availability is based upon your residential zip code.

SPD and Plan Document

This section provides a summary of the Exclusive 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. You may be required to pay a COPAYMENT and get preauthorization for certain services. The chart below contains some important Plan features and coverage information. For more information, see the "Detailed List of Covered Services" on page 21.

Plan feature	Coverage amount
Deductible	Employee: None Family members: None
Out-of-pocket maximum	Employee: None Family members: None
Copayment	Plan pays 100% after the applicable copayments: ▪ Primary Physician office visits: $20 ▪ Specialist visit: $40 ▪ Mental health/substance abuse office visits: $20 ▪ Hospital stay: $150 per day, up to a 4 day maximum ▪ OUTPATIENT surgery/procedure: $150 ▪ Emergency room: $125 ▪ Urgent Care Center: $35
Prescription Drugs	There is a pharmacy network for retail and Express Scripts by Mail for mail order PRESCRIPTION DRUGS.
Contact Information	***For medical services:*** If you are a resident of Connecticut, the District of Columbia (Washington D.C.), Georgia, Kansas, Maine, New Jersey, New York, Ohio or West Virginia. Plan availability is based upon your residential zip code. Aetna (Claims Administrator) Phone: +1 866 210 7858 Website: www.aetna.com/docfind/custom/mmc ***For prescription drug coverage:*** Express Scripts (Pharmacy Benefits Manager) Phone: +1 800 987 8360 Website (for members): www.express-scripts.com Express Scripts Group #: MMCRX05 Marsh & McLennan Companies does not administer this Plan. For medical services, Claims Administrator's decisions are final and binding; for prescription drug services, Pharmacy Benefits Manager's decisions are final and binding.

Participating in the Plan

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

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

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 Marsh & McLennan Companies (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), Marsh & McLennan Agency LLC – Northeast (MMA-Northeast)) is shown below:

Eligible Marsh & McLennan Companies Employees	Semi-monthly Cost	Weekly Cost
Employee Only	$88.54	$40.86
Employee + Spouse	$212.49	$98.07
Employee + Child(ren)	$187.95	$86.74
Family	$309.87	$143.02

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.

Section 152 Dependents

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

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

Imputed Income for Domestic Partner Coverage in the Aetna EPO

Eligible Marsh & McLennan Companies Employees	Semi-monthly	Weekly
Employee + Domestic Partner (non-qualified)	$225.46	$104.46
Employee + Child(ren) (non-qualified	$150.17	$69.31
Employee + Domestic Partner (non-qualified) & Child(ren)	$252.44	$116.51
Employee + Domestic Partner & Child(ren (Domestic Partner and Child(ren) non-qualified)	$402.61	$185.82

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.

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

The Plan helps you and your family pay for medical care. You may be required to pay a COPAYMENT and get preauthorization for certain services. For more information, see the "Detailed List of Covered Services" on page 21.

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

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

Refer to "What's Not Covered" on page 25 to find out about the 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 certain services. For more information on the preauthorization process and applicable services, refer to the description under "Utilization Review" on page 5.

Out-of-Pocket Maximums

What is the out-of-pocket maximum?

The Plan does not have an OUT-OF-POCKET MAXIMUM.

Networks

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

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

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

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

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

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

Is there a network of providers for behavioral health treatment?

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

You receive benefits only when you are treated by providers in the network. Contact the Claims Administrator or access their website to be connected with a behavioral specialist.

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 procedures or treatments require preauthorization:

- all hospital admissions including:
  - mental health
  - alcohol and substance abuse
  - organ and tissue transplant
  - maternity coverage
  - all INPATIENT surgeries

- DURABLE MEDICAL EQUIPMENT, prosthetics and orthotics over $1,000
- home health care (includes private duty nursing when pre-authorized for home health care)
- HOSPICE care
- skilled nursing care.

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 7 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, but not less than 7 days prior to the procedure or treatment.

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

How do I obtain preauthorization?

Initiate the preauthorization process by calling the Claims Administrator.

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

You must obtain preauthorization as soon as possible but at least 7 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.

Does the Plan cover office visits?

The Plan covers office visits at 100% after the $20 COPAYMENT for a primary physician visit (including mental health and substance abuse visits). The copayment for a specialist visit is $40.

