Benefits Handbook Date April 1, 2023

Kaiser Medical Plan Options

Marsh McLennan

Kaiser Medical Plan Options

Selecting a medical plan option for 2023 involves three key choices for eligible individuals.

- Select one of three medical plan options. A range of coverage levels and costs is offered.
- Select coverage for:
  - yourself only-- Employee
  - yourself and your spouse or domestic partner--Employee + Spouse
  - yourself and your child or children--Employee + Child(ren)
  - yourself, your spouse or domestic partner, and children—Employee + Family
- Select your medical plan THIRD PARTY ADMINISTRATOR (or carrier with respect to the insured programs):
  - All eligible individuals resident in any state except Hawaii may choose from among:
    - Aetna
    - Anthem BlueCross BlueShield (Anthem BCBS)
    - Surest

  Information about the Aetna, Anthem BCBS and Surest administered medical plan options is covered in a separate section of the Benefits Handbook.

  - Eligible individuals resident in CA, CO, GA, MD, VA, OR, WA, and Washington DC, have an additional choice to consider:
    - Kaiser Permanente (Kaiser)

  Note: This section of the Benefits Handbook provides information about the Kaiser administered medical plan options only.

  - Eligible individuals who are resident in Hawaii, may only choose between:
    - HMSA's Health Plan Hawaii Plus HMO (HMO)
    - HMSA's Preferred Provider Plan (PPP)

  Information about the Hawaii medical plan options is covered in a separate section of the Benefits Handbook.

SPD and Plan Document

This section provides a summary of the Medical Plan (the "Plan") options available through Kaiser as of January 1, 2023.

This section, together with the *Administrative Information* section and the applicable section about participation, as well as the Kaiser Evidence of Coverage (EOC) forms the Summary Plan Description and plan document of the Plan.

All medical plan options described in this section of the Benefits Handbook offer comprehensive health services.

References in this section to Marsh & McLennan Companies mean Marsh McLennan.

Note: Be sure to read about Health Care Flexible Spending Accounts (HCFSAs), Health Savings Accounts (HSAs) and Limited Purpose Health Care Flexible Spending Accounts (LPHCFSAs). Understanding these tax-advantaged arrangements may be important to your selection of a medical 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 medical plan. Your ERISA rights in connection with this Plan are detailed in the *Administrative Information* section.

Important Information About Your Personal Health Information

- The Company does not collect, maintain, or report on any personal health information pertaining to you or any covered dependents.
- As a participant in our health plan, your personal health information is protected by federal law.
- Our medical Third Party Administrators (or carriers with respect to the insured programs) are required to protect your personal health information in accordance with federal law and data privacy agreements with the Company and/or plan fiduciaries.
- Please note that states seeking to prohibit or limit certain services covered under Company-sponsored plans might attempt to challenge your right to privacy under federal law. If a state's legal challenge is successful, there may be legal consequences associated with you procuring a service covered under a Company-sponsored plan that is or may become prohibited or limited under state law. If you have any questions regarding potential risks, please seek professional legal advice.

Contents

The Medical Plan Options at a Glance

The chart below outlines some important Plan features and coverage information that distinguish the two medical plan options available only to residents of California (CA), Colorado (CO), Georgia (GA), Maryland (MD), Virginia (VA), Oregon (OR), Washington (WA) and Washington D.C. (DC). Additional information is provided throughout this section of the Benefits Handbook, as well as in the Kaiser Permanente Evidence of Coverage available on Colleague Connect (**https://mmcglobal.sharepoint .com/sites/home**). Select **Pay & Benefits**, under **Find a document**, select **Search all documents**.

Please note: The Evidence of Coverage is the binding document between Kaiser Permanente and its members. A Plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition. The services and supplies must be provided, prescribed, authorized, or directed by a Plan physician. You must receive the services and supplies at a Plan facility or skilled nursing facility inside our Service Area, except where specifically noted to the contrary in the Evidence of Coverage. For details on the benefit and claims review and adjudication procedures, please refer to Kaiser Permanente's Evidence of Coverage. If there are any discrepancies between benefits included in this Benefits Handbook section and the Evidence of Coverage (EOC), the EOC will govern.

