

November 1, 2007

Limited Purpose Health Care
Flexible Spending Account
MMC



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Limited Purpose Health Care Flexible Spending Account

The Limited Purpose Health Care Flexible Spending Account allows you to put aside money before taxes are withheld so that you can pay for certain eligible medical, dental and vision expenses that are not reimbursed by any other coverage you and your qualifying family members have.

Since you can't be covered by a traditional health care flexible spending account if you contribute to a health savings account, you have the option to elect the Limited Purpose Flexible Spending Account. Unlike a traditional health care flexible spending account, the Limited Purpose Health Care Flexible Spending Account (FSA) can be used in addition to the MMC Health Savings Account. The Limited Purpose Health Care Flexible Spending Account provides you two ways to help you pay for certain health care expenses:

- *reimburse eligible dental, vision and preventive care expenses not reimbursed by any other health plan*
- *reimburse qualified medical expenses, including coinsurance and copayments, INCURRED after you have satisfied the MMC Consumer Directed Health Plan deductible applicable to you (that is, the individual or family deductible, depending on your level of coverage).*

SPD and Plan Document

This section provides a summary of the Limited Purpose Health Care Flexible Spending Account 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.

Contents

The Plan at a Glance	1
Participating in the Plan	3
Enrollment	3
Contributions	4
Taxes.....	6
How the Plan Works.....	6
Reimbursements	7
Examples of Eligible Expenses	12
Examples of Ineligible Expenses.....	16
About Your Account	16
Glossary.....	17

The Plan at a Glance

Plan Feature	Highlights
How the Plan Works	<ul style="list-style-type: none"> ▪ You may contribute to the Plan through payroll deductions on a before-tax basis. ▪ When you have reimbursable health care expenses, you can receive your money back tax-free, up to the amount that is in your account when you ask for reimbursement.
Eligibility	<ul style="list-style-type: none"> ▪ You are eligible if you are an employee classified on payroll as a U.S. salaried employee of MMC or any subsidiary or affiliate of MMC (Kroll, Inc., and any of its subsidiaries). ▪ You are eligible if you are classified on payroll as a U.S. full-time regular employee of Kroll, Inc. or any of its subsidiaries. ▪ See “Participating in the Plan” on page 3 for details.
Enrollment	<ul style="list-style-type: none"> ▪ You are eligible to enroll: <ul style="list-style-type: none"> – within 30 days of the date you become eligible – during Annual Enrollment ▪ You must enroll each PLAN YEAR in order to participate in the Limited Purpose Health Care Flexible Spending Account.
Contributions	<ul style="list-style-type: none"> ▪ You can contribute between \$120 and \$7,200 per Plan year
Reimbursements	<ul style="list-style-type: none"> ▪ In general, the Plan will reimburse: <ul style="list-style-type: none"> – eligible dental, vision or preventive care expenses not covered by another plan or eligible medical expenses INCURRED after you meet the applicable MMC Consumer Directed Health Plan deductible and that generally would be qualified medical expenses under federal tax law, and – eligible health care expenses incurred in the Plan year (including the GRACE PERIOD) for which you make contributions (During the grace period, you may be reimbursed only for eligible dental, vision or preventive care expenses or for qualified medical expenses incurred after you have met the current Plan year’s MMC Consumer Directed Health Plan deductible.) ▪ Some expenses are reimbursable only after you have met your MMC Consumer Directed Health Plan deductible.

Plan Feature	Highlights
<i>Unused Contributions</i>	<ul style="list-style-type: none"> <li data-bbox="532 247 1430 533">▪ If you have a balance remaining in your Limited Purpose Health Care Flexible Spending Account after December 31 of the Plan year, you have a grace period (until March 15 of the following Plan year to incur eligible dental, vision and preventive care expenses (provided you were still participating on December 31 of the Plan year and excluding expenses incurred after your employment ends). The Plan will not reimburse qualified medical expenses during the grace period, unless you have met the MMC Consumer Directed Health Plan deductible for the current Plan year. <li data-bbox="532 541 1430 604">▪ You have until May 31 to submit for reimbursement eligible expenses you incur during the Plan year and during the grace period. <li data-bbox="532 613 1430 701">▪ In accordance with IRS rules, you will forfeit any account balance not used to pay eligible expenses incurred by March 15 of the following Plan year (the end of grace period) if they are not submitted by May 31.
Contact Information	<p data-bbox="532 722 886 753">For more information, contact:</p> <p data-bbox="532 756 1192 787">Aetna Flexible Spending Account (Claims Administrator)</p> <p data-bbox="532 789 704 821">P.O. Box 4000</p> <p data-bbox="532 823 850 854">Richmond, KY 40476-4000</p> <p data-bbox="532 856 805 888">Phone: (888) 238-6226</p> <p data-bbox="532 890 773 921">Fax: (888) 238-3539</p> <p data-bbox="532 924 1081 955">Website: www.aetna.com/docfind/custom/mmc</p> <p data-bbox="532 957 1365 1016">MMC does not administer this plan. Aetna Flexible Spending Account's decisions are final and binding.</p>

Participating in the Plan

You are eligible to participate in the Limited Purpose Health Care Flexible Spending Account if you meet the eligibility requirements described in the *Participating in Health Spending Accounts* section.

If you are an eligible employee contributing to a health spending account, you can use that account to cover eligible health care expenses for family members who meet the eligibility requirements that are described in the *Participating in Health Spending Accounts* section.

You have to participate in the MMC Consumer Directed Health Plan and the MMC Health