A Primary Physician is your family practitioner, general practitioner, gynecologist, internal medicine doctor, obstetrician/gynecologist pediatrician and nurse practitioner**.**

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

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 routine examinations at 100%. See the schedule and benefits covered below.

Schedule	
Routine Physical for adults over age 19	One visit per calendar year
Well Child Care	Please refer to the claims administrator for Well Child Care age and frequency limits
Well Woman Care	One well woman visit per calendar year; includes examinations or primary and preventive obstetrics, gynecological services and cervical cancer/pap smear screening
Colonoscopy	Covered once every 10 years for participants age 40 and over*
Colorectal Cancer Screening, Sigmoidoscopy, Fecal Occult Blood Test Screening	Screening covered once per calendar year for participants age 40 and over*
Prostate Specific Antigen (PSA)	One routine screening per calendar year covered for covered male participants age 40 and over*
Mammogram	One baseline between the ages 35 through 39 and one per calendar year for covered female participants age 40 and over*
Osteoporosis	Screening for all women age 60+ (regardless of risk)

* Age and frequency limits may not apply for non-routine medically-necessary services and procedures. Please refer to the claims administrator for age & frequency limits.

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 at 100% after the $20 COPAYMENT for the initial obstetrics visit. There is no copayment for subsequent visits.

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

The Plan covers hospital charges for maternity admissions, including newborn nursery care, at 100% after the $150 hospital copayment per day, up to a 4 day maximum per admission.

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. While you are in the hospital, the Plan covers hospital visits by a physician for both the mother and baby at 100% after the $150 hospital copayment per day, up to a 4 day maximum.

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).

Does the Plan cover midwife services?

The Plan covers midwives at 100% after the $150 hospital copayment per day, up to a 4 day maximum per admission.

Does the Plan offer a maternity wellness program?

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

For more information about the Aetna maternity program, call +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 office visits related to infertility at 100% after the $20 COPAYMENT for a primary physician visit. The copayment for a specialist visit is $40.

The Plan covers infertility treatments at 100% with no copayment. If services are performed at an outpatient facility, the Plan covers infertility treatments at 100% after a $150 copayment. The following infertility treatments are covered under the Plan:

- 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

- in vitro fertilization (limited to three attempts per lifetime) including:
  - gamete intrafallopian transfer (GIFT)
  - zygote intrafallopian transfer (ZIFT).

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

Does the Plan cover artificial insemination?

Artificial insemination is covered at 100% with no copayment. There is a lifetime maximum benefit of six cycles per lifetime.

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

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

Are contraceptive devices covered under the Plan?

The Plan pays 100% after the $20 copayment in primary physician's office (including an OB/GYN) and $40 copayment in specialist's office

Oral and injectible contraceptives are covered under the prescription drug plan.

Does the Plan cover vasectomy?

The Plan covers INPATIENT vasectomy at 100% after the $150 hospital copayment per day, up to a 4 day maximum per admission. You must obtain preauthorization before you are admitted to the hospital.

The Plan covers OUTPATIENT vasectomy at 100% after the $150 surgical copayment.

Vasectomy reversals are not covered.

Does the Plan cover tubal ligation?

The Plan covers inpatient tubal ligation at 100%. You must obtain preauthorization before you are admitted to the hospital.

The Plan covers outpatient tubal ligation at 100%.

Tubal ligation reversals are not covered.

Inpatient Hospital and Physician Services

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

The Plan pays INPATIENT hospital charges at 100% after the $150 hospital COPAYMENT per day, up to a 4 day maximum per admission.

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 7 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 7 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 100% after the $150 hospital copayment per day, up to a 4 day maximum per admission.

Does the Plan cover ambulance charges?

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

Does the Plan cover hospice care?

The Plan covers charges for HOSPICE care at 100% with no copayment.

You must obtain preauthorization 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.

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 25 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, 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 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 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.

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 DEDUCTIBLE and OUT-OF-POCKET MAXIMUM.

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 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.

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 through the age of 50 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.

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.

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.
- You have received pre authorization from the claims administrator

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 the “What’s Not Covered” on page 25 for TMJ exclusions.

