

January 1, 2008

Vision Care Plan MMC



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Vision Care Plan

The Vision Care Plan offers you the opportunity to elect affordable, high-quality eyecare coverage—including exams, lenses, frames, and contact lenses—through VSP.

While you must enroll and pay for coverage under the Vision Care Plan, MMC also provides eligible employees and their family members with automatic discounts on certain types of vision care, through the Vision Discount Program. For more information, see the Vision Discount Program section.

SPD and Plan Document

This section provides a summary of the Vision Care Plan (the “Plan”) as of January 1, 2008.

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

A Note about ERISA

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

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Plan at a Glance

The Plan helps you and your family pay for vision care. The chart below contains some important Plan features.

Plan feature	In-Network	Out-of-Network
Eye Examination	Covered in full, after a \$10 copayment, once every 12 months	Up to \$40, after a \$10 copayment, once every 12 months
Lenses	Covered in full, after a \$20 copayment, once every 12 months	Based on lens type, up to <ul style="list-style-type: none"> ▪ \$25-Single Vision, ▪ \$41-Lined Bifocal, ▪ \$58-Lined Trifocal or Progressive, ▪ \$80-Lenticular, after a \$20 copayment, once every 12 months
<ul style="list-style-type: none"> ▪ Single Vision ▪ Lined Bifocal ▪ Lined Trifocal ▪ Progressive 		
Frames	Covered up to \$150, once every 24 months, plus 20% discount on any out-of-pocket costs	Up to \$45, once every 24 months
Contact Lenses (in lieu of lenses and frame)	<ul style="list-style-type: none"> ▪ Elective: Covered up to \$150, once every 12 months, plus 15% discount on your contact lens exam (fitting and evaluation) ▪ Medically Necessary (requires VSP approval): Covered in full, after a \$10 copayment, once every 12 months 	<ul style="list-style-type: none"> ▪ Elective: Up to \$105, once every 12 months ▪ Medically Necessary: Up to \$210 after a \$10 copayment, once every 12 months
Contact Information	For more information, contact: VSP (Claims Administrator) Phone: (800) 877-7195 Email: www.vsp.com Online chat: www.vsp.com <ul style="list-style-type: none"> ▪ MMC does not administer this Plan. VSP's decisions are final and binding. 	

Participating in the Plan

You are eligible to participate in the Vision Care Plan if you meet the eligibility requirements described in the *Participating in Healthcare Benefits* section and have passed the eligibility date described in that section.

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

Enrollment

To participate in this plan, you must enroll for coverage. You may enroll only:

- within 30 days of the date you become eligible to participate
- during Annual Enrollment
- within 30 days of a qualifying change in family status that makes you eligible to enroll
- within 30 days of losing other coverage that you had relied upon when you waived your opportunity to enroll in this plan.

Enrollment procedures for you and your eligible family members are described in the *Participating in Healthcare Benefits* section.

Cost of Coverage

You pay the full cost of coverage for both you and your ELIGIBLE FAMILY MEMBERS.

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

You can choose from three levels of coverage. Cost for each coverage level for eligible employees is shown below.

	Semi-monthly Cost	Weekly Cost
Employee Only	\$3.96	\$1.83
Employee + one	\$7.93	\$3.66
Family	\$11.89	\$5.49

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

ID Cards

With VSP, there are no ID cards for in-network or out-of-network services.

Once your enrollment has been provided to VSP, you will be able to click on 'Verify Your Coverage' through www.vsp.com to view your eligibility and coverage information. You will need to input the last four digits of your ID number (which is your Social Security Number), along with your first and last name.

When you are ready to receive in-network services, simply:

- Find a VSP network doctor, then
- make an appointment and tell the doctor you are a VSP member through Marsh & McLennan Companies, Inc. (MMC)

Your doctor and VSP will handle the rest.

How the Plan Works

The Vision Care Plan provides coverage to help with your and your family's vision care expenses. As a participant of this Plan, services can be received from any VSP network doctor or out-of-network provider. However, you get the best value from your VSP benefit when you visit a VSP network doctor.

Do I have to satisfy a deductible to use the Plan?

There are no deductibles under this Plan.

Am I responsible for a copayment when I visit my VSP doctor?

Yes, you will need to pay any copayment(s) to the VSP doctor during your visit. Copayments apply to both you and your family members covered under the Vision Care Plan. Click on Verify Your Coverage through www.vsp.com for copayment information.

You may submit a Health Care Flexible Spending Account (FSA) claim form for expenses not covered by the Plan (for any copayments or any other amount not covered) to the Flexible Spending Account CLAIMS ADMINISTRATOR for processing, if you have an account.

About the Vision Discount Program

The Vision Care Plan provides you with an affordable eye care plan. Without coverage, you could spend \$300 or more for your exam and prescription glasses.

The Vision Discount Program provides you with discounts on vision services received from VSP network doctors.

When would I use the Vision Discount Program over the Plan?

You can use the Vision Discount Program for:

- an additional pair of glasses (lenses and frame) at a discount
- additional contact lenses at a discount
- an eye examination for a family member who is not covered under the Vision Care Plan

Finding a VSP Network Doctor

Finding a VSP network doctor is easy. Visit VSP's online Doctor Directory at www.vsp.com or contact VSP's Member Services Department at 1-800-877-7195.

Once I find a VSP network doctor, or if I decide to change my VSP network doctor, how do I notify VSP of my selection?

It is not necessary to notify VSP when selecting or changing VSP network doctors. When you're ready, simply make an appointment with your new VSP network doctor and inform them of your VSP coverage through Marsh & McLennan Companies, Inc (MMC).

Does VSP's network of doctors include optometrists as well as ophthalmologists?

Yes, VSP's network of doctors includes professionally certified optometrists and ophthalmologists.

Non-VSP Doctors

Can I see an out-of-network provider?

Yes, VSP will reimburse you up to the amount allowed under your Plan's out-of-network provider reimbursement schedule. The reimbursement rate does not guarantee full payment, and VSP cannot monitor the quality of services received from an out-of-network provider.

What to Know About Vision Care

Why should I have my eyes examined regularly?

According to the American Optometric Association, routine eye exams can detect a number of serious health conditions such as glaucoma, cataracts, diabetes, and even cancer.

How frequently should I have my eyes examined?

You and your doctor should determine the eye exam schedule that best meets your eye care needs. However, as a general rule, the American Optometric Association recommends that you should not go beyond two years to have your eyes examined. Those with a family history of eye diseases, diabetic patients, and anyone whose general health is poor or who are taking medications that may have potential side effects on the eye may need to have their eyes examined twice a year.

Do I need a special eye exam as I get close to, or past, age 40?

The American Optometric Association recommends that you continue to have your regular eye exam at least every two years. As you age, you are more susceptible to certain eye diseases such as cataracts, glaucoma, and macular degeneration. Getting your eyes regularly examined helps your eye doctor detect the first signs of disease and prescribe the appropriate treatments to prevent vision loss.

When should my child have their first eye exam?

The American Optometric Association recommends that children have their first regular eye exam at 6 months. A thorough exam should be done by age 3 because this is the age when a child's visual system undergoes its most rapid development and vision correction is most effective.

How frequently should children's eyes be examined after their initial exam?

According to the American Optometric Association, children's eyes should be examined every two years—or more frequently if there is an eye or vision problem or a family history of eye disease. School children use their eyes more frequently than some adults

to read and perform other school activities, so it's important for them to have regular eye exams. Also, it is important to remember that an eye screening typically offered at school only tests distance and will not detect some vision problems. Your child could have problems with near vision, eye coordination and focusing and still have 20/20 distance vision.

What is the difference between a routine eye exam and a contact lens exam?

Routine eye exams are designed to detect vision problems and are an important preventive measure for maintaining your overall health and wellness. In fact, according to the American Optometric Association, a thorough eye exam can detect certain medical conditions, such as glaucoma and diabetes.

Contact lens exams are designed to evaluate your vision with contact lenses. Although your vision may be clear and you feel no discomfort from your lenses, there are potential risk factors with improper wearing or fitting of contact lenses that can affect the overall health of your eyes.

Why is the contact lens exam not covered as part of my routine eye exam?

The Plan covers routine eye exams. A contact lens exam is an additional exam for contact lens wearers to determine the proper size and shape of contact lenses for your eyes and to evaluate your vision with the contact lenses. Depending on your needs, a doctor will provide services, such as training and education. You should discuss the services that your doctor provides to better understand the value of the contact lens exam, as well as the extent of the services necessary for your own eye health.

Coordinating with other plans

How are other plans' benefits coordinated with benefits under this Plan?

To coordinate benefits, the patient must provide the VSP network doctor with both covered members' names and the employee's social security number.

What if I am covered under two VSP plans?

If you are covered by two VSP plans, the following options for coordinating benefits exist:

- One pair of glasses: When the patient obtains one complete pair of glasses, the VSP benefits can be coordinated to offset plan copayment(s), lens options and/or frame overage.
- Two pairs of glasses: When the patient obtains two pairs of glasses, the secondary examination amount can be applied toward out-of-pocket expenses on both complete pairs of glasses.

For More Information

For more information on how benefits are coordinated if you have coverage from another plan, the *Participating in Healthcare Benefits* section.

- Contact lenses: When the patient receives contact lenses and an eye exam, the exam can be paid using the primary benefit. The contact lens allowances under both plans and a secondary exam amount can be applied toward the contact lenses.
- Contact lenses and glasses: When a patient receives prescription glasses (lenses and frame) or contact lenses, the secondary plan amounts available for services received through the primary plan (lenses, frame or contacts) can be applied to offset out-of-pocket expenses.

What's Covered

The table below summarizes the Plan's reimbursement levels.

Vision Care Plan	In-Network Coverage	Out-of-Network Reimbursements
Eye Examination	Covered in full, after a \$10 copayment, once every 12 months	Up to \$40, after a \$10 copayment, once every 12 months
Lenses	Covered in full, after a \$20 copayment, once every 12 months	Based on lens type, up to \$25-Single Vision, \$41-Lined Bifocal, \$58-Lined Trifocal or Progressive, \$80-Lenticular, after a \$20 copayment, once every 12 months
<ul style="list-style-type: none"> ▪ Single Vision ▪ Lined Bifocal ▪ Lined Trifocal ▪ Progressive 		
Frames	Covered up to \$150, once every 24 months, plus 20% discount on any out-of-pocket costs	Up to \$45, once every 24 months
Contact Lenses (in lieu of Lenses and Frame)	<p>Elective: Covered up to \$150, once every 12 months, plus 15% discount on your contact lens exam (fitting and evaluation)</p> <p>Medically Necessary (requires VSP approval): Covered in full, after a \$10 copayment, once every 12 months</p>	<p>Elective: Up to \$105, once every 12 months</p> <p>Medically Necessary: Up to \$210 after a \$10 copayment, once every 12 months</p>

Vision Care Plan	In-Network Coverage	Out-of-Network Reimbursements
Lens Options		
▪ UV Coating	Up to a 20% savings	Not available
▪ Tint (Solid and Gradient)	Up to a 20% savings	Not available
▪ Scratch Resistance	Up to a 20% savings	Not available
▪ Basic Polycarbonate (for children up to age 19)	Up to a 20% savings	Not available
▪ Standard Anti-Reflective	Up to a 20% savings	Not available
Extra Discounts and Savings		
Laser Vision Correction	PRK, LASIK and Custom LASIK available at a discounted fee	Not available
Additional Pairs of Prescription Glasses	20% off additional pairs of prescription glasses (lenses and frame)	Not available
Sunglasses (prescription and non-prescription)	20% off sunglasses, both prescription and non-prescription (lenses and frame)	Not available
Replacement Contact Lenses	15% off the contact lens exam (discount does not apply to the contact lens materials), plus exclusive pricing on annual supplies of popular contact lens brands	Not available
Mail Order Contact Lenses	Home or office delivery options available when annual supplies of popular contact lens brands are purchased through VSP's Member Contact Lens Program	Not available

More on Covered Services

Can I choose contact lenses instead of glasses?

Yes, the Vision Care Plan provides coverage for either glasses or contact lenses. You can choose to purchase contact lenses through VSP's Contact Lens Care Program. Keep in mind that by choosing contact lenses you will not be eligible to receive glasses (lenses and a frame) during the same service period.

What is VSP's Contact Lens Care Program?

The Contact Lens Care Program provides a \$120 elective contact lens (ECL) allowance for professional contact lens care and an initial supply of non-specialty contacts for members who currently wear contact lenses that are included on the approved list of popular brands of soft contact lenses. The list of approved contact lenses can be found on www.vsp.com.

Members not qualifying for the program can apply the allowance to VSP doctors' contact lens services (less a 15% discount) and materials.

Costs not covered by the program are the patient's responsibility. Your cost for the Vision Care Plan includes membership in VSP's Member Contact Lens Program.

How do I qualify for VSP's Contact Lens Care Program?

To qualify to receive benefits under the VSP's Contact Lens Care Program you must:

- be an existing contact lens wearer
- currently use contact lenses from VSP's approved list of popular brands of soft contact lenses
- continue to use contact lenses from VSP's approved list of popular brands of soft contact lenses
- have no more than a minor prescription change as determined by your provider

Does the Plan cover contact lens accessories and solutions?

No. The Vision Care Plan does not cover contact lens accessories and solutions.

Do all VSP network doctors have a selection of frames I can choose from?

Yes, all VSP network doctors have a selection of frames in their offices.

Am I limited to the kind of frame I can pick?

Your VSP frame benefit offers you the freedom to choose a frame that complements your appearance and lifestyle. If you choose a frame exceeding your plan allowance, you'll be responsible for paying this amount (less a 20% discount on your out-of-pocket costs available through VSP network doctors) in addition to any applicable copayments at the time of your visit.

You may submit a Health Care Flexible Spending Account (FSA) claim form for expenses not covered by the Plan (for any copayments or any other amount not covered) to the FSA CLAIMS ADMINISTRATOR for processing, if you have an account.

Does the Plan cover lens options?

No. The Vision Care Plan does not cover lens options. However, VSP network doctors provide up to a 20% savings off the retail price on lens options, such as scratch resistant and anti-reflective coatings.

Does the Plan cover replacement eyeglasses or contact lenses?

No. The Vision Care Plan does not cover replacement eyeglasses or contact lenses. If you need to replace your prescription eyewear, VSP network doctors provide a 20% discount off the retail price on additional prescription glasses and sunglasses and exclusive pricing on annual supplies of popular brands of contacts.

Does the Plan cover prescription and non-prescription sunglasses?

No. Your VSP Plan does not cover prescription and non-prescription sunglasses. However, VSP network doctors provide a 20% discount off the retail price on additional prescription glasses and sunglasses including non-prescription sunglasses.

Does the Plan cover safety eyewear?

No. The Vision Care Plan does not cover safety eyewear. However, VSP network doctors provide a 20% discount off the retail price on additional prescription glasses and sunglasses.

How can I find out more about Laser Vision Correction?

VSP offers discounted services for laser vision correction surgery to correct such visual acuity problems as near sightedness, farsightedness and even astigmatism. For more details, look for Laser Vision Correction at www.vsp.com.

You undergo laser vision correction surgery at your own risk; neither VSP nor MMC can be held responsible for the outcome.

What's Not Covered

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses; or two pairs of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.

- Corrective vision treatment of experimental nature such as but not limited to Radial Keratotomy (RK) and Photorefractive Keratectomy (PRK) surgery.

Filing a Claim

Do I need to fill out a claim form for in-network eyecare services?

No. If you use an in-network provider, you do not need to complete any paperwork or forms. Simply call a VSP network doctor to schedule an appointment and tell them you're a VSP member through Marsh & McLennan Companies, Inc. (MMC). The doctors and VSP will handle the rest.

Do I need to fill out a claim form for any out-of-network eyecare service?

Yes, if you receive services from an out-of-network provider, you pay the provider in full at the time of service. To receive reimbursement, either complete the Out-of-Network Reimbursement Form available from www.vsp.com or send the following to the CLAIMS ADMINISTRATOR:

- Itemized receipt listing the services you received
- Name, address and telephone number of the out-of-network provider
- Covered member's social security number
- Covered member's name, telephone number and address
- Name of the organization that provides your VSP coverage (either Marsh & McLennan Companies, Inc. or MMC)
- Patient's name, date of birth, telephone number and address
- Patient's relationship to the covered member (such as "self", "spouse", "child")

Keep a copy for your records and mail your information to the CLAIMS ADMINISTRATOR.

What is the time period for submitting an out-of-network claim?

Out-of-network claims must be submitted to the Claims Administrator within six months from the date of service for reimbursement.

Can I track the status of my claims?

You can find out the status of your claims by contacting VSP's Member Services Department either by phone (1-800-877-7195), Email (form found on www.vsp.com), or Online Chat (form found on www.vsp.com).

For Flexible Spending Account Reimbursement

You may submit a Health Care Flexible Spending Account (FSA) claim form for expenses not covered by the Plan (for any copayments or any other amount not covered) to the Flexible Spending Account Claims Administrator for processing, if you have an account.

Appealing a Claim

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

Glossary

ACTIVE WORK STATUS

You must be actively-at-work during your approved scheduled work week and not on any type of leave.

ACTIVELY AT WORK

You are “actively at work” if you are fulfilling your job responsibilities at a Company-approved location on the day coverage is supposed to begin (e.g., you are not out ill or on a leave of absence).

AFTER-TAX (POST-TAX) CONTRIBUTIONS

Contributions taken from your paycheck after taxes are withheld.

APPROVED SPOUSE AND DOMESTIC PARTNER

Adding a spouse or same gender or opposite gender domestic partner to certain benefits coverage is permitted upon employment or during the Annual Enrollment period for coverage effective the following January 1st if you satisfy the plans’ criteria, or immediately upon satisfying the plans’ criteria if you previously did not qualify. To obtain spousal or domestic partner coverage, you will need to complete an Affidavit of Eligible Family Membership via MMC Benefits Online 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; or

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
 - not be Medicare eligible
 - currently reside together, and have resided together for at least the previous 12 months, and intend to do so permanently, and
 - have agreed to share responsibility for each other's common welfare and basic financial obligations
 - not related by blood to a degree of closeness that would prohibit marriage under applicable state law.
- MMC reserves the right to require documentary proof of your domestic partnership at any time, for the purpose of determining benefits eligibility. If requested, you must provide documents verifying either the registration of your domestic partnership with a state or local authority or your cohabitation and/or mutual commitment.

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

BEFORE-TAX (PRE-TAX) CONTRIBUTIONS

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

CLAIMS ADMINISTRATOR

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

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

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

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

COORDINATION OF BENEFITS

You or a covered family member may be entitled to benefits under another group health plan (such as a plan sponsored by your spouse's employer) that pays part or all of your health

treatment costs. If this is the case, benefits from this plan will be “coordinated” with the benefits from the other plan. In addition to having your benefits coordinated with other group health plans, benefits from this plan are coordinated with “no fault” automobile insurance and any payments recoverable under any workers’ compensation law, occupational disease law or similar legislation.

COVERED SERVICE(S)

Detailed list of covered vision services covered under the plan.

Covered vision 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.

DISABILITY

A physical or mental impairment that substantially limits one or more of an individual’s major life activities.

ELIGIBLE FAMILY MEMBERS

Child/Dependent Child means:

- your natural child
- a child for whom you 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.

ELIGIBLE KROLL EMPLOYEES

As used throughout this document, "Kroll Employees" are defined as employees classified on payroll as U.S. full-time regular employees of Kroll, Inc. or any of its subsidiaries.

ELIGIBLE MMC EMPLOYEES (OTHER THAN KROLL)

As used throughout this document, "MMC Employees (other than Kroll)" are defined as employees classified on payroll as U.S. salaried employees of MMC or any subsidiary or affiliate of MMC (other than Kroll Inc., and any of its subsidiaries).

FULL-TIME REGULAR EMPLOYEE OF KROLL

Employees that were not hired to perform short term projects, special programs of a temporary nature and will not be terminated from employment upon completion of their assignment.

IN-NETWORK PROVIDERS

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

MMC BENEFITS ON-LINE

MMC's PeopleLink Website which contains access to your personalized home page. Go to the Enterprise Menu (upper left) and click on the MMC Benefits Online heading; then click the MMC Benefits Online link. Next, follow the appropriate path to this transaction.

OUT-OF-NETWORK PROVIDERS

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

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.

QUALIFYING EVENT

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

WAITING PERIOD/ELIMINATION PERIOD

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