

Benefits Handbook Date May 1, 2016

HMSA's Preferred Provider Plan (PPP)

Marsh & McLennan Companies



HMSA's Preferred Provider Plan (PPP)

HMSA's Preferred Provider Plan (PPP) has the largest network of health care providers in Hawaii, including all major hospitals. You may select any participating provider in the network to manage your care, or you may choose a non-participating provider. Generally, your costs are lower if you use a participating provider. PPP also offers members access to over 500,000 Blue Cross and Blue Shield providers nationwide through the BlueCardSM program and emergency care anywhere in the world through HMSA's Away From Home Care Program.

SPD and Plan Document

This section provides a summary of the HMSA's Preferred Provider Plan (PPP) (the "Plan") as of January 1, 2016.

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

A Note about ERISA

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

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The Plan at a Glance

This Plan helps you and your family pay for medical care. You may pay a COPAYMENT for certain services. The chart below contains some important Plan features and coverage amounts. For more information, see the **HMSA's Preferred Provider Plan-A Guide to Benefits**. Go to Colleague Connect (<https://colleagueconnect.mmc.com>), click **Career & Rewards** and select **Career & Rewards Forms/Documents** under Resources.

Plan Feature	Coverage Amount
Deductible	<p><i>In-Network:</i></p> <ul style="list-style-type: none"> ▪ Employee: None ▪ Family Members: None <p><i>Out-of-Network:</i></p> <ul style="list-style-type: none"> ▪ Employee: \$100 ▪ Family members: \$300 maximum
Out-of-pocket maximum	<ul style="list-style-type: none"> ▪ Employee \$2,500 ▪ Family Members \$7,500
Copayments	<p><i>In-Network:</i></p> <ul style="list-style-type: none"> ▪ Physician office/hospital visits: \$12 copay/visit ▪ Specialist visit: \$12 copay/visit ▪ Urgent care center: \$12 copay/visit ▪ Emergency room: \$75 copay/visit <p><i>Out-of-Network:</i></p> <ul style="list-style-type: none"> ▪ 70% covered after DEDUCTIBLE (Out-of-network benefits are based on eligible charges) ▪ Emergency Room: \$75 copay/visit (not subject to annual deductible)
Hospital Stay	<p><i>In-Network:</i></p> <ul style="list-style-type: none"> ▪ 90% covered (based on a semi-private room) <p><i>Out-of-Network:</i></p> <ul style="list-style-type: none"> ▪ 70% covered after deductible <p><i>(Out-of-network benefits are based on eligible charges of a semi-private room)</i></p>

Plan Feature	Coverage Amount
Retail prescription drugs	<p>In-Network:</p> <ul style="list-style-type: none"> ▪ Generic: \$7 copayment, 30-day supply* ▪ Preferred Brand-Name: \$30 copayment, 30-day supply* ▪ Other Brand-Name: \$65 copayment (\$30 plus a \$35 other brand-name cost share), 30-day supply* ▪ Diabetic Supplies: \$30 copayment, 30-day supply* <p>* Maintenance Prescriptions: In addition to the mail order option for obtaining maintenance prescriptions, you can also go to any pharmacy in the "90 Day at Retail" pharmacy network to obtain maintenance prescriptions.</p> <p>Out-of-Network:</p> <ul style="list-style-type: none"> ▪ Generic: Plan pays 80% after the \$7 copayment for up to a 30-day supply ▪ Preferred Brand-Name: Plan pays 80% after the \$30 copayment for brand name prescriptions up to a 30-day supply ▪ Other Brand-Name: Plan pays 80% after the \$65 copayment (\$30 plus a \$35 other brand name cost share) for up to a 30-day supply ▪ Diabetic Supplies: Plan pays 80% after the \$30 copayment, 30-day supply
Mail-order prescription drugs	<ul style="list-style-type: none"> ▪ Generic: \$11 copayment, 90-day supply ▪ Preferred Brand-Name: \$65 copayment, 90-day supply ▪ Other Brand-Name: \$170 copayment (\$65 plus \$105 other brand name cost share), 90-day supply ▪ Diabetic Supplies: \$65 copayment, 90-day supply ▪ Out-of-Network: Not covered
Contact Information	<p>Contact for Medical Service and Prescription Drug Coverage: HMSA (Claims Administrator and Pharmacy Benefit Manager) Phone: +1 808 948 6111 Website: www.hmsa.com</p> <p>Marsh & McLennan Companies does not administer this plan. The Claims Administrator's decisions are final and binding.</p>

Participating in the Plan

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

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

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

Retiree Eligibility

Certain retirees who are not yet 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
- within 60 days of a qualifying change in status that makes you eligible to enroll.

Enrollment procedures for you and your ELIGIBLE FAMILY MEMBERS are described in the *Participating in Healthcare Benefits* section.

Cost of Coverage

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

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

You can choose from four levels of coverage. Cost for each coverage level for eligible Marsh & McLennan Companies employees (other than Marsh & McLennan Agency LLC – Southwest (including Prescott Paillet Benefits) (collectively MMA Southwest) (MMA-Southwest), Marsh & McLennan Agency LLC – Northeast (MMA-Northeast), or Security Insurance Services of Marsh & McLennan Agency) is shown below.

Eligible Marsh & McLennan Companies Employees	Semi-monthly Cost	Weekly Cost
Employee Only	\$21.88	\$10.10
Employee + Spouse	\$199.75	\$92.19
Employee + Child(ren)	\$157.53	\$72.71
Family	\$286.38	\$132.18

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

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

Imputed Income for Domestic Partner Coverage

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

The table below shows the imputed income amounts for ELIGIBLE MARSH & MCLENNAN COMPANIES EMPLOYEES (other than MMA-Southwest, MMA-Northeast, or Security Insurance Services of Marsh & McLennan Agency):

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 HMSA PPP		
Eligible Marsh & McLennan Companies Employees	Semi-monthly	Weekly
Employee + Domestic Partner (non-qualified)	\$395.85	\$182.70
Employee + Child(ren) (non-qualified)	\$282.75	\$130.50
Employee + Domestic Partner (non-qualified) & Child(ren)	\$424.13	\$195.75
Employee + Domestic Partner & Child(ren) (Domestic Partner and Child(ren) non-qualified)	\$706.88	\$326.25

Imputed income rates for domestic partner coverage are not available for employees of MMA-Southwest, MMA-Northeast, or Security Insurance Services of Marsh & McLennan Agency. 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

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

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

How the Plan Works

This Plan helps you and your family pay for medical care. The PPP offers medical benefits for your health care needs including office visits, INPATIENT facility services, OUTPATIENT facility services, and other provider services. This coverage offers you flexibility in the way you obtain medical benefits. In general, to get the best benefits possible, you should seek services from **HMSA Participating Providers**.

For more information, including coverage criteria, other limitations of covered services, and excluded services, see the **HMSA's Preferred Provider Plan-A Guide to Benefits**. Go to Colleague Connect (<https://colleagueconnect.mmc.com>), click **Career & Rewards** and select **Career & Rewards Forms/Documents** under Resources.

Certain expenses not covered by the Plan may be reimbursed through a Health Care Flexible Spending Account.

To receive benefits, the care you receive must be a covered treatment, service, or supply and ordered by a recognized and approved provider.

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

Filing a Claim

Generally, you don't need to file a claim. All participating and many nonparticipating providers in the state of Hawaii will file claims for you. If your nonparticipating provider does not file a claim for you, you will need to submit an itemized bill or receipt listing the services you received within 90 days of the last day on which you received services.

For Flexible Spending Account Reimbursement

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

Appealing a Claim

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

Glossary

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.

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 declaring that:

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 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.

In order to cover the child(ren) of a spouse or domestic partner, you will be required to complete an Affidavit of Eligible Family Member. Go to Colleague Connect (<https://colleagueconnect.mmc.com>), click **Career & Rewards** and select **Mercer Marketplace benefits enrollment website** under Resources.

BEFORE-TAX (PRE-TAX) CONTRIBUTIONS

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

CLAIMS ADMINISTRATOR/PHARMACY BENEFIT MANAGER

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

COINSURANCE

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

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

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

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

COORDINATION OF BENEFITS

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

COPAYMENT

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

COVERED SERVICE(S)

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

Covered health services must be provided:

- when the plan is in effect
- prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description
- only when the person who receives services is a covered person and meets all eligibility requirements specified in the plan.

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

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

DEDUCTIBLE

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

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

Under the HMSA's Preferred Provider Plan, Child/Dependent Child means:

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

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

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

Note: While married children are eligible for healthcare coverage under your plan until the end of the calendar year in which they attain 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 OR MERCER PEOPLEPRO)

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

ELIGIBLE MMA EMPLOYEES

As used throughout this document, "MMA Employees" are defined as employees classified on payroll as US regular employees of MMA-Corporate, MMA-Alaska, MMA-Southwest, MMA-Northeast, or Security Insurance Services of Marsh & McLennan Agency.

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 or Mercer PeoplePro) 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.

EMERGENCY ROOM COVERAGE

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

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

Some examples of emergencies include:

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

- severe abdominal pain
- persistent vomiting
- severe allergic reactions.

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

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

EXPLANATION OF BENEFITS (EOB)

A summary of benefits processed by the Claims Administrator.

GLOBAL BENEFITS DEPARTMENT

Refers to the Global Benefits Department, located at 121 River Street, Hoboken, NJ 07030.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

HOSPICE

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

IN-NETWORK PROVIDERS

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

INPATIENT

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

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.

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.

OUTPATIENT

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

OUT-OF-POCKET EXPENSES

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

PREAUTHORIZATION/PRECERTIFICATION/UTILIZATION REVIEW

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

PREDETERMINATION OF BENEFITS

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

PRE-EXISTING CONDITION

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

PRESCRIPTION DRUGS

- **Preferred 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.
- **Other Brand Prescription Drugs.** Prescription drugs that do not appear on the preferred brand 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.

PRIOR APPROVAL

Prior approval helps ensure you receive proper treatment and services and that these services are provided in the appropriate setting.

QUALIFIED FAMILY STATUS CHANGE (STATUS CHANGE, QUALIFIED CHANGE IN FAMILY STATUS)

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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

QUALIFYING EVENT

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

REASONABLE & CUSTOMARY (R&C) CHARGES/FEES

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

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

URGENT CARE SERVICES

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

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

WAITING PERIOD/ELIMINATION PERIOD

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