Detailed List of Covered Services

The Plan covers medically necessary covered services and supplies for the diagnosis and treatment for an illness or injury. The Claims Administrator determines whether the service or supply is covered and determines the amount to be reimbursed.

Most services and supplies are subject to a COPAYMENT.

You will only receive coverage if you use an in-network provider.

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

Benefit	Coverage
Alcohol and substance abuse	Preauthorization is required for both detoxification and rehabilitation. ***Inpatient and Residential* Treatment Facility:*** Detoxification: Plan pays 100% after the $150 copayment per day, up to a 4 day maximum, per hospital/residential treatment facility admission Rehabilitation: Plan pays 100% after the $150 copayment per day, up to a 4 day maximum, per hospital/residential treatment facility admission ***Outpatient:*** Plan pays 100% after the $20 mental health/substance abuse provider copayment per visit
Allergy tests	Plan pays 100% after the $20 copayment in a primary physician's office or the $40 specialist copayment in a specialist's office
Allergy treatment	Plan pays 100%. Subject to $20 copayment if billed by physician as an office visit.
Alternative medicine	Not covered
Ambulance charges	Plan pays 100% with no copayment for medically necessary emergencies
Artificial insemination	Plan pays 100% with no copayment Subject to Plan limitations
Chiropractors	Plan pays 100% after the $40 copayment per visit for up to 20 visits per calendar year
Contraceptive devices	Plan pays 100% after the $20 copayment in primary physician's office (including an OB/GYN) and $40 copayment in specialist's office and $150 copayment in OUTPATIENT facility setting
Cosmetic surgery	Not covered
Dental treatment	Not covered except for extraction of impacted wisdom teeth and injury to sound and natural teeth, but only if treatment is finished within 12 months of the date of injury
Doctor delivery charge for newborns	Plan pays 100% after the $150 hospital copayment per day, up to a 4 day maximum
Durable medical equipment	Plan pays 100% with no copayment if prescribed by a physician; preauthorization is required for purchases and rentals over $1,000.
Emergency room	Plan pays 100% after the $125 copayment (applied to the $150 hospital copayment if admitted within 24 hours) for life-threatening injury or illness You must contact the Claims Administrator within 48 hours of an emergency hospital admission
Gynecology visits	Plan pays 100% after the $20 copayment Plan pays 100% for one routine exam per calendar year

Benefit	Coverage
Hearing care	Plan pays 100% after the $20 copayment in a primary physician's office or the $40 copayment in a specialist's office for treatment. Hearing exams are covered when provided as part of a preventive/wellness visit. Plan pays for hearing aids once every 36 months; per ear.
Home health care	Plan pays 100% with no copayment and a maximum benefit of 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	Plan pays 100% with no copayment Preauthorization is required
Immunizations (routine)	Plan pays 100% with no copayment Immunizations for travel are not covered
Infertility treatment	Plan pays 100% for diagnosis and treatment after the $20 copayment in primary physician's office (including an OB/GYN) and $40 copayment in specialist's office Plan pays 100% for assisted reproduction procedures and in vitro fertilization with no copayment Subject to Plan limits
Inpatient hospital and physician services	Plan pays 100% after the $150 hospital copayment per day, up to a 4 day maximum per hospital admission Preauthorization is required
Laboratory charges	Plan pays 100% with no copayment
Mammograms	Plan pays 100% with no copayment Plan limits apply
Mastectomy - reconstructive surgery	Plan pays 100% with $150 hospital copayment per day, up to a 4 day maximum
Maternity hospital stay	Plan pays 100% after the $150 hospital copayment per day, up to a 4 day maximum Preauthorization is required
Mental health	***Inpatient and Residential** Treatment Facility:*** Plan covers INPATIENT treatment at 100% after the $150 copayment per day, up to a 4 day maximum per hospital/residential treatment facility admission Preauthorization is required ***Outpatient:*** Plan covers Outpatient treatment at 100% after the $20 mental health/substance abuse provider copayment per visit
Occupational therapy	Plan pays 100% after the $40 specialist copayment per visit for up to 60 visits per calendar year (combined 60-visit maximum with physical therapy and speech therapy)

Benefit	Coverage
Organ transplant	Plan pays 100% after the $150 hospital copayment per day, up to a 4 day maximum Preauthorization is required Organ donor search is covered
Outpatient physician services	Plan pays 100% after the $20 copayment for a primary physician office visit or the $40 copayment for a specialist office visit
Physical exams for adults age 19 and over	Plan pays 100% with no copayment (once per calendar year)
Physical exams for children	Plan pays 100% with no copayment. 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.
Physical therapy	Plan pays 100% after the $40 specialist copayment per visit for up to 60 visits per calendar year (combined 60-visit maximum with occupational therapy and speech therapy)
Pregnancy termination	Plan pays 100% after the $150 hospital copayment per day, up to a 4 day maximum (preauthorization is required) or the $150 surgical copayment if performed on an outpatient basis
Prenatal visits	Plan pays 100% after the $20 copayment for the initial obstetrics visit. There is no copayment for subsequent visits
Prostate specific antigen test - PSA	Plan pays 100% with no copayment Plan limits apply
Prescription drugs	There is a pharmacy network for retail and Express Scripts by Mail for mail order PRESCRIPTION DRUGS.
Sex Transformation Operation (and related services)	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.
Skilled Nursing Facility	100% with no copayment for up to 120 days per calendar year Preauthorization is required
Speech therapy	Plan pays 100% after the $40 specialist copayment per visit for up to 60 visits per calendar year (combined 60-visit maximum with occupational therapy and physical therapy)
Surgery	***Inpatient:*** Plan pays 100% after the $150 hospital copayment per day, up to a 4 day maximum per admission; preauthorization is required ***Outpatient:*** Plan pays 100% after the $150 surgical copayment For Gender Reassignment surgery, certain cosmetic procedures are not covered.

Benefit	Coverage
Tubal ligation	***Inpatient:*** Plan pays 100%; preauthorization is required ***Outpatient:*** Plan pays 100% Reversals are not covered
Urgent care facility	Plan pays 100% after the applicable $35 copayment
Vasectomy	***Inpatient:*** Plan pays 100% after the $150 hospital copayment per day, up to a 4 day maximum Preauthorization is required ***Outpatient:*** Plan pays 100% after the $150 surgical copayment Reversals are not covered
Vision care	Plan pays 100% after the $20 copayment in a primary physician's office or the $40 copayment in a specialist's office for treatment as a result of injury or illness No coverage for routine vision care
X-rays	Plan pays 100% with no copayment

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
- Wilderness Programs

- 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 three months per calendar year
- 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.
- Some travel expenses related to covered transplantation services may be reimbursed at the Claims Administrator's discretion

Vision and Hearing

- Purchase cost of eye glasses or contact lenses
- 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)
- 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 maximum allowed amount
- 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, in almost all cases, you do not have to file a claim form. The providers will file a claim directly with the Claims Administrator. One exception may be approved emergency care obtained out-of-network. In the very rare cases that you might need to file a claim, contact the Claims Administrator.

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

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 also 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 prescription was filled to submit 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 expenses while living or traveling outside of the U.S., you must contact the Claims Administrator to receive an international claims form. The form must be submitted with the original claim, itemized bill and medical records. The bill must be in English with a conversion of currency to U.S. dollars. Eligible prescription drug expenses will be processed using an

equivalent national drug code (NDC) and will be subject to the standard prescription drug claim processing rules.

Note: Due to the complexity of international bills, the Claims Administrator may require additional time to process your claims.

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

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 **Aetna EPO**. 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 and 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 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 or over 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 Marsh & McLennan Companies' 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, 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.

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.

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).

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.

OUT-OF-NETWORK PROVIDERS

Health care providers who are not in-network providers and do not charge reduced fees. Except in an emergency or when needed for urgent care services, you do not receive benefits if you receive care outside the network.

OUT-OF-POCKET MAXIMUM

The maximum amount you have to pay under some plans (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.

OUTPATIENT

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

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.

MAXIMUM ALLOWABLE CHARGE

Charges/fees that do not exceed the prevailing charges for comparable services in your provider’s area. The Claims Administrator determines these limits based on the complexity of the service, the range of services provided and the prevailing charge level in the geographic area

where the provider is located. The plan's reasonable and customary guidelines include up to the 90th percentile of providers' charges in the area.

The plan does not cover amounts charged by providers in excess of the maximum allowable 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 maximum allowable charge, 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.