Benefits Handbook Date September 1, 2013

Comprehensive Medical Plan (CMP)

Marsh & McLennan Companies

Comprehensive Medical Plan (CMP)

The Comprehensive Medical Plan (CMP) offers comprehensive health services from participating and non-participating providers. Generally, your care is covered after you pay a deductible. 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.

Certain services are subject to precertification review.

A Note about ERISA

While this Plan is generally covered by the Employee Retirement Income Security Act of 1974 (ERISA), a federal law that governs employer-sponsored plans, certain parts of ERISA do not apply to this Plan because of its status as a retiree-only plan. Your ERISA rights in connection with this Plan are detailed in the *Administrative Information* section.

SPD and Plan Document

This section provides a summary of the Comprehensive Medical Plan ("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.

Contents

The Plan at a Glance

Plan feature	Coverage amount
Deductible	▪ The Plan uses a "banded" approach to deductibles and OUT-OF-POCKET MAXIMUMS. See "Deductibles" on page 18.
Out-of-pocket maximum	▪ The Plan uses a "banded" approach to deductibles and out-of-pocket maximums. See "Out-of-Pocket Maximums" on page 20.
Hospital stay	▪ Plan pays 80% after the Plan DEDUCTIBLE has been met.
Surgery in a hospital	▪ Plan pays 80% after the Plan deductible has been met.
Retail prescription drugs	▪ Use a participating retail pharmacy in the Pharmacy Benefits Manager's network to receive a discounted price. ▪ **Generic:** – Plan pays 80% of the Pharmacy Benefits Manager's negotiated price after the Plan deductible has been met. **Note:** Retail prescription claims are applicable to deductible and out-of-pocket limits. ▪ **Brand-Name:** – **In network:** Plan pays 80% of the Pharmacy Benefits Manager's negotiated price after the Plan deductible has been met. – **Out-of-Network:** Plan pays 80% of the Pharmacy Benefits Manager's negotiated price. ▪ You have a "grace period" during which you may fill long term prescriptions up to three times at a participating retail pharmacy and still pay the participating retail pharmacy copayment. Beginning with the fourth time you fill the prescription, you will pay COINSURANCE of 50% for each medication. You should continue to fill your short term prescriptions, such as antibiotics, at a participating retail pharmacy.
Mail-order drugs	▪ The Plan covers 100% of the price after a $15 copayment for generic drugs and $30 copayment for brand name drugs. **Note:** Prescription mail order claims do not apply to deductible or out-of-pocket limits.
Wellness benefit	▪ Not covered
Lifetime maximum	▪ $2,000,000 for each person covered under the Plan
Contact Information	***For Medical Services:*** United HealthCare (Claims Administrator) PO Box 740800 Atlanta, GA 30374-0800 Phone: +1 800 645 6555 Website: www.myuhc.com/groups/mmc ***For Prescription Drug Coverage:*** Express Scripts (Pharmacy Benefits Manager) Express Scripts Customer Service: +1 800 987 8360 Website (for members): www.express-scripts.com Express Scripts Group #: MMCRX05 Marsh & McLennan Companies (Company) does not administer claims under this Plan. For medical claims, UHC's decisions are final and binding; for prescription drug services, Express Scripts' decisions are final and binding.

Participating in the Plan

You are eligible to participate in the Plan if you meet the eligibility requirements.

You also have the option to cover your eligible family members.

Eligibility

You are eligible if you retire from Marsh & McLennan Companies, a Marsh & McLennan Companies operating company (other than (i) Marsh & McLennan Agency, LLC and any of its subsidiaries and generally, either (ii) CS Stars, LLC (formerly Corporate Systems, Inc.) or (iii) Mercer Human Resources Services (now referred to as Mercer Outsourcing)) or Johnson & Higgins January 1, 1983 or later and:

- are a retiree age 65 or over, or
- a retiree under age 65 but has a covered dependent who is age 65 or over*

* You are treated as a "retiree" if you are not currently employed by Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies and have previously met the eligibility requirements under this Plan (terminated employment at age 55 or over with at least five years of vesting service or at age 65 or over).

You can also cover your eligible family members.

Eligibility for the Comprehensive Medical Plan begins for you and your covered family member(s) once one of you is deemed to be MEDICARE eligible. Once deemed to be Medicare eligible, you and your covered family member(s) must transfer to this post-65 plan regardless of whether you or your spouse enroll/enrolled in Medicare. You must contact the Employee Service Center at +1 866 374 2662 within 30 days of your or your covered family member(s) Medicare eligibility date.

Note: Although you may be eligible to participate in retiree medical coverage, the opportunity to defer your retiree medical coverage election only applies to employees that terminate employment on or after April 1, 2010.

Can I cover my spouse?

You can cover your legally married spouse.

My spouse/approved domestic partner also works for (or is retired from) the Company; can I still cover my spouse under the Plan?

You can cover your spouse/approved domestic partner as a family member under this Plan or, if eligible, your spouse/approved domestic partner can elect employee coverage under the Company's active or pre-65 retiree medical plans. Your spouse/approved domestic partner cannot be covered as both, an employee under the Company's active or pre-65 retiree medical plans and as a family member under this Plan. Also, your spouse/approved domestic partner cannot be covered as both a retiree and a family member under this Plan.

Can I cover my approved domestic partner under this plan?

Yes, your domestic partner of the same or opposite sex is eligible for coverage as of January 1, 2009. If you enroll your domestic partner, you must submit an Affidavit of eligible family membership, available through PeopleLink (www.mmcpeoplelink.com).

Your contribution to cover a domestic partner is the same as the cost to cover other eligible family members. Under current tax laws, the Company's cost for providing health care coverage to domestic partners results in "imputed income" to you, and you must pay tax on this income. See "Cost of Coverage" on page 12.

Can I cover my dependent child?

You can cover:

- 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 placed with you for adoption.

My spouse/approved domestic partner also works for the Company; can we both cover our child?

Your child can be covered as a family member under this Plan or as a family member under your spouse/approved domestic partner's coverage under the Company's active or pre-65 retiree medical plans. Your child cannot be covered as both, a family member under this Plan and a family member under the Company's active or pre-65 retiree medical plans. To be covered, your child has to meet the applicable dependent child eligibility requirements.

Can I cover my grandchild?

You cannot cover your grandchild under this plan unless you are the legally appointed guardian or you have legally adopted the child, and the child resides with you.

Can I cover my child when a Qualified Medical Child Support Order (QMCSO) is in effect?

In order to add a child as required by a Qualified Medical Child Support Order, submit the QMCSO to the GLOBAL BENEFITS DEPARTMENT for validation. If the QMCSO is determined to be complete and valid, you will be notified and your child will be added to your coverage.

My dependent child is having a baby; what will be covered?

If your daughter is covered under the Plan, she is covered for maternity benefits, which include delivery of the baby.

Dependent Eligibility Requirements

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

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

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 reaches the limiting age.

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

Note: Age 26 dependent eligibility (See “Children” under “Eligible Family Members” in the *Participating in Healthcare Benefits* section for details.) pertains only to dependents of those retirees that were initially enrolled in one of the Marsh & McLennan Companies pre-65 retiree plans (See *Participating in Pre-65 Retiree Medical Coverage* section for details) and then enrolled in the Comprehensive Medical Plan on or after 1/1/2011.

I am divorced and do not have sole custody of my child; can I still cover my child under the Plan?

You can still cover your child under the Plan if:

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

Can I cover my child, over 19 years of age, who is temporarily out of school?

If your child is temporarily out of school for the summer or other school breaks, you can continue coverage as long as your child still meets the definition of an eligible child.

You can continue this coverage regardless of whether or not your child is employed during the school breaks.

Can I cover my child who permanently leaves school?

You can continue to cover your child through the end of the month in which your child leaves school, as long as your child continues to meet the eligibility requirements.

When your child no longer meets the eligibility requirements, you must remove your child from coverage by accessing PeopleLink (www.mmcpeoplelink.com). No refund of contributions will be paid beyond the date eligibility ceases. If you fail to remove your child from coverage and any claims are paid for expenses incurred after the date eligibility ceases, you and your family must reimburse the Plan for these claims.

Can I cover my disabled child?

You can cover your disabled child over the limiting age. To be eligible for coverage, your child has to be an unmarried child incapable of self support by reason of a total mental or physical disability as determined by the Claims Administrator.

In order to register a child as disabled, you must contact the Claims Administrator for the appropriate form. The form must be completed and returned to the Claims Administrator no later than 30 days after the disabled child's coverage would otherwise end. The Claims Administrator will review the request for disabled status and will notify the Company and the retiree whether the child is determined as disabled. If approved, eligibility records will be adjusted to allow for coverage beyond age 19 or 25 as long as the child meets the remaining eligibility requirements.

Your child's disability has to begin before the date eligibility would otherwise end.

If approved, eligibility records will be adjusted to allow for coverage beyond the limiting age as long as your child meets the remaining eligibility requirements.

Your child also has to be covered under a Company-sponsored medical plan before the limiting age.

Can I cover my married child who is still dependent on me?

No, you cannot cover a married child, even if the child is dependent on you.

To remove your child from coverage, effective the date of the child's marriage or to make a coverage change, sign in to PeopleLink (www.mmcpeoplelink.com), select the **Health** tab and under **Medical Plans**, click **Comprehensive Medical Plan**. Then go to **Take Action** in the right navigation bar and select **Enroll, view, change benefits**. No refund of contributions will be paid beyond the date eligibility ceases. If you fail to remove your

child from coverage and any claims are paid for expenses incurred after the date eligibility ceases, you and your family must reimburse the Plan for these claims. Failure to timely remove your child may also result in missing the child's opportunity for COBRA continuation coverage.

Enrolling/Terminating Retiree Medical Plan Coverage

How do I enroll in retiree medical coverage?

In order to initiate your retiree medical coverage election, you must call the Employee Service Center at least 30 days prior to your Retiree Medical Coverage Participation Date. 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, to make your election. The requirement to contact the Employee Service Center at least 30 days prior to your Retiree Medical Coverage Participation Date will be waived if you elect to participate in retiree medical coverage within 60 days following your termination from the Company.

If you are eligible to participate in retiree medical coverage and you elect to participate, your Retiree Medical Coverage Participation Date will be reflected as the 1st of the month following your termination date, or if you defer your election and elect coverage at a later date, the 1st of any month, **but no later than the 1st of the month following your attainment of age 65** (retiree medical coverage participation dates always are on the 1st of a month).

If you defer your retiree medical coverage participation election date beyond 60 days of your termination date, you can elect to participate at a later date (**no later than the 1st of the month following your attainment of age 65**) provided you submit proof of continuous coverage.