For example: If you are enrolled with family coverage in the $1,500 Deductible Plan in California, your individual deductible will be limited to $3,000 ($3,000 for other regions) and your individual out-of-pocket maximum will be limited to $3,000 ($6,000 in other locations). Please refer to Kaiser Permanente's Evidence of Coverage available on Colleague Connect, for additional details.

Plan feature	**$1,500 Deductible Plan**[1,6]	**$3,000 Deductible Plan**[1,6]
Deductible	Employee: $1,500 Family[2]: $3,000[4]	Employee: $3,000 Family[2]: $6,000[3]
Out-of-pocket maximum (including deductible)	Employee: $3,000 Family[2]: $6,000[4]	Employee: $5,500 Family[2]: $11,000[3]
Coverage levels	80% COINSURANCE after deductible	70% coinsurance after deductible
Physician office visits		
Primary Care Physician (PCP)/Specialist Visit	80% coinsurance after deductible	70% coinsurance after deductible
Specialist Visit	80% coinsurance after deductible	70% coinsurance after deductible

Plan feature	$1,500 Deductible Plan[1,6]	$3,000 Deductible Plan[1,6]
Hospital Facility		
INPATIENT	80% coinsurance after deductible	70% coinsurance after deductible
OUTPATIENT	80% coinsurance after deductible	70% coinsurance after deductible
Emergency Room (waived if admitted)	80% coinsurance after deductible	70% coinsurance after deductible
Prescription drugs	There is a pharmacy network for retail and mail order PRESCRIPTION DRUGS. Prescriptions are purchased through Kaiser Permanente. There is a pharmacy located in every Kaiser medical center.	
Retail Prescriptions[5] (30-day supply)		
▪ Generic	80% coinsurance after deductible	70% coinsurance after deductible
▪ Formulary Brand	80% coinsurance after deductible	70% coinsurance after deductible
▪ Non-Formulary Brand	80% coinsurance after deductible	70% coinsurance after deductible
Mail-order Prescriptions[5] (90-day supply)		
▪ Generic	80% coinsurance after deductible	70% coinsurance after deductible
▪ Formulary Brand	80% coinsurance after deductible	70% coinsurance after deductible
▪ Non-Formulary Brand	80% coinsurance after deductible	70% coinsurance after deductible
Contact Information	Contact for Medical and Prescription Drug Services: Kaiser Permanente (Claims Administrator) See the Kaiser Claims Administrator chart for address information. Kaiser Customer Service: See the phone numbers listed by region below. Website: www.kp.org. Marsh McLennan does not administer claims under this plan. For medical and prescription drug claims, Kaiser's decisions are final and binding.	

[1] These plans are named for the deductible applicable to the “individual” for in-network service providers. The deductibles applicable to any other coverage level (for example, “Family coverage”) or for services provided by out-of-network service providers will be significantly higher than (in many instances, double) the amounts captured in the names of the plans.

[2] “Family” applies to all coverage levels except, Employee-Only.

[3] Not “True” Family: For the $3,000 Deductible Plan, if more than one person in a family is covered under this plan, there are two ways the plan will begin to pay benefits for a covered family member. When a covered family member meets his or her individual deductible, benefits begin for that covered family member only, but not for the other covered family members. When the family deductible is met, benefits begin for every covered family member whether or not they have met their own individual deductibles. The family deductible can only be met by one covered family member or a combination of covered family members, as amounts counted toward individual deductibles count toward the larger family deductible. The out-of-pocket maximum functions in the same way. When a covered family member meets his or her individual out-of-pocket maximum, the out-of-pocket maximum is satisfied for that covered family member only, but not for the other covered family members. When the family out-of-pocket maximum is met, the out-of-pocket maximum is satisfied for every covered family member whether or not they have met their own individual out-of-pocket maximums. The family out-of-pocket maximum can only be met by one covered family member or a combination of covered family members, as amounts counted toward individual out-of-pocket maximums count toward the larger family out-of-pocket maximum.

[4] “True” Family: The $1,500 Deductible Plan does not require that you or a covered family member meet the “individual” deductible in order to satisfy the family deductible. If more than one person in a family is covered under this plan, benefits begin for any one covered family member only after the family deductible is satisfied. The family deductible may be met by one covered family member or a combination of covered family members. The out-of-pocket maximum functions in the same way. If more than one person in a family is covered under this plan, the out-of-pocket maximum is satisfied for any one covered family member when the family out-of-pocket maximum is satisfied. The family out-of-pocket maximum may be met by one covered family member or a combination of covered family members.

[5] Please note your Rx benefits may vary from what is shown depending on your state of residence. Please refer to the Kaiser Permanente Evidence of Coverage for more detail.

[6] Kaiser does not provide out-of-network coverage except in an emergency.

Kaiser Claims Administrator Address Information

Kaiser Permanente- Northern CA
P.O. Box 12923
Oakland, CA 94612

Kaiser Permanente- Southern CA
P.O. Box 7004
Downey, CA 90242-0361

Kaiser Permanente- CO
P.O. Box 373150
Denver, CO 80237-9998

Kaiser Permanente- GA
P.O. Box 370010
Denver, CO 80237-9998

Kaiser Permanente- Mid-Atlantic (MD, VA, DC)
P.O. Box 371860
Denver, CO 80237-9998

Kaiser Permanente- Northwest (Oregon and Southwest WA)
P.O. Box 370050
Denver, CO 80237-9998

Kaiser Permanente- Washington (Western Washington and Spokane area)
P.O. Box 30766
Salt Lake City, UT 84130-0766

Kaiser Customer Service Phone Numbers

Region	*Toll Free*	*TTY*
Georgia	+1 888 865 5813	711
Northern California	+1 800 464 4000	711
Southern California	+1 800 464 4000	711
Northwest (Oregon and Southwest WA)	+1 800 813 2000	711
Colorado	+1 800 632 9700	711
Mid-Atlantic (MAS)	+1 800 777 7902	711
Washington (Western Washington and Spokane area)	+1 888 901 4636	711

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. The Kaiser medical plan options are available only if you live in CA, CO, GA, MD, OR, VA, WA, and DC.

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 and their eligible family members who are not yet deemed to be 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 (generally in October with respect to overage for the following calendar year)
- within 60 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 plan option and level of coverage you choose. The cost may change each year.

You can choose from four levels of coverage. Cost for each coverage level for eligible Marsh McLennan Employees (other than Marsh & McLennan Agency LLC – Northeast (MMA-Northeast), Security Insurance Services of Marsh & McLennan Agency LLC) or Marsh & McLennan Agency LLC, Private Client Services – National Region (MMA PCS – National) is shown below.

	$1,500 Deductible Plan		**$3,000 Deductible Plan**	
Coverage Level	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***
Employee Only	$82.46	$38.06	$31.46	$14.52
Employee + Spouse/Domestic Partner	$218.17	$100.69	$104.40	$48.18
Employee + Child(ren)	$164.89	$76.10	$70.85	$32.70
Employee + Family	$308.87	$142.55	$143.37	$66.17

Medical rates are not available for employees of MMA-Northeast or Security Insurance Services of Marsh & McLennan Agency LLC. For contribution rates, contact HR Services 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 all eligible Marsh McLennan Employees (including MMA-Northeast and Security Insurance Services of Marsh & McLennan Agency LLC):

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

	$1,500 Deductible Plan		**$3,000 Deductible Plan**	
Coverage Level	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***
Employee + Domestic Partner (non-qualified)				
	$359.65	$165.99	$324.28	$149.66
Employee + Child(ren) (non-qualified)				
	$256.89	$118.57	$231.63	$106.90
Employee + Domestic Partner (non-qualified) & Child(ren)				
	$385.34	$177.85	$347.45	$160.36
Employee + Domestic Partner & Child(ren) (Domestic Partner and Child(ren) (non-qualified)				
	$642.23	$296.42	$579.08	$267.26

ID Cards

If you are enrolled in employee only coverage you will automatically be sent one ID card for your medical coverage and prescription drug coverage. You will be sent on additional ID card if you enroll one or more family members in the Plan. Each enrolled family member will receive their own ID card.

You will be sent your ID card(s) within 7 to 10 days of your enrollment. You may also access your digital ID card via www.kp.org. Be sure to select your applicable Kaiser region.

You may request additional ID cards. Contact Member Services or go to www.kp.org (for regions outside of WA) and www.kp.org/wa (for Western Washington and Spokane area).

How the Kaiser Medical Plan Options Work

This Plan helps you and your family to pay for medical care. Generally, the Plan's reimbursement is 80% for most services (70% under the $3,000 Deductible Plan). You select a primary care physician (PCP) who will manage your care and refer you to a specialist or other provider in the network if necessary. **Except in an emergency or for**

services authorized by Kaiser you do not receive benefits if you receive care outside the network. Note: For emergency care outside the network, you will be responsible to pay the billed charges subject to deductible, coinsurance and out-of-pocket if Kaiser cannot have the charges re-priced through their relationship with the vendors who re-price claims via their network.

For more information, including coverage criteria, other limitations of covered services, and excluded services, see the Kaiser Permanente Evidence of Coverage (EOC) available on Colleague Connect (**https://mmcglobal.sharepoint.com/sites/home**). Select **Pay & Benefits**, under **Find a document**, select **Search all documents**.

Some services have specific limits or restrictions; as described in the Kaiser EOC.

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.

Health Savings Account and Flexible Spending Accounts

If you elect the $1,500 Deductible Plan or the $3,000 Deductible Plan, you can elect to participate instead in a Health Savings Account (HSA) and, if you choose, a Limited Purpose Health Care Flexible Spending Account (LPHCFSA).

For details about the FSA, HSA, or the LPHCFSA, see the *Health Care Flexible Spending Account, Health Savings Account, or Limited Purpose Health Care Flexible Spending Account* sections.

Deductibles

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

The deductibles vary under each of the medical plan options available to you (as shown in the table below).

Plan feature	$1,500 Deductible Plan[4]	$3,000 Deductible Plan[4]
Deductible	Employee: $1,500 Family[1]: $3,000[3]	Employee: $3,000 Family[1]: $6,000[2]

1 "Family" applies to all coverage levels except, Employee-Only.

2 Not "True" Family: For the $3,000 Deductible Plans, if more than one person in a family is covered under this plan, there are two ways the plan will begin to pay benefits for a covered family member. When a covered family member meets his or her individual deductible, benefits begin for that covered family member only, but not for the other covered family members. When the family deductible is met, benefits begin for every covered family member whether or not they have met their own individual deductibles. The family deductible can only be met by one covered family member or a combination of covered family members, as amounts counted toward individual deductibles count toward the larger family deductible. The out-of-pocket maximum functions in the same way. When a covered family member meets his or her individual out-of-pocket maximum, the out-of-pocket maximum is satisfied for that covered family member only, but not for the other covered family members. When the family out-of-

pocket maximum is met, the out-of-pocket maximum is satisfied for every covered family member whether or not they have met their own individual out-of-pocket maximums. The family out-of-pocket maximum can only be met by one covered family member or a combination of covered family members, as amounts counted toward individual out-of-pocket maximums count toward the larger family out-of-pocket maximum.

[3] "True" Family: The $1,500 Deductible Plan does not require that you or a covered family member meet the "individual" deductible in order to satisfy the family deductible. If more than one person in a family is covered under this plan, benefits begin for any one covered family member only after the family deductible is satisfied. The family deductible may be met by one covered family member or a combination of covered family members. The out-of-pocket maximum functions in the same way. If more than one person in a family is covered under this plan, the out-of-pocket maximum is satisfied for any one covered family member when the family out-of-pocket maximum is satisfied. The family out-of-pocket maximum may be met by one covered family member or a combination of covered family members.

[4] These plans are named for the deductible applicable to the "individual" for in-network service providers. The deductibles applicable to any other coverage level (for example, "Family coverage") or for services provided by out-of-network service providers will be significantly higher than (in many instances, double) the amounts captured in the names of the plans.

How do deductibles work?

Under the $1,500 Deductible Plan

If the "employee" coverage level is elected, the Plan will begin reimbursing benefits for the one covered individual once he or she has met the individual deductible.

For all regions except California, for any other coverage level (employee + spouse, employee + child(ren) or family), the Plan will begin reimbursing benefits for a covered family member (including a newborn) once the family deductible is met. In meeting your family deductible, each family member's (including a newborn's) covered expenses (medical and prescription drug expenses) count toward the family deductible. Once this family deductible is met, the Plan will pay benefits for all family members.

In California only, the Plan will begin reimbursing benefits for a covered family member (including a newborn) once he or she has met a deductible of $3,000, (even if the entire family deductible has not been met). The family deductible is the maximum amount you have to pay before the Plan will reimburse any benefits.

Under the $3,000 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) once he or she has met the individual deductible (even if the entire family deductible has not been met). The family deductible is the maximum amount you have to pay before the Plan will reimburse any benefits.

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?

Under the $1,500 Deductible Plan

Most of your medical and prescription drug expenses (including preventive drugs) apply toward the deductible.

Under the $3,000 Deductible Plan

Most of your medical and prescription drug expenses (including preventive drugs) apply toward the deductible.

Out-of-Pocket Maximums

The maximum amount you have to pay toward the cost of the medical care you receive in the course of one year (excluding your contributions to participate in the plan). The out-of-pocket maximums vary under each of the medical plan options as follows:

Plan feature	$1,500 Deductible Plan[4]	$3,000 Deductible Plan[4]
Out-of-pocket maximum (including deductible)	Employee: $3,000 Family[1]: $6,000[3]	Employee: $5,500 Family[1]: $11,000[2]

1 "Family" applies to all coverage levels except, Employee-Only.

2 Not "True" Family: For the $3,000 Deductible Plan, if more than one person in a family is covered under this plan, there are two ways the plan will begin to pay benefits for a covered family member. When a covered family member meets his or her individual deductible, benefits begin for that covered family member only, but not for the other covered family members. When the family deductible is met, benefits begin for every covered family member whether or not they have met their own individual deductibles. The family deductible can only be met by one covered family member or a combination of covered family members, as amounts counted toward individual deductibles count toward the larger family deductible. The out-of-pocket maximum functions in the same way. When a covered family member meets his or her individual out-of-pocket maximum, the out-of-pocket maximum is satisfied for that covered family member only, but not for the other covered family members. When the family out-of-pocket maximum is met, the out-of-pocket maximum is satisfied for every covered family member whether or not they have met their own individual out-of-pocket maximums. The family out-of-pocket maximum can only be met by one covered family member or a combination of covered family members, as amounts counted toward individual out-of-pocket maximums count toward the larger family out-of-pocket maximum.

3 "True" Family: The $1,500 Deductible Plan does not require that you or a covered family member meet the "individual" deductible in order to satisfy the family deductible. If more than one person in a family is covered under this plan, benefits begin for any one covered family member only after the family deductible is satisfied. The family deductible may be met by one covered family member or a combination of covered family members. The out-of-pocket maximum functions in the same way. If more than one person in a family is covered under this plan, the out-of-pocket maximum is satisfied for any one covered family member when the family out-of-pocket maximum is satisfied. The family out-of-pocket maximum may be met by one covered family member or a combination of covered family members.

4 These plans are named for the deductible applicable to the "individual" for in-network service providers. The deductibles applicable to any other coverage level (for example, "Family coverage") or for services provided by out-of-network service providers will be significantly higher than (in many instances, double) the amounts captured in the names of the plans.

Prescription drug expenses apply toward the out-of-pocket maximum.

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

How does the annual out-of-pocket maximum (limit) work for family members?

Under the $1,500 Deductible Plan

In meeting your family out-of-pocket maximum, each family member's (including a newborn's) covered expenses (medical and prescription drug expenses) count toward the family out-of-pocket maximum.

For all regions except California, if you cover eligible family members, you must meet the family out-of-pocket maximum. Once this out-of-pocket maximum has been met, the Plan will pay benefits for all family members at 100%.

In California only, the Plan will begin reimbursing benefits for a covered family member (including a newborn) at 100% once he or she has met the individual out-of-pocket maximum of $3,000 (even if the entire family out-of-pocket maximum has not been met).

Under the $3,000 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) at 100% once he or she has met the individual out-of-pocket maximum (even if the entire family out-of-pocket maximum has not been met).

Networks

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

The Plan only covers in-network claims. Out-of-network claims are only covered if there's an emergency or if Kaiser authorizes a specific service.

Filing a Claim

How do I file a claim for benefits?

In almost all cases, 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.

Typically, 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 Plan except in an emergency or if authorized by Kaiser.

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

As a new hire, you are "Actively-At-Work" on the first day that you begin fulfilling your job responsibilities with the Company at a Company-approved location. If you are absent for any reason on your scheduled first day of work, your coverage will not begin on that date. For example, if you are scheduled to begin work on August 3rd, but are unable to begin work on that day (e.g., because of illness, jury duty, bereavement or otherwise), your coverage will not begin on August 3rd. Thereafter, if you report for your first day of work on August 4th, your coverage will be effective on August 4th.

After-tax (Post-tax) Contributions

Contributions taken from your paycheck after taxes are withheld.

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 the plan pays after you meet your deductible. For purposes of the charts in this document, the percentages represent the portion of the costs that the Plan pays for covered services. So, for example, if the chart indicates 80%, the portion you will be responsible for is 20%.

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, and
- Only when the person who receives services is a covered person and meets all eligibility requirements specified in the Plan.

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

The Claims Administrator determines only the extent to which a service or goods or supplies is covered under the plan and not whether the service or goods or supplies 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 goods or supplies 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.

ELIGIBLE FAMILY MEMBERS

To cover an eligible family member, you will be required to certify in the Mercer Marketplace Benefits Enrollment Website that your eligible family member meets the eligibility criteria as defined below.

Spouse/Domestic Partner means:

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 Plan's criteria, or immediately upon satisfying the Plan's criteria if you previously did not qualify.

Spouse / Domestic Partner

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

Spouse Only

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

Domestic Partner Only

- Although not registered with a US 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 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.

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 a 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 Marsh & McLennan Companies Employees (other than MMA)

Marsh & McLennan Companies employees (other than MMA) are defined as employees classified on payroll as a US regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other than MMA and any of its subsidiaries).

Eligible MMA Employees

As used throughout this document, “MMA Employees” are defined as employees classified on payroll as a US regular employee of Marsh & McLennan Agency LLC – Corporate (MMA-Corporate), Marsh & McLennan Agency LLC – Alaska (MMA-Alaska), Marsh & McLennan Agency LLC – Northeast (MMA-Northeast), Security Insurance Services of Marsh & McLennan Agency LLC or Marsh & McLennan Agency LLC, Private Client Services – National Region (MMA PCS – National).

Eligible Retiree

An employee is eligible for coverage under this plan if he/she is a US 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 is deemed to be eligible for Medicare, the person who is age 65 or is eligible for Medicare is 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 1166 Avenue of the Americas, 31st Floor, New York, NY 10036.

Health Insurance Portability and Accountability Act (HIPAA)

A Federal law, HIPAA imposes requirements on employer health plans including 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

Being treated and admitted at a covered facility for an overnight stay either by a physician or from the emergency room.

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

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

Medicare

The US 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).

Out-of-network Providers

Non-preferred health care providers who do not charge reduced fees to members. Services received from out-of-network providers are not covered, except in an emergency.

Out-of-pocket Expenses

Subject to the following, 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.

Outpatient

Treatment/care received 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.

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.

Waiting Period/Elimination Period

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