Your retiree medical coverage will take effect the 1st of the month following the earlier of loss of continuous coverage or the 1st of the month following attainment of age 65. If you do not contact the Employee Service Center at least 30 days prior to your participation date, your coverage will begin the 1st of the next month following notification if within 63 days of loss of continuous coverage. **If you notify the Employee Service Center beyond 63 days of your loss of continuous coverage or following your attainment of age 65, you will be denied retiree medical coverage.**

When should I contact the Employee Service Center to elect my retiree medical coverage?

To elect retiree medical coverage, you must 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, at least 30 days prior to your Retiree Medical Coverage Participation Date. The requirement to contact the Employee Service Center at least 30 days prior to your Retiree Medical Coverage Participation Date will be waived if you elect to participate in retiree medical coverage within 60 days of your termination from the Company.

For example:

- If you terminate on June 30th, you can contact the Employee Service Center on August 15th to elect Retiree Medical Coverage effective July 1st. This election is valid since it is within 60 days of the loss of your active medical coverage.
- If you terminate on June 30th, you cannot contact the Employee Service Center on September 15th to elect Retiree Medical Coverage effective July 1st. This election is beyond the 60 days.

Do I have to re-enroll each year?

No, generally you do not need to re-enroll each year, but each year the determination will be made and communicated whether re-enrollment will be required for the upcoming year.

Can I terminate my retiree medical coverage?

Yes, you can terminate your retiree medical coverage at any time by calling the Employee Service Center at +1 866 374 2662, any business day, from 8:00 a.m. to 8:00 p.m. Eastern time. Alternatively, you can send a letter requesting the discontinuance of your retiree medical coverage to:

Employee Service Center
P.O. Box 9740
Providence, RI 02940-9740

Whether you terminate coverage via the phone or in writing, you must submit a termination of coverage request 30 days prior to your coverage end date (always the last day of a month).

Retiree medical coverage cannot be terminated on a retroactive basis, nor can paid premiums be refunded. Also remember, terminated retiree medical coverage cannot be reinstated. You have a one-time opportunity to elect retiree medical coverage.

Can I elect COBRA coverage if I terminate my Retiree Medical Plan coverage?

No. Your request to discontinue your Retiree Medical Plan coverage is not considered a QUALIFYING EVENT. COBRA coverage is not an available option following your termination of Retiree Medical Plan coverage.

Deferring Retiree Medical Plan Coverage

If I defer my retiree medical coverage election, will I remain eligible for the present medical plan design and coverage?

No, if you defer your retiree medical coverage election, you will be eligible for the benefit plans and options available at the time of your election to participate.

If I defer my retiree medical coverage participation election beyond 60 days of my termination date, will I retain the employer subsidy enhanced severance benefit under the severance plan?

No, if you are eligible for Enhanced Severance Benefits under the Company Severance Pay Plan and choose to defer your retiree medical coverage beyond 60-days of your termination date, you will forfeit the Company contribution towards the premium cost of retiree medical coverage.

Can the Company change the medical post-termination eligibility rules?

Yes, the Company reserves the right to make changes to plan design including eligibility rules, continuous coverage, etc.

How do I defer my retiree medical coverage participation election?

No action is required to defer your retiree medical coverage participation election. Once you decide to initiate your retiree medical coverage participation election, 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, to make your election and then submit proof of continuous coverage within the required time period.

If I defer my retiree medical coverage participation election beyond 60 days of my termination date, how do I show proof of continuous coverage?

To enroll in retiree medical coverage after 60 days following your termination date, the Retiree Medical Plan requires that you provide a HIPAA NOTICE OF CREDITABLE COVERAGE certificate(s) for each eligible family member you wish to enroll to prove "continuous coverage" from your date of termination with the Company to your Retiree Medical Coverage Participation Date.

When you contact the Employee Service Center to make your retiree medical participation election, you must also send in your proof of continuous coverage to the address listed below:

Employee Service Center – H&B
P.O. Box 9740
Providence, RI 02940-9740

What are examples of continuous medical coverage that provide HIPAA creditable coverage certificates?

You should check with the coverage provider to make sure they will provide a HIPAA certificate upon request. Be sure to keep your HIPAA certificates in a safe place. Under current HIPAA rules, the following types of coverage qualify as creditable coverage:

- Group health plan coverage (whether as an active or former employee, a spouse, a dependent, or as a COBRA beneficiary)
- Individual or group health insurance policy
- MEDICARE or Medicaid
- Military health insurance program
- The Federal Employees Health Benefits Program
- Health program of the Indian Health Service or a tribal organization
- State health benefits risk pool
- Peace Corps
- Public health plan (including U.S. and foreign government plans whether insured or self-insured
- State Children's Health Insurance Plan (SCHIP).

The following coverage is not considered creditable coverage:

- Coverage under any plan that is excluded from the definition of a group health plan such as dental or vision plans.
- Plans providing specified disease or limited accident benefit coverage.

What is considered "continuous coverage" if I elect to defer my retiree medical coverage election?

If your proof of "continuous coverage" does not show a coverage gap (single period of 63 or more days without coverage), you will be deemed to have "continuous coverage". If you have a period of 63 or more days for which you do not have a HIPAA certificate, your request for retiree medical coverage participation will be denied. Note, time spent in a group health plan waiting period or in an application review period for an individual policy will not count as part of the coverage gap.

For example, if you terminate employment on May 1, 2010 and wish to enroll in retiree medical coverage with a Retiree Medical Participation Date of October 1, 2011, and you provide HIPAA certificates:

Covering the Period of:	"Continuous Coverage" Status
▪ May 1, 2010 – January 1, 2011 ▪ February 15, 2011 - September 30, 2011	You are deemed to have "continuous coverage" because the period from January 1, 2011 to February 15, 2011 for which you do not have a HIPAA certificate is less than 63 days.
▪ May 1, 2010 – January 1, 2011 ▪ July 1, 2011 - September 30, 2011	You will not be deemed to have "continuous coverage" because the period from January 1, 2011 to July 1, 2011 for which you do not have a HIPAA certificate is more than 63 days.
▪ June 1, 2010 – January 1, 2011 ▪ February 15, 2011 - September 30, 2011	You are deemed to have "continuous coverage" because the period from May 1, 2010 to June 1, 2010 and January 1, 2011 to February 15, 2011 for which you do not have HIPAA certificates are each less than 63 days.

What happens if I do not provide proof of continuous coverage by my elected Retiree Medical Coverage Participation Date?

If proof of continuous coverage is not received by your elected Retiree Medical Coverage Participation Date, your coverage will not go into effect. If proof of continuous coverage is received within 63 days of your requested Retiree Medical Coverage Participation Date and it is deemed to be in good order, your retiree medical coverage will go into effect retroactively.

If proof of continuous coverage is not received in good order within the 63 day grace period, you will be denied retiree medical coverage.

If I defer retiree medical coverage, will I automatically receive a COBRA package?

Yes, upon termination, Trion will automatically mail a package, including a COBRA election form and an explanation of your COBRA rights to your home address on file. If you wish to elect COBRA coverage, complete your election form and return it to Trion within your 60-day COBRA election period.

If I elect COBRA for my spouse, can my spouse elect retiree medical if I die during my retiree medical deferral period?

No. If your spouse is not covered under your retiree medical (COBRA coverage is not retiree medical coverage) at the time of your death, your spouse will not have the option to elect retiree medical coverage.

If I participate in retiree medical coverage or defer retiree medical coverage and then die, can my spouse elect retiree medical coverage?

No. If your spouse is not covered under your retiree medical at the time of your death, your spouse will not have the option to elect retiree medical coverage.

Enrollment Changes

During Annual Enrollment, can I change my Retiree Medical Plan coverage?

Yes. During Annual Enrollment you can make the following Retiree Medical Plan changes:

- End coverage for a dependent, or
- End coverage for yourself and your covered dependents.

Can I re-enroll after terminating my Retiree Medical Plan coverage during Annual Enrollment?

No. If you terminate your Retiree Medical Plan coverage, you will not be able to re-enroll at a later date.

Can I drop my spouse/domestic partner from the Company retiree medical plan and at a later date request my spouse's/domestic partner's reinstatement?

If your spouse/domestic partner starts a job and obtains coverage through their employer, you can drop your spouse from the Company retiree medical plan. Subsequently, if your spouse/domestic partner loses coverage due to their termination of employment, you can add your spouse/domestic partner to your Company retiree medical plan coverage.

Can I add my spouse/domestic partner to the Company retiree medical plan if my spouse/domestic partner loses coverage?

If your spouse/domestic partner loses coverage due to their termination of employment, you can add your spouse/domestic partner to your Company retiree medical plan coverage.

Can I enroll my spouse in a Company retiree medical plan coverage option upon termination of COBRA coverage?

Yes, if you choose to elect COBRA for your spouse at retirement, once COBRA coverage is exhausted, you can enroll your spouse in the applicable Company retiree medical plan option in which you are enrolled within 30 days of the event. Termination of COBRA is considered a HIPAA QUALIFYING EVENT.

Can I make a change to my Retiree Medical Plan coverage during the year?

Yes. You may add a dependent during the year if you have a qualifying family status change, such as marriage or death. The change must be consistent with the event.

You can also decrease coverage or cancel coverage at any time during the year. The change does not need to be consistent with a qualifying family status event.

How do I make a change to my Retiree Medical Plan coverage during the year?

To make a change during the year, you must send a written request to the Employee Service Center at the address below within 30 days of the status change.

Employee Service Center
P.O. Box 9740
Providence, RI 02940-9740

ID Cards

If you are enrolled in retiree only coverage, you will automatically be sent one ID card. You will be sent one additional ID card if you enroll one or more family members in the program. Each ID card will list the retiree's name only.

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

Cost of Coverage

Am I eligible for Company-subsidized retiree medical coverage?

You are eligible for Company-subsidized retiree medical coverage (the annual increase in Company contributions for retiree medical coverage will not exceed 5%) if you:

- Were participating in the Retiree Medical Plan as of January 1, 2006;
- Were actively employed by the Company or one of its participating subsidiaries as of December 31, 2005 and had, as of that date, either attained age 45 or completed at least 15 years of vesting service; or
- Certain other employees who, in conjunction with a business reorganization in which the employees would no longer be working for an employer participating in the Retiree Medical Plan, retained eligibility for the Retiree Medical Plan provided that they remain employed within the Company's controlled group.

Eligibility for Company-subsidized medical coverage is dependent upon meeting the retiree medical coverage criteria as previously stated in the "Eligibility" section.

Who pays for retiree medical coverage?

The Company and ELIGIBLE RETIREES share the cost of retiree medical coverage, based on retirees' years of service. Retirees with less than 10 years of vesting service pay the full cost of retiree medical coverage. The Company determines the cost to be borne by the retiree, and the Company pays the remainder of the cost.

How much do I have to pay for coverage?

The cost of Company-subsidized retiree medical coverage (if you satisfy the eligibility requirements) depends on your age, length of Company service, date of hire and the level of coverage you choose.

The cost of retiree coverage takes into consideration the increased cost in providing coverage for retirees.

The annual increase in Company contributions for retiree medical coverage will not exceed 5%.

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.

2013 Plan Year Costs

If you retired on or before January 1, 1991 or you were eligible to retire on January 1, 1991—Retirees

Medicare Eligible	**Monthly Cost**
Individual coverage	$215.94
Family coverage (spouse and each dependent child eligible for MEDICARE)	$431.91
Family coverage (spouse or dependent child not eligible for Medicare)	$766.63

If you retired after January 1, 1991 and you were not eligible to retire on January 1, 1991—Retirees

Years of service	**Monthly cost for Individual coverage**	**Monthly cost for family coverage with all members Medicare eligible**	**Monthly cost for family coverage with any members not Medicare eligible**
Less than 10 years	$396.92	$793.84	$1,569.19

If you retired after January 1, 1991 and you were not eligible to retire on January 1, 1991—Retirees			
10-14	$383.34	$766.68	$1,484.79
15-19	$355.19	$711.91	$1,244.37
20-24	$285.57	$571.15	$1,005.51
25 and more	$215.94	$431.91	$766.63

How much do I have to pay if I am not eligible for Company-subsidized retiree coverage?

If you are not eligible for Company-subsidized retiree medical coverage, you pay the full cost for coverage based on the Company Retiree Medical Plan's group rates.

The cost of unsubsidized retiree medical coverage depends on the level of coverage you choose.

2013 Plan Year Costs

If you retired on or before January 1, 1991 or you were eligible to retire on January 1, 1991—Retirees		
Monthly cost for Individual coverage	**Monthly cost for family coverage with all members Medicare eligible**	**Monthly cost for family coverage with any members not Medicare eligible**
$396.92	$793.84	$1,569.19

2013 Plan Year Costs

If you retired after January 1, 1991 or you were not eligible to retire on January 1, 1991—Retirees		
Monthly cost for Individual coverage	**Monthly cost for family coverage with all members Medicare eligible**	**Monthly cost for family coverage with any members not Medicare eligible**
$396.92	$793.84	$1,569.19

Will my costs change?

Your cost for medical coverage may change. Generally, these changes occur each January 1.

The Company reserves the right to change the amount you are required to contribute at any time.

Do I pay for my coverage with before-tax or after-tax dollars?

You pay for your medical coverage with after-tax dollars.

What happens if I am eligible for Company-subsidized retiree medical coverage, retire and am later rehired?

If you are eligible for Company-subsidized retiree medical coverage, retire and are later rehired by the Company or any subsidiary or affiliate of the Company, your coverage under the Plan will be suspended during the period you are employed by the Company or any subsidiary or affiliate of the Company. You however, will retain your eligibility for retiree medical coverage, provided you initially retired from a participating Company with at least 10 years of vesting service (meeting the current minimum service requirement for the Company subsidy) and you elected the Company Retiree Medical Plan when you initially retired and were still covered under the Plan when you were rehired.

If you are eligible for the retiree medical coverage (retire from a participating Company at age 55 or older with at least five years of vesting service or age 65 or older), you will forfeit the retiree medical coverage and will not be eligible for any retiree medical coverage when you retire again from the Company if any of the following occur:

- you leave the Company before you are eligible for retirement
- you do not initially retire from a participating Company
- you leave a participating Company after you are eligible for retirement and either you do not elect retiree medical coverage or you drop the coverage prior to the date of your rehire.

What happens if I am eligible for unsubsidized retiree medical coverage, retire and am later rehired?

If you are eligible for unsubsidized retiree medical coverage, retire and are later rehired by the Company or any subsidiary or affiliate of the Company, your coverage under the Plan will be suspended during the period you are employed by the Company or any subsidiary or affiliate of the Company. You however, will retain your eligibility for unsubsidized retiree medical coverage when you retire again from the Company or any subsidiary or affiliate of the Company, if you meet the eligibility requirements applicable to you at the time of your retirement.

When Coverage Starts

The coverage, if elected, is effective on your retirement date and continues for as long as the coverage is offered by the Company, provided you pay the required contributions. If you terminate employment in the middle of the month, your employee coverage continues until the end of the month. There will be no lapse in coverage. If you do not enroll in coverage upon your retirement, you may not enroll at a later time. Additionally, if you enroll for medical coverage at retirement but discontinue it later, you may not re-enroll.

If you experience a qualified family status change (such as marriage or birth), your family member's coverage will become effective on the date of the event, if you enroll the family member within 60 days of the qualified family status change.

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

When does my child's coverage start?

Your newborn natural child is eligible for coverage at birth, your legally adopted child is eligible for coverage on the day the adoption is legally finalized. Your stepchild is eligible for coverage upon marriage of his or her parent. However, you must enroll your child within 60 days of the event.

What happens if my family member is in the hospital when coverage is supposed to start?

If you are adding a family member as a result of a family status change and he or she is confined to a health care facility or home under a physician's care on the date coverage would otherwise become effective, your family member's medical coverage will begin 30 days after the confinement ends or before 30 days with proof that the family member is fully recovered.

Changing Levels of Coverage

You can change your level of coverage:

- during Annual Enrollment
- within 60 days of certain qualified family status changes.

See "Enrollment Changes" to determine whether your qualified family status change allows you to enroll, increase, decrease, or discontinue coverage.

When Coverage Ends

Coverage ends on the first of the following to occur:

- the date of your death
- the date the Plan is terminated
- the date you no longer meet the eligibility requirements
- the date you discontinue coverage
- the last date you've paid contributions if you do not make the required contributions.

You may continue coverage under COBRA if you experience a COBRA QUALIFYING EVENT. For more information on COBRA coverage, see "About COBRA Coverage" in the *Participating in Healthcare Benefits* section

How long can I cover my child?

Generally, you can cover your child through the end of the calendar year in which the child attains age 19. You may be able to extend coverage for your child until age 25, as long as your child is:

- a full-time student (generally those with 12 or more accredited hours of course work per semester, or full-time as determined by the school), unmarried, and dependent on you or your spouse or approved domestic partner for support, or
- disabled.

If your child continues to be disabled over the age limit for coverage, your child may still be eligible to continue coverage. Otherwise, if your child reaches the age limit for coverage or no longer meets the Plan's eligibility requirements, you must remove your child from coverage. To make a coverage change, sign in to PeopleLink (www .mmcpeoplelink.com), select the **Health** tab and under **Medical Plans**, click **Comprehensive Medical Plan**. Then go to **Take Action** in the right navigation bar and select **Enroll, view, change benefits**. No refund of contributions will be paid beyond the date eligibility ceases. If you fail to remove your child from coverage and any claims are paid for expenses incurred after the date eligibility ceases, you and your family must reimburse the Plan for these claims. Failure to timely remove your child may also result in missing the child's opportunity for COBRA continuation coverage.

Can I convert this coverage to an individual policy when my coverage ends?

No, you cannot convert this coverage to an individual policy when your coverage ends.

Continuing Coverage under COBRA

You cannot continue coverage under COBRA if you are eligible for MEDICARE.

However, your eligible dependents can continue coverage under this plan through COBRA if they experience a COBRA qualifying event and register their event within the legally allowable time frame. For more information on COBRA coverage, see "About COBRA Coverage" in the *Participating in Healthcare Benefits* section.

How the Plan Works

This plan helps you and your family pay for medical care. As a Comprehensive Medical Plan participant, you may choose, each time you need medical treatment, to use:

- any physician, hospital or lab; or
- a provider who participates in the Preferred Provider Network and has agreed to charge reduced fees to Comprehensive Medical Plan members. Using the Preferred Provider network is more cost effective than using non-network providers because their fees are typically less than those charged by non-network providers

If you use a Preferred Provider, you do not need to submit a claim form. PREFERRED PROVIDERS bill the Claims Administrator directly.

If you or a covered family member is deemed to be eligible for MEDICARE, Medicare is the primary coverage and the Comprehensive Medical Plan is the secondary coverage. Once deemed to be Medicare eligible, you and your covered family member(s) must transfer to the Comprehensive Medical Plan regardless of whether you or your spouse enroll/enrolled in Medicare. You must contact the Employee Service Center at +1 866 374 2662 within 30 days of your or your covered family member(s) Medicare eligibility date.
Generally, the Plan's reimbursement is 80% of the covered service charge, up to the Preferred Provider's negotiated fee if you use a Preferred Provider, or up to the reasonable and customary charge if you do not use a Preferred Provider. You pay the remainder of the fee. (In certain cases, such as, for retiree prolonged illness benefits, the Plan will pay 100% of the charges.)

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

Refer to the section "What's Not Covered" on page 53 to find out about the services that are not covered under the Plan.

Precertification review may be required in order to receive coverage for certain services. For more information on the precertification process and applicable services, refer to the description under "Utilization Review" on page 22 and contact UHC.

Deductibles

What is the individual deductible?

The DEDUCTIBLE is the amount you have to pay before the Plan will pay any benefits.

The Plan's individual deductibles and OUT-OF-POCKET MAXIMUMS are outlined in the chart below.

If you retired on or after January 1, 2009	
Individual Deductible Amount	Individual Out-of-Pocket Maximum
$500	$2,100

Retired before January 1, 2009		
Band Level	Individual Deductible Amount	Individual Out-of-Pocket Maximum
Band A	$0	$300
Band B	$100	$300
Band C	$200	$300
Band D	$200	$1,000
Band E	$400	$1,000
Band F	$400	$2,000
Band G	$400	$3,000
Band H	$700	$3,000

To find out what your band is, please contact the Employee Service Center at +1 866 374 2662.

What is the family deductible?

The deductible is the amount you have to pay before the Plan will pay any benefits.

The Plan's family deductibles and out-of-pocket maximums are outlined in the chart below.

If you retired on or after January 1, 2009	
Family Deductible Amount	Family Out-of-Pocket Maximum
$1,000	$3,150

Retired before January 1, 2009		
Band Level	Family Deductible Amount	Family Out-of-Pocket Maximum
Band A	$0	$450
Band B	$200	$450
Band C	$400	$450
Band D	$400	$1,500
Band E	$800	$1,500
Band F	$800	$3,000
Band G	$800	$4,500

If you retired on or after January 1, 2009	
Family Deductible Amount	Family Out-of-Pocket Maximum
$1,000	$3,150

Retired before January 1, 2009		
Band Level	Family Deductible Amount	Family Out-of-Pocket Maximum
Band H	$1,400	$4,500

To find out what your band is, please contact the Employee Service Center at +1 866 374 2662.
In meeting your family deductible, each family member's (including a newborn's) covered expenses up to his or her individual deductible count toward the family deductible. Once this family deductible is met, the Plan will begin to pay benefits for all family members. The Plan will also begin to pay applicable benefits for any covered family member who meets the individual deductible, even if the total family deductible is not met.

Do I have to meet a new deductible every year?

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

What expenses apply toward the deductible?

Most of your payments for eligible charges apply toward the medical deductible.

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

- amounts in excess of a reasonable and customary charge
- any excluded services
- amount exceeding the network negotiated price for PRESCRIPTION DRUGS.

Out-of-Pocket Maximums

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

The Plan's deductibles and OUT-OF-POCKET MAXIMUMS are outlined in the chart below.

If you retired on or after January 1, 2009	
Individual Deductible Amount	Individual Out-of-Pocket Maximum
$500	$2,100

Retired before January 1, 2009		
Band Level	Individual Deductible Amount	Individual Out-of-Pocket Maximum
Band A	$0	$300
Band B	$100	$300
Band C	$200	$300
Band D	$200	$1,000
Band E	$400	$1,000
Band F	$400	$2,000
Band G	$400	$3,000
Band H	$700	$3,000

To find out what your band is, please contact the Employee Service Center at

+1 866 374 2662.

The Plan's deductibles apply towards the annual out-of-pocket maximum.

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

- amounts exceeding Plan limits
- amounts exceeding the network negotiated price for PRESCRIPTION DRUGS
- amounts your physician or health care provider may charge above the reasonable and customary charge
- speech therapy for a child.

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

The Plan's deductibles and out-of-pocket maximums are outlined in the chart below.

If you retired on or after January 1, 2009	
Family Deductible Amount	Family Out-of-Pocket Maximum
$1,000	$3,150

Retired before January 1, 2009		
Band Level	Family Deductible Amount	Family Out-of-Pocket Maximum
Band A	$0	$450
Band B	$200	$450
Band C	$400	$450
Band D	$400	$1,500
Band E	$800	$1,500
Band F	$800	$3,000
Band G	$800	$4,500
Band H	$1,400	$4,500

To find out what your band is, please contact the Employee Service Center at +1 866 374 2662.
The out-of-pocket limit does not apply to:

- amounts exceeding Plan limits
- amounts exceeding the network negotiated price for prescription drugs
- amounts your physician or health care provider may charge above the reasonable and customary charge
- speech therapy for a child.

Utilization Review

Which utilization review services are offered?

The Plan offers precertification review, CASE MANAGEMENT REVIEW, and organ transplant review.

You may obtain more information about these review services by calling +1 800 645 6555.

Precertification Review

Precertification review is a utilization review service that helps ensure you receive proper treatment and services, and that these services are provided in the appropriate setting.

What services require precertification?

The following services require that you obtain precertification review:

- all hospital admissions
- DURABLE MEDICAL EQUIPMENT when the purchase or rental price exceeds $1,000
- 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 precertify within 48 hours of service.

When to obtain precertification review

You, your family member or health care professional must obtain precertification review as soon as you know you need a service requiring precertification review but no later than seven days prior to the procedure or treatment.

Do I need to obtain precertification if I am retired and age 65 or over?

No. Precertification is not required. However, any covered family member who is under age 65 is still subject to precertification review.

How do I obtain precertification review?

Initiate precertification review by calling +1 800 645 6555. You will be asked for the following information:

- the name, address, date of birth and Social Security number of the retired employee and, if not the same person, of the patient
- the attending physician's name, address and telephone number
- the admitting diagnosis and requested treatment.

A medical professional will then call your physician to learn the medical information about your case. Medical reviews are performed by health care professionals (typically a registered nurse) who have access to the latest medical information. Physician advisors are also available in each specialty that may assist in the precertification review service.

What happens if I fail to obtain precertification?

If you fail to obtain precertification review, your benefits will be reduced by 30%, up to $5,000 per incident (the penalty for participants residing in Hawaii is 10% up to $5,000).

Suppose, for example, you enter the hospital for surgery which you did not precertify. The bill for the surgery was $3,000, which is within the reasonable and customary limit. Because you had satisfied the annual DEDUCTIBLE, the Plan would normally reimburse $2,400, or 80% of the bill, and you would be responsible for the remaining 20%, or $600, as the Plan COINSURANCE.

However, because you failed to obtain precertification review, in this instance the Plan would reimburse only $1,500 or 50% of the bill. You would be required to pay 30% of the bill—in this case, $900—in addition to the normal $600 coinsurance. Similar reductions are applied to all related charges until the $5,000 limit in penalty amounts is met.

If you are eligible for 100% reimbursement—because you met your out-of-pocket limit or you qualify for prolonged illness coverage—you will receive 70% reimbursement.

Regardless of whether you precertify your treatment, you will not receive reimbursement for any treatment that is not necessary.

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

You must obtain precertification review as soon as possible but at least seven 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 precertify within 48 hours of the service.

Is a second opinion required and/or covered?

If a review of your medical information indicates the need, the Plan may require that you receive a second opinion before concluding that your suggested course of treatment is appropriate for Plan coverage.

The Plan pays the full cost of a required second opinion. If you get a second opinion that is not required by the Plan, the Plan will pay 80% of the cost for the second opinion after the Plan deductible has been met.

Case Management Review

When the precertification review 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. Throughout the treatment plan, the case manager acts as the patient's advocate and is available to offer support to both the patient and his or her family. 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 Comprehensive Medical Plan would not ordinarily cover.

Because health care contracts nationwide, 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. The objective is to support you in getting the health care you need while minimizing your out-of-pocket expense for treatment.

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 Claims Administrator 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).

Prolonged Illness Coverage

Prolonged illness coverage protects you from spending your out-of-pocket limit year after year on covered expenses for a continuing illness or medical condition that affects you or a covered family member. If you are approved for prolonged illness coverage the Plan will reimburse 100% (rather than 80%) of related covered expenses for this specific illness or condition, after the annual Plan DEDUCTIBLE is satisfied.

This protection is available only if you qualify for the coverage as of December 31, 2008.

This example illustrates how prolonged illness coverage works. Assume a retired employee who earned $35,000 a year as of the December 1 before retirement has a spouse with a chronic heart condition. Reasonable and customary medical expenses for the condition amount to $10,000 the first year and $10,000 in following years. The retired employee's individual out-of-pocket limit is $1,750 (5% of base salary as of the December 1 before your retirement). The Plan would cover expenses as follows:

First year	
Prolonged illness expense	$10,000
Less individual out-of-pocket limit	-1,750
The Plan pays	$8,250
Following years	
Prolonged illness expense	$10,000
Less individual deductible	-350
The Plan pays	$9,650

Because of this provision, you have saved $1,400 in medical expenses related to this condition each following year.

Is prolonged illness coverage subject to the various Plan limits?

Prolonged illness coverage is subject to all Plan limits, such as, reasonable and customary charges and the LIFETIME MAXIMUM.

Participation will be frozen to retirees who have qualified as of December 31, 2008.

How do I qualify and obtain prolonged illness coverage?

To qualify for prolonged illness coverage, you or a covered family member must spend the out-of-pocket limit in one calendar year on covered expenses related to one illness or condition.

Participation will be frozen to retirees who have qualified as of December 31, 2008.

How will I know if I am approved for prolonged illness coverage?

The Plan's Claims Administrator will send you notification as to whether or not you qualify for prolonged illness.

If I am approved, when will prolonged illness coverage take effect?

The coverage will begin on January 1 of the following year.

Do I have to reapply each year for coverage?

Once you qualify for prolonged illness coverage, you do not have to reapply each year for that condition.

Coordinating with Other Plans

What is 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.

How does coordination of benefits work when my spouse and I are covered under two plans?

When you or your spouse are covered under two plans, there are certain rules that determine which plan pays its benefits first. The Plan that covers you or your spouse as the retired employee pays its benefits before the Plan that covers you or your spouse as a family member.

If it is determined that the other plan will pay first, the benefits payable under the Comprehensive Medical Plan will be reduced by the amount or value of the services paid by the other plan.

You should submit your claims to the primary plan first. When you receive a payment from the primary plan, you should submit a claim form and a copy of the Explanation of Benefits to the secondary payer, for any additional benefit.

How does coordination of benefits work when children are covered under two plans and the parents are not divorced or separated?

The benefit plan of the parent whose birthday falls earlier in the calendar year pays first. If you and your spouse have the same birthday, the Plan that covered you or your spouse longer pays first. If the other plan does not have the parent birthday rule, the other plan's COORDINATION OF BENEFITS rule applies.

You should submit your claims to the primary plan first. When you receive a payment from the primary plan, you should submit a claim form and a copy of the Explanation of Benefits to the secondary payer, for any additional benefit.

How does coordination of benefits work for children of divorced or separated parents?

The Plan that pays first is determined in this order:

- If a court decree has established financial responsibility for your child's health care expenses, and the Plan of that parent has actual knowledge of those terms, the Plan of the parent with this responsibility pays first.

- Next, the Plan of the parent with legal custody of your child pays.
- Then, the Plan of the spouse of the parent with custody of your child pays (if applicable).
- Then, the Plan of the biological parent not having custody of your child pays.
- Then, the Plan of the spouse of the parent not having custody of your child pays.

In the case of joint custody where no financial responsibility for a child's health care has been established by the court, the Plan of the parent whose birthday falls earlier in the year will pay first.

You should submit your claims to the primary plan first. When you receive a payment from the primary plan, you should submit a claim form and a copy of the Explanation of Benefits to the secondary payer, for any additional benefit.

How does coordination of benefits work when one person is covered as the retired employee under two plans?

If you are covered as the retired employee under two separate medical plans, your medical plan that has covered you for the longest time will be the primary plan and will pay its benefits first.

You should submit your claims to the primary plan first. When you receive a payment from the primary plan, you should submit your claim and a copy of the Explanation of Benefits to the secondary payer, for any additional payment.

Coordination of Benefits with Medicare

What happens if I am a retiree and I enroll for a Medicare Prescription Drug Plan?

The MEDICARE Modernization Act (MMA) added a voluntary prescription drug benefit to the Medicare Program effective January 1, 2006. If you are currently enrolled in the Company medical coverage and you enroll in Medicare prescription drug coverage, you and your covered family members will lose all coverage under the Company medical plans beginning on the date your Medicare prescription drug coverage takes effect. If you later decide you no longer want Medicare prescription drug coverage, you may not re-enroll in the Company medical coverage in the future.

As a retiree, how does Medicare affect my benefits under the Comprehensive Medical Plan?

Once you or a covered family member attains age 65, or is deemed to be Medicare eligible, you or your family member must obtain Medicare Parts A and B if you are eligible, even if you are not eligible for free Medicare Part A coverage. Once you are retired and Medicare eligible, benefits from the Comprehensive Medical Plan are paid on the basis that you have secured both Medicare Part A and B coverages—even if you

have not. This is also true for covered family members who are eligible for Medicare Parts A and B.

Once you are retired and deemed to be eligible for Medicare, Medicare becomes your primary medical coverage; this plan becomes secondary. The premiums for this retiree coverage may be adjusted when you become eligible for Medicare Parts A and B (Medicare is not primary for you or your covered family members under age 65 or who are not deemed to be Medicare eligible).

The Medicare Part B benefit equals 80% of the Medicare approved fee (after the DEDUCTIBLE) for a covered service. Some doctors agree to accept the Medicare approved fee as a payment. Whether or not the doctor accepts the Medicare assignment determines how benefits from the Comprehensive Medical Plan are coordinated with Medicare benefits.

Please note that, because of coordination with Medicare, the Plan's Preferred Provider Network feature is not available to you or your covered family members once you or a covered family member attains age 65 or are deemed to be eligible for Medicare.

How does the Comprehensive Medical Plan determine what my benefit would be?

The Comprehensive Medical Plan determines what your benefit would be based on your doctor's fee up to the lesser of the reasonable and customary charge and the Medicare approved fee. The Plan then subtracts the Medicare benefit from this amount, and pays any remaining balance.

The following example illustrates how the Plan coordinates with Medicare for a retired employee who has already met the deductible and whose doctor accepts Medicare assignment. The Medicare approved fee for this service is $200 and this fee is less than the reasonable and customary amount.

Medicare		Comprehensive Medical Plan (CMP) (before coordination)		Benefit from the Plan (after coordination)	
Approved Fee	$200	Covered medical expense	$200	Allowable Benefit	$160
Coverage level	× 80%	Coverage level	× 80%	Medicare benefit	$160
Medicare benefit	$160	Allowable Benefit	$160	Plan benefit	$0

Amount that counts towards out-of-pocket limit: $40

In the above example, if the physician does not accept Medicare assignment, the Medicare allowed charge (which can be higher than the Medicare approved fee) is used

instead of the Medicare approved fee to determine the covered expense under the (All States)—Comprehensive Medical Plan (CMP).

In order for any dollar amounts to be applied to your deductible and out-of-pocket amounts, you must first submit your claims to Medicare for processing. Upon receipt of your Medicare EXPLANATION OF BENEFITS (EOB) you must submit the EOB, along with your original claim, to the Claims Administrator.

Injury and Illness Caused by a Third Party

If I become injured or ill as a result of an accident caused by a third party, what happens to any payment I may receive?

To the maximum extent permitted by law, the Plan is entitled to equitable or other permitted remedies, including a lien or constructive trust, to recover any amounts received as a result of a judgment, settlement or other means of compensation for conditions or injuries which have resulted in the payment of benefits under this plan. This will include, but is not limited to, damages for pain and suffering and lost income.

The Plan is entitled to recover these amounts from the participant; any covered family member or beneficiary, or any other person holding them, up to the amount of all payments made or payable in the future. The Plan has priority to any and all funds recovered in any full or partial recovery, including funds intended to compensate for attorney's fees and other expenses.

As a condition of receiving benefits under this plan, you agree that:

- You will promptly notify the Claims Administrator of any settlement negotiations, settlement, or judgment in any litigation related to an event or condition for which you have received, or expect to receive, benefits under this plan; and
- Future benefits, even for an unrelated event or condition, may be reduced by the amount of any judgment or settlement, or similar compensation which the Plan would be entitled to under the rules above but is unable to recover.

Filing a Claim

If you use a Preferred Provider, you do not need to submit a claim form. PREFERRED PROVIDERS bill the Claims Administrator directly.

If you receive services from a provider who does not participate in the Preferred Provider network, you generally need to file a claim to receive benefits. However, if you sign up for the MEDICARE CROSS-OVER feature, MEDICARE Part B expenses (e.g., doctor's services, OUTPATIENT care, lab tests, DURABLE MEDICAL EQUIPMENT, home health care) need only be submitted to Medicare. Medicare will automatically submit these claims directly to the Claims Administrator. (See "How does the Medicare Cross-Over feature work?" on page 31 for information about the Medicare Cross-Over feature.)

How do I file a claim for benefits?

If you are covered by Medicare, you must first submit your claims to Medicare, since Medicare is the primary payer. Then, you need to submit a Comprehensive Medical Plan Claim Form to the Claims Administrator, along with a copy of your Explanation of Medicare Benefits statement. However, if you sign up for the Medicare Cross-Over feature, Medicare Part B and durable medical equipment claims will automatically be forwarded by Medicare to the Claims Administrator—you will not have to file separate claims for these services.

If you or a dependent is not covered by Medicare, you need to submit a claim form to the Claims Administrator. You can obtain a Comprehensive Medical Plan Claim Form (United Healthcare Medical Claim Form) on PeopleLink (www.mmcpeoplelink.com) or contact the Claims Administrator at +1 800 645 6555. Select the **Health** tab and under **Medical Plans**, click **Comprehensive Medical Plan**. Then go to **Forms and Documents** in the right navigation bar and select **Medical/Dental/Flexible Spending Accounts**.

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

Mail the completed claim form and all relevant documentation (including an Explanation of Medicare Benefits statement, if applicable) as the form instructs. You may include more than one bill with a claim, even if the bills are for different medical services. It normally takes up to 10 business days from receipt of your claim for the Claims Administrator to process the claim.

You have up to 15 months following the date the expense was incurred to file a medical claim.

Medicare Cross-Over

How does the Medicare Cross-Over feature work?

With Medicare Cross-Over, Medicare pays first and then automatically forwards claims electronically to the Claims Administrator for processing. This means that you will not have to file separate claims with the Claims Administrator for these services. Medicare Cross-Over applies to Medicare Part B (medical) services, such as:

- doctor’s services
- outpatient medical and surgical services and supplies
- diagnostic tests
- ambulatory surgery center facility fees for approved procedures
- durable medical equipment

- outpatient mental health care
- outpatient occupational and physical therapy, including speech-language services
- home health care.

The Medicare Cross Over feature does not apply to Medicare Part A (e.g., hospital) claims or PRESCRIPTION DRUGS. You still need to file a claim form with the Claims Administrator to be reimbursed for these expenses.

How do I sign up for Medicare Cross-Over?

To sign up for Medicare-Cross Over, complete the Medicare Cross-Over Enrollment Form and send it to the Claims Administrator at the address on the form. It typically takes six to eight weeks for Medicare Cross-Over to take effect. The Medicare Cross-Over Enrollment Form is available on PeopleLink or by calling the Claims Administrator at +1 800 645 6555.

Medicare Cross-Over is available to participants who have primary coverage with Medicare, if they do not have group coverage from another source. Anyone who has Medicare-primary and has secondary coverage from a source other than United Healthcare should not enroll in Medicare Crossover.

How do I know that Medicare submitted the claim to the Claims Administrator?

Check every Explanation of Medicare Benefits (EOMB) you receive from Medicare. It should contain a message indicating that your claim has been sent to your secondary provider (the Claims Administrator). If your EOMB does not state that your claim was forwarded, you will have to submit the claim yourself.

How do I file a prescription drug claim form?

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

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

How do I file a claim for hospital charges?

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

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

How do I file a claim for services incurred outside the United States?

If you incur medical expenses while living or traveling abroad, your claim's processing will be expedited if the receipts are in English or if the person providing the services gives you a letter in English explaining the treatment. The Claims Administrator will convert the bill to U.S. dollars using an exchange rate on the day the services were performed.

How does claims processing work?

After the Claims Administrator receives a claim form and approves the claim, a check will be sent to the provider or you, as indicated on your claim form.

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

Most claims are normally processed within two weeks after the claim is filed.

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

What is an Explanation of Benefits (EOB)?

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

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

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

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

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

What happens if I am overpaid for a claim?

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

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

How do I appeal a benefit determination or denied 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 see the *Administrative Information* section for more information on the appeal process.

What's Covered

Pre-existing Conditions

There are no exclusions, limitations or waiting periods for PRE-EXISTING CONDITIONS for you or any covered family members.

Office Visits

Does the Plan cover office visits for preventive / wellness care?

The Plan does not include preventive/WELLNESS BENEFITS for retirees.

Preventive/Wellness Care

The Plan does not cover preventive/wellness care if you retire and participate in this plan.

Does the Plan cover gynecology visits?

The Plan does not include preventive/wellness benefits for retirees. If the visit to the gynecologist is for treatment of a medical condition, it is not considered routine care and will be covered at 80% after the Plan's DEDUCTIBLE has been met.

Does the Plan cover mammograms?

The Plan does not include preventive/WELLNESS BENEFITS for retirees. However, if your doctor recommends a non-routine mammogram as a follow-up to a medical diagnosis, the Plan covers your mammogram at 80% after the Plan's deductible has been met.

Does the Plan cover Pap smears?

The Plan does not include preventive/wellness benefits for retirees. However, if your doctor recommends a non-routine Pap smear as a follow-up to a medical diagnosis, the Plan covers your Pap smear at 80% after the Plan's deductible has been met.

Does the Plan cover prostate specific antigen (PSA) tests?

The Plan does not include preventive/wellness benefits for retirees. However, if your doctor recommends a non-routine PSA test as a follow-up to a medical diagnosis, the Plan covers your PSA test at 80% after the Plan's deductible has been met.

Are immunizations for business travel covered under the Plan?

The Plan does not cover immunizations for business travel.

Maternity

Maternity coverage is available to eligible covered participants.

Does the Plan cover prenatal visits?

The Plan covers prenatal visits at 80% after the Plan's DEDUCTIBLE has been met.

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

The Plan covers charges for delivery of the baby at 80% after the Plan's deductible has been met.

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

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

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

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

The Plan covers hospital charges for maternity admissions at 80% with no copayment after the Plan deductible has been met.

The Plan covers newborn nursery care at 80% after the Plan's deductible has been met.

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

The Plan is in accordance with the Newborn and Mothers Healthcare Protection Act. Under the Act, the mother and the newly born child are covered for a minimum of 48

hours of care following a vaginal delivery and 96 hours following a Cesarean section. However, the mother's provider may—after consulting with the mother—discharge the mother earlier than 48 hours following a vaginal delivery (96 hours following a Cesarean section).

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

Family Planning

Does the Plan cover infertility treatment?

The Plan covers infertility treatments at 80% after the Plan's DEDUCTIBLE has been met. There is a maximum of $15,000 per lifetime for infertility treatments. These infertility treatments are covered under the Plan:

- assisted reproduction procedures (including drugs, facility charges and related expenses) due to infertility
- gamete intrafallopian transfer (GIFT)
- in vitro fertilization
- microinjection techniques
- zygote intrafallopian transfer (ZIFT).

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

Does the Plan cover artificial insemination?

Artificial insemination is covered at 80% after the Plan's deductible has been met and up to a maximum benefit of four times per month for one six-month period per lifetime (does not count toward the $15,000 maximum for other infertility treatments). You should obtain a predetermination of benefits to determine your coverage and benefits for these services.

Does the Plan cover vasectomy?

The Plan covers vasectomy at 80% after the Plan's deductible has been met.

Vasectomy reversals are not covered.

Does the Plan cover tubal ligation?

The Plan covers tubal ligation at 80% after the Plan's deductible has been met.

Tubal ligation reversals are not covered.

Does the Plan cover pregnancy terminations?

The Plan covers pregnancy terminations at 80% after the Plan's deductible has been met.

Inpatient Hospital and Physician Services

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

The Plan pays INPATIENT hospital charges at 80% after the Plan DEDUCTIBLE has been met.

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

You must obtain precertification review as soon as possible but at least seven 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 precertification review as soon as possible but at least seven 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 precertify within 48 hours of the service.

Does the Plan cover hospital visits by a physician?

The Plan covers hospital visits by a physician at 80% after the Plan deductible has been met.

Does the Plan cover ambulance charges?

The Plan covers transportation by professional ambulance, other than air ambulance, to and from a medical facility at 80% after the Plan's deductible has been met.

Transportation by regularly-scheduled airline, railroad or air ambulance to the nearest medical facility qualified to give the required treatment is covered if the participant is being moved to the nearest facility that can render the treatment, and this facility cannot (in sufficient time) be reached by a professional ambulance.

Does the Plan cover hospice care?

The Plan covers charges for HOSPICE care at 80% after the Plan's deductible has been met.

You must obtain precertification review before you undergo hospice care.

Surgery

Does the Plan cover inpatient surgery?

The Plan covers charges for surgery at 80% after the Plan's DEDUCTIBLE has been met.

To get full benefits, you may have to obtain a second surgical opinion before your surgery.

Does the Plan cover outpatient surgery?

The Plan covers charges for OUTPATIENT surgery at 80% after the Plan's deductible has been met.

You must obtain precertification review before you undergo certain outpatient procedures.

Does the Plan cover anesthesiologist charges?

The Plan covers charges for anesthesiologist services at 80% after the Plan's deductible has been met.

Does the Plan cover assistant surgeon charges?

The Plan covers charges for assistant surgeon services at 20% after the Plan's deductible has been met.

Do I need a second opinion before having surgery?

A second surgical opinion is covered at 100%, if required, with no deductible; it is covered at 80%, if not required, after the Plan's deductible has been met. If the second opinion doesn't agree with the first, the Plan still pays at the levels listed above.

Does the Plan cover cosmetic surgery?

The Plan doesn't cover cosmetic surgery.

What should I do if I need multiple surgical procedures performed concurrently?

The Claims Administrator reviews concurrent multiple surgical procedures on a case by case basis to determine the appropriate reasonable and customary level of reimbursement. For an estimate of what the Plan will pay, you will need to have a PREDETERMINATION OF BENEFITS, and submit the predetermination of benefits to the Claims Administrator, listing the diagnosis, procedure codes and charges, before you undergo the surgical procedures.

Does the Plan cover organ transplants?

The Plan covers organ transplant expenses at 80% after the Plan's deductible has been met.

You must obtain authorization from the Claims Administrator before you undergo any one of the following: the evaluation, the donor search, the organ procurement / tissue harvest, and the transplant procedure.

Certain transplants are only payable if they are performed at the Claims Administrator's designated transplant facility. These transplants are:

- heart
- lung
- heart / lung
- liver
- kidney
- pancreas
- kidney / pancreas
- bone marrow / stem cell
- intestinal
- others as determined by the Claims Administrator.

Covered expenses include pre-transplant evaluation for one of the transplants listed above, organ acquisition and procurement, hospital and physician fees, transplant and procedures, follow-up care for a period of up to one year after the transplant, search for bone marrow / stem cells from a donor who is not biologically related to the patient.

The Plan will assist the patient and one family member or companion, or two family members or companions for a pediatric recipient, with travel and lodging to the designated transplant facility if the transplant recipient resides more than 50 miles from the designated transplant facility, and will pay reasonable expenses up to a set per diem. There is a combined overall LIFETIME MAXIMUM of $10,000 for all transportation, lodging and meal expenses incurred by the transplant recipient and one family member or companion, or recipient and family members or companions for a pediatric recipient, in connection with all transplant procedures under this plan.

In the case of an organ or tissue transplant, donor charges are covered only if the recipient is covered under this plan. If the recipient is not covered under this plan, no benefits are payable for the donor charges.

The search for bone marrow / stem cells from a donor who is not biologically related to the patient is not covered unless the search is made in connection with a transplant procedure arranged by a designated transplant facility.

Does the Plan cover mastectomies and reconstructive services?

The Plan pays for in-network providers and of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met to the extent required under the Women's Health and Cancer Rights Act. These services include:

- reconstruction of the breast on which a mastectomy has been performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance,
- prosthesis, and
- treatment of physical complications at all stages of a mastectomy, including lymphedema.

Emergency Room

Does the Plan cover emergencies?

The Plan covers emergency care for life-threatening injury or illness in a hospital emergency room at 80% after the Plan's DEDUCTIBLE has been met.

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

What are some examples of life threatening illness or injury requiring emergency treatment?

Some examples of life threatening illnesses or injuries requiring emergency treatment are:

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

Mental Health

Does the Plan cover inpatient hospitalization for mental health treatment?

The Plan covers treatment of mental health conditions in a hospital or mental health facility at 80% after the Plan's DEDUCTIBLE has been met.

You must obtain precertification review before you are admitted to the hospital.

Does the Plan cover outpatient mental health treatment?

The Plan covers OUTPATIENT mental health visits at 80% after the Plan's deductible has been met.

Alcohol and Substance Abuse

Does the Plan cover inpatient hospitalization for alcohol and substance abuse treatment?

The Plan covers alcohol and substance abuse treatment in a hospital or mental health facility at 80% after the Plan's DEDUCTIBLE has been met.

The following chart represents the covered length of stay for the various INPATIENT treatments:

Treatment	Length of stay
Alcohol detoxification	Up to three days
Single drug dependency detoxification	Up to seven days
Multiple substance dependency detoxification	Up to 14 days

You must obtain precertification review before you are admitted to the hospital.

Does the Plan cover outpatient alcohol and substance abuse treatment?

The Plan covers OUTPATIENT visits for alcohol and substance abuse treatment at 80% after the Plan's deductible has been met.

The out-of-pocket limit does not apply to this benefit.

Speech, Physical and Occupational Therapy

Does the Plan cover speech therapy?

The Plan covers speech therapy by a licensed speech therapist at 80% after the Plan's DEDUCTIBLE has been met. There is a maximum benefit of 20 visits per calendar year for speech therapy.

The Plan covers speech therapy for children through age three whose speech is impaired due to infantile autism, developmental delay or cerebral palsy, hearing

impairment, or major congenital anomalies that affect speech such as cleft lip and cleft palate.

The Plan covers speech therapy for individuals over age three if services are provided to restore speech lost or impaired due to surgery, radiation therapy or other treatment which affects the vocal cords, cerebral thrombosis (cerebral vascular accident), brain damage due to brain lesion (aphasial), or accidental injury.

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

Does the Plan cover physical therapy?

The Plan covers physical therapy at 80% after the Plan's deductible has been met. There is a maximum benefit of 20 visits per calendar year for physical therapy.

Does the Plan cover occupational therapy?

The Plan covers occupational therapy visits at 80% after the Plan's deductible has been met. There is a maximum benefit of 20 visits per calendar year for occupational therapy.

Allergies

The Plan covers allergy tests at 80% after the Plan's DEDUCTIBLE has been met.

The Plan covers allergy treatment at 80% after the Plan's deductible has been met.

CAT/PET Scans

The Plan covers CAT/PET scans at 80% after the Plan's DEDUCTIBLE has been met.

You must obtain precertification review before you undergo a PET scan.

Chiropractors

The Plan covers chiropractor charges at 80% after the Plan's DEDUCTIBLE has been met.

There is a maximum benefit of 20 visits per calendar year for chiropractic care.

Cardiac Rehabilitation

The Plan covers cardiac rehabilitation at 80% after the Plan's DEDUCTIBLE has been met.

There is a maximum benefit for cardiac rehabilitation of 36 visits per calendar year.

Durable Medical Equipment

The Plan covers charges for DURABLE MEDICAL EQUIPMENT at 80% after the Plan's DEDUCTIBLE has been met and if the equipment is prescribed by a physician.

Examples of durable medical equipment are appliances which replace a lost body organ or part or help an impaired one to work; orthotic devices such as arm, leg, neck and back braces; equipment needed to increase mobility; such as a wheelchair; hospital-type

beds; respirators or other equipment for the use of oxygen; and monitoring devices such as CPAP/biPAP machines for sleep apnea.

The Claims Administrator decides whether to cover the purchase or rental of durable medical equipment. Precertification is needed for durable medical equipment when the purchase or rental price exceeds $1,000.

Hearing Care

The Plan covers hearing care charges as a result of injury at 80% after the Plan's DEDUCTIBLE has been met. Hearing exams, hearing aid evaluations, hearing aids and care received because of hearing loss as a result of age are not covered.

Home Health Care

The Plan covers charges for non-custodial home health care at 80% after the Plan's DEDUCTIBLE has been met.

There is a maximum benefit for home health care of 40 visits per calendar year for home-bound patients.

You must obtain precertification review before you incur home health care charges.

Laboratory Charges

The Plan covers laboratory charges at 80% after the Plan's DEDUCTIBLE has been met.

Medical Supplies

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.

MRIs

The Plan covers magnetic resonance imaging (MRIs) at 80% after the Plan's DEDUCTIBLE has been met.

You must obtain precertification review before you undergo an orthopedic MRI.

Skilled Nursing Facility

The Plan covers skilled nursing facility benefits at 80% of a facility's regular semi-private room rate. The maximum benefit for care in a skilled nursing facility is 120 days per calendar year.

X-rays

The Plan covers X-ray charges for the diagnosis or treatment of an illness or injury at 80% after the Plan's DEDUCTIBLE has been met.

Mastectomy – Reconstructive Surgery

Does the Plan cover mastectomy-related services?

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

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

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

The mastectomy-related benefits are subject to the same deductibles and COINSURANCE applicable to other medical and surgical benefits provided under this Plan. See the "Detailed List of Covered Services" on page 49 for the applicable Mastectomy – reconstructive surgery coverage.

Prescription Drugs

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

If you use a participating retail pharmacy in the Pharmacy Benefits Manager's network, the Plan covers PRESCRIPTION DRUGS at 80% of the Pharmacy Benefits Manager's negotiated price after the Plan's DEDUCTIBLE has been met. You will pay 20% of the Pharmacy Benefits Manager's negotiated price after the Plan's deductible has been met.

If you use a pharmacy out of the network, the Plan covers brand-name drugs at 80% of the Pharmacy Benefits Manager's negotiated price after the Plan's deductible has been met. You will be responsible for the cost above the negotiated price if you use a pharmacy that does not participate in the Pharmacy Benefits Manager's network.

Unless your physician specifically prescribes a brand name medicine, prescriptions will be filled with the generic equivalent.

You may purchase up to a 30-day supply of medicine from a participating retail pharmacy. You pay the pharmacy directly for the network negotiated price for your prescription and the Pharmacy Benefits Manager forwards your claim to the Plan's Claims Administrator for processing.

Effective January 1, 2009, you will have a "grace period" during which you may fill long term prescriptions up to three times at a participating retail pharmacy and still pay the participating retail pharmacy copayment. Beginning with the fourth time you fill the

prescription, you will pay COINSURANCE of 50% for each medication. You should continue to fill your short term prescriptions, such as antibiotics, at a participating retail pharmacy.

Does the Plan cover generic drugs?

If you use a participating retail pharmacy in the Pharmacy Benefits Manager's network, the Plan covers generic prescription drugs at 80% of the Pharmacy Benefits Manager's negotiated price after the Plan's deductible has been met. You will pay 20% of the Pharmacy Benefits Manager's negotiated price after the Plan's deductible has been met

If you use a pharmacy out of the network, the Plan covers generic prescription drugs at 80% of the Pharmacy Benefits Manager's negotiated price after the Plan's deductible has been met. You will be responsible for the cost above the negotiated price if you use a pharmacy that does not participate in the Pharmacy Benefits Manager's network.

You may purchase up to a 30-day supply of medicine from a participating retail pharmacy. You pay the pharmacy directly and the claim is processed electronically by the Pharmacy Benefits Manager.

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.

What if my physician prescribes a brand name medication due to medical necessity?

If there is a medical reason for your brand name prescription when a generic prescription drug is available, Express Scripts requires a benefit coverage review, which you can request by contacting Express Scripts' Member Services at +1 800 987 8360 or their Appeals Unit at +1 800 864 1135.

Is there a mail-order program?

The Plan's mail-order drug service allows participants to order up to a 90-day supply of prescription medicine by mail (unless there is an FDA advisory on prolonged use of the prescription, in which case the supply is limited to 30 days). The Plan covers 100% of the price after a $15 copayment for generic drugs and $30 copayment for brand name drugs.

To use the mail-order service, send your prescription and a check or credit card number for the cost of the medication as the form instructs. Your medicine will be sent to you within 7 to 10 business days from when your claim is received.

Note: Prescription mail order claims do not apply to deductible or out-of-pocket limits. Retail prescription claims are applicable to deductible and out-of-pocket limits.

Can the Plan's mail-order drug service send prescription medicine outside the U.S.?

The Plan's mail-order drug service does not ship medications overseas. Prescriptions are shipped to U.S. territories, such as Guam, Puerto Rico etc. The mail-order drug service will also ship prescriptions to an APO (Army Post Office), a DPO (Diplomatic Post Office) or a FPO (Field Post Office).

Can the Plan's mail-order drug service fill a prescription prescribed by a non-U.S. doctor?

If an overseas physician has a dual-license to practice and prescribe in the United States the mail-order drug service will be able to fill the prescription, but the delivery/shipping address must be in the U.S.

Does the Plan cover birth control pills?

The Plan covers birth control pills at 80% after the Plan's deductible has been met if the Claims Administrator determines the prescription to be a covered service.

Does the Plan cover Viagra®?

The Plan reimburses expenses for up to 8 Viagra® tablets per 30-day period at 80% after the Plan's deductible has been met or up to 24 Viagra® tablets per 90-day period for a $30 brand copayment when prescribed for a male patient's use if the Claims Administrator determines the prescription to be a covered service.

What prescription drugs require prior authorization?

The following drugs require prior authorization by the Pharmacy Benefits Manager:

Drug Class	Example medications
Growth hormones	Humatrope®, Serostim®
Dermatologic agents (for use over age 35)	Retin-A®, Avita®, Solodyn, Tazorac®
Antipsoriatic drugs	Raptiva®
Weight loss drugs	Xenical®, Meridia®
Allergy & Asthma	Xolair
Cancer Therapy	Gleevec, Revlimid, Temodar, Thalomid
Erythroid Stimulants	Aranesp, Epogen, Procrit
Fertility Agents	Clomid, Ganirelix, Lupron, Novarel, Ovidrel
Immune Globulins	Immune Globulins IV (Gammagard), Immune Globulines SubQ (Vivaglobin), Gammaplex
Interferons	Actimmune, Alferone-N, Infergen, Intron-A, Pegasys, Peg-Intron, Rebetron
RSV	Synagis

Drug Class	Example medications
Meloid Stimulants	Leukine, Neulast, Neumega, Neupogen, Nplate
Pulmonary Arterial Hypertension	Tracleer, Revatio, Ventavis
Anti Narcoleptic Agents	Provigil
Select Androgens & Anabolic Steroids	Oxandrin Androgel, Testim, Androderm

What prescription drugs require a coverage review?

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 criteria cannot be determined from past history. If you know in advance that your prescription requires a coverage review, ask your doctor to call the coverage management team before you go to the pharmacy.

Medications subject to step therapy are:

Step Therapy

Drug Therapy	Drug Name/ Category
Rheumatoid Arthritis Agents	Enbrel, Humira, Simponi
CNS Stimulants/Strattera/Amphetamines	Adderall, Adderall XR, Vyvanse, Ritaline
Dermatological - Eczema	Protopic, Elidel
Osteoporosis	Forteo
Pain Management	Actiq, Fentora

Contact the Pharmacy Benefits Manager for more information.

Preferred Drug Step Therapy – Preferred drug step therapy helps members find the most cost-effective and appropriate medicine for certain medical conditions. Your prescription may be subject to preferred drug step therapy if it falls under one of these categories:

- Anti-Depression: Selective Serotonin Receptor Inhibitor (SSRI Therapy)
- Glaucoma Treatment
- High Blood Pressure Therapy: Angiotensin II Receptor Blockers (ARBs)
- Insomnia
- Migraine Headache Therapy
- Nasal Allergy Therapy

- Osteoporosis
- Stomach Acid Reducers: Proton Pump Inhibitors or PPIs

Drugs subject to preferred drug step therapy may be modified. Contact the Pharmacy Benefits Manager for more information.

What prescription drugs require periodic review?

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**. Below is a list of these medications.

Drug Class	Example Medications	Limit
Anti-emetrics	Zofran, Kytril	7 days of treatment per month at the maximum daily dose
	Emend	1 treatment course per 18 days
Anti-fungals	Lamisil, Sporanox	3 months of treatment per 180 days
Antiviral Agents	Incivek, Victrelis	Therapy dependent
Dermatological Agents	Solodyn	30 tablets per 23 days; 90 tablets per 69 days
Erectile Dysfunction	Viagra	8 units per 30 days/24 units per 90 days
Fertility Agents	Gonal-F, Follistim	Therapy dependent
Hypnotic Agents	Ambien	60 treatment nights per 90 day period
Migraine Therapy	Imitrex, Maxalt	4 headaches per month at the maximum daily dose
Pain Management	Actiq, Fentora	Therapy dependent
Psoriasis Agents	Stelara	Therapy dependent
Rheumatoid Arthritis Agents	Enbrel, Humira	Therapy dependent
Smoking Cessation	Nicotrol, Zyban	3 months of treatment per 12 months
Vaginitis Therapy	Diflucan	300 mg per 30 days

Contact the Pharmacy Benefits Manager for more information.

Is there a special network of pharmacies?

There is a participating retail pharmacy network administered by the Plan's 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.

Should you need to file a claim, contact the Pharmacy Benefits Manager.

Claim forms are available on the Pharmacy Benefits Manager's website. If you file a claim 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 expense was incurred to submit a claim. You are responsible for the difference between the discounted in-network price and the out-of-pocket price and the appropriate coinsurance.

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

After you enroll in the Comprehensive Medical Plan, you are mailed a prescription drug card to use when you purchase prescription medicines. The card is personalized with your name and the name(s) of your covered family member(s). You will be sent one additional ID card if you enroll one or more family members in the program.

You must show this card at a participating retail pharmacy to ensure that you are charged the reduced network fee. (Please note that the discounted fee is only available if you show your card at the time of your purchase; retroactive fee reductions are not available. Check your receipt at the pharmacy for the authorization code to ensure that you were charged the reduced network fee.)

You may purchase up to a 30-day supply of medicine from a participating retail pharmacy. You pay the pharmacy directly and the Pharmacy Benefits Manager process your claim electronically.

You may also use the Pharmacy Benefits Manager's network to purchase prescription items that the Comprehensive Medical Plan may not cover, such as nicotine patches, Rogaine, at discounted prices.

Detailed List of Covered Services

The Plan reimburses 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. If you are coordinating benefits with more than one plan, see "Coordinating with Other Plans" on page 27 for details on how this may impact your reimbursement levels for covered services.

Most services and supplies are subject to a DEDUCTIBLE

Benefit	Coverage
Alcohol and substance abuse	INPATIENT*:* Plan pays 80% after the Plan deductible has been met up to $25,000 for each approved stay. You must obtain precertification review before you undergo inpatient treatment. ***Treatment and Length of Stay:*** Alcohol detoxification: Up to three days Single drug dependency detoxification: Up to seven days Multiple substance dependency detoxification: Up to 14 days. ***Outpatient:*** Plan pays 80% after the Plan deductible has been met up to $2,000 (excluding medications) per calendar year.
Allergy tests	Plan pays 80% after the Plan deductible has been met
Allergy treatment	Plan pays 80% after the Plan deductible has been met
Alternative medicine	Not covered
Ambulance charges	Plan pays 80% for transportation by professional ambulance to and from a medical facility after the Plan deductible has been met
Birth control pills	Plan pays 80% after the Plan deductible has been met
Cardiac rehabilitation	Plan pays 80% after the Plan deductible has been met for up to 36 visits per calendar year
CAT / PET scans	Plan pays 80% after the Plan deductible has been met
Chiropractors	Plan pays 80% after the Plan deductible has been met for up to 20 visits per calendar year
Cosmetic surgery	Not covered
Dental treatment	Not covered
Doctor delivery charge for newborns	Plan pays 80% with no copayment after the Plan deductible has been met
Durable medical equipment	Plan pays 80% after the Plan deductible has been met if prescribed by a physician. Precertification is needed for DURABLE MEDICAL EQUIPMENT when the purchase or rental price exceeds $1,000
Emergency room	Plan pays 80% after the Plan deductible has been met for life-threatening injury or illness
Gynecology visits	Not covered if routine For treatment of a medical condition, Plan pays 80% after the Plan deductible has been met
Hearing care	Plan pays 80% after the Plan deductible has been met if required due to an injury
Home health care	Plan pays 80% after the Plan deductible has been met for up to 40 visits per calendar year for home-bound patients Subject to precertification review

Benefit	Coverage
Hospice care	Plan pays 80% after the Plan deductible has been met Subject to precertification review
Immunizations	Not covered
Infertility treatment	Plan pays 80% (for certain infertility treatments for up to $15,000 per lifetime) after the Plan deductible has been met You should obtain a PREDETERMINATION OF BENEFITS.
Inpatient hospital services	Plan pays 80% after the Plan deductible has been met Subject to precertification review
Laboratory charges	Plan pays 80% after the Plan deductible has been met
Mail-order drugs	Plan covers 100% of the price after a $15 copayment for generic drugs and $30 copayment for brand name drugs
Magnetic resonance imaging—MRI	Plan pays 80% after the Plan deductible has been met
Mammograms	Not covered if routine For a non-routine mammogram as a follow-up to a medical diagnosis, Plan pays 80% after the Plan deductible has been met
Mastectomy—reconstructive surgery	Plan pays 80% after the Plan deductible has been me.
Maternity hospital stay	Plan pays 80% after the Plan deductible has been met
Mental health	***Inpatient:*** Plan pays 80% after the Plan deductible has been met for each approved stay. You must obtain precertification review before you undergo Inpatient treatment. A treatment is considered one continuous hospital stay. **Additional Limits:** ***Outpatient:*** Plan pays 80% after the Plan deductible has been met.
Midwives	Plan pays 80% after the Plan deductible has been me.
Occupational therapy	Plan pays 80% after the Plan deductible has been met for up to 20 visits per calendar year
Outpatient physician services	Plan pays 80% after the Plan deductible has been met
Organ transplant	Plan pays 100% after the Plan deductible has been met
Pap smears	Not covered if routine For a non-routine Pap smear as a follow-up to a medical diagnosis, Plan pays 80% after the Plan deductible has been met
Physical exams for adults	Not covered
Physical exams for children	Not covered

Benefit	Coverage
Physical therapy	Plan pays 80% after the Plan deductible has been met for up to 20 visits per calendar year
Pregnancy termination	Plan pays 80% after the Plan deductible has been met
Prenatal visits	Plan pays 80% after the Plan deductible has been met
Preventive/Wellness care	Not covered
Prostate specific antigen test—PSA	Not covered if routine For a non-routine PSA as a follow-up to a medical diagnosis, Plan pays 80% after the Plan deductible has been met
Retail prescription drugs	There is a participating retail pharmacy network. *Generic:* ***In-network:*** Plan pays 80% of the Pharmacy Benefits Manager's negotiated price after the Plan deductible has been met ***Out-of-network:*** Plan pays 80% of the Pharmacy Benefits Manager's negotiated price after the Plan deductible has been met *Brand Name:* ***In-network:*** Plan pays 80% of the Pharmacy Benefits Manager's negotiated price with no copayment after the Plan deductible has been met ***Out-of-network:*** Plan pays 80% of the Pharmacy Benefits Manager's negotiated price after the Plan deductible has been met **Note:** Retail prescription claims are applicable to deductible and out-of-pocket limits
Skilled nursing facility	Plan pays 80% of a facility's regular semi-private room rate after the Plan deductible has been met for up to 120 days per calendar year Subject to precertification review
Speech therapy	Plan pays 80% after the Plan deductible has been met for up to 20 visits per calendar year
Surgery	Plan pays 80% after the Plan deductible has been met (for assistant surgeon, the Plan pays 20%) Subject to precertification review Predetermination of benefits is recommended for multiple surgical procedures
Tubal ligation	Plan pays 80% after the Plan deductible has been met
Vasectomy	Plan pays 80% after the Plan deductible has been met
Vision care	Not covered
X-rays	Plan pays 80% after the Plan deductible has been met

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.

Preventive/Wellness Care

- Blood cell counts
- Blood tests for prostate screening
- Chest X rays
- Cholesterol tests
- EKGs
- Mammograms
- Pap smears
- Routine physical exams, including pelvic exams
- Sigmoidoscopy
- Tuberculosis tests
- Urinalysis
- Well child care and immunizations

Alternative Treatments

- Acupressure and acupuncture
- 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) and the dental damage must be severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident. Dental services for final treatment to repair the damage must be started within three months of the accident and completed within 12 months of the accident
- 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
  - Syringes
  - Diabetic test strips
- 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
- Residential treatment services

- 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
- Treatment provided in connection with autism
- Treatment provided in connection with tobacco dependency
- 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
- Enteral feedings and other 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

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

- 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 regardless of the reason for the hair loss

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

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

Work-Related Accident and Illness

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

All Other Exclusions

- Health services and supplies that do not meet the definition of a Covered Service
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type
- Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders with 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
- Spinal treatment (including chiropractic and osteopathic manipulative therapy) including:
  - Services and supplies for analysis and adjustments of spinal subluxation (dislocation)
  - Diagnosis and treatment by manipulation of the skeletal structure
- Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature, including oral appliances
- Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, or a congenital anomaly

- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea
- Sex transformation operations
- Custodial care
- Domiciliary care (e.g., group living arrangements)
- Private duty nursing
- Respite care
- Rest cures
- Psychosurgery (brain surgery to treat psychiatric symptoms)
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Medical and surgical treatment of excessive sweating (hyperhidrosis)
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing
- Any charges higher than the reasonable and customary charge
- Any charge for services, supplies or equipment advertised by the provider as free
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency
- Any charges prohibited by federal anti-kickback or self-referral statues
- Any additional charges submitted after payment has been made and your account balance is zero
- Any OUTPATIENT facility charge in excess of payable amounts under MEDICARE
- 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

Glossary

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.

The Company 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 **Comprehensive Medical Plan**. Then go to **Take Action** in the right navigation bar and select **Enroll, view, change benefits.**

Case Management Review

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

Claims Administrator/Pharmacy Benefits Manager

Provider that administers the Plan and processes claims; the provider'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.

COBRA coverage is considered alternative coverage to retiree medical coverage. If you elect retiree medical coverage, you will not be eligible for COBRA in the future. In addition, if you waive retiree medical coverage (at retirement or later), you will not be eligible for coverage under this Plan in the future.

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.

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 CHILD(REN)

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 unmarried child over the limiting age, who is incapable of self support by reason of a total physical or mental disability as determined by the Claims Administrator
- your legally adopted child or a child or child placed with you for adoption.

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

- dependent on you for maintenance and support, and
- under 19 years of age or
- under 25 years of age if a full-time student in a college or other accredited institution (generally those with 12 or more accredited hours of course work per semester, or full-time as determined by the school) and not employed on a full-time basis and
- unmarried.
- The Company has the right to require documentation to verify dependency (such as a copy of the court order appointing legal guardianship). Company medical coverage does not cover foster children or other children living with you, including your grandchildren, unless you are their legal guardian with full financial responsibility—that is, you or your spouse claims them as a dependent on your annual tax return.

Note: Age 26 dependent eligibility (See "Children" under "Eligible Family Members" in the *Participating in Healthcare Benefits* section for details.) pertains only to dependents of those retirees that were initially enrolled in one of the Marsh & McLennan Companies pre-65 retiree plans (See *Participating in Pre-65 Retiree Medical Coverage* section for details) and then enrolled in the Comprehensive Medical Plan on or after 1/1/2011.

Eligible Retirees

You are eligible if you are a:

- retiree age 65 or over, or
- a retiree under age 65 but has a covered dependent who is age 65 or over*, and
- retired from the Company, a Company operating company (other than (i) Marsh & McLennan Agency, LLC and any of its subsidiaries and generally, either (ii) CS Stars, LLC (formerly Corporate Systems, Inc.) or (iii) Mercer Human Resources Services (now referred to as Mercer Outsourcing)) or Johnson & Higgins January 1, 1983 or later.

* You are treated as a "retiree" if you are not currently employed by the Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies and have previously met the eligibility requirements under this Plan (terminated employment at age 55 or over with at least five years of vesting service or at age 65 or over).

You can also cover your eligible family members.

Explanation of Benefits (EOB)

A summary of benefits processed by the Claims Administrator.

Global Benefits Department

Refers to the 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.

INPATIENT

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

LIFE-THREATENING ILLNESS OR INJURY - EMERGENCY ROOM COVERAGE

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

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

Some examples of emergencies:

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

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

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

LIFETIME MAXIMUM

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

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 Company prescription drug coverage. It highlights issues you'll want to think about as you consider your prescription drug options.

MEDICARE

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

MEDICARE CROSS-OVER

To sign-up for Medicare Cross-Over, complete the Medicare Cross-Over Enrollment Form, available on PeopleLink or by calling the Claims Administrator.

Medicare Cross-Over applies to Medicare Part B (medical) services. With this feature, Medicare pays first and then automatically forwards claims electronically to the Claims Administrator for processing. This means that you will not have to file separate claims with the Claims Administrator for these services.

Medicare Cross-Over does not apply to Medicare Part A (e.g., inpatient) claims or prescription drugs. You still need to file a claim with the Claims Administrator to be reimbursed for these expenses.

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.

NON-PREFERRED PROVIDERS

Health care providers who are not preferred providers and do not charge reduced fees.

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).

OUTPATIENT

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

Out-of-pocket Maximum

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

Preferred Providers

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

Prescription Drugs

- **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.

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.

SECOND OPINIONS

The Plan may require that you receive a second opinion before concluding that your suggested course of treatment is appropriate for plan coverage.

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.

WELLNESS BENEFIT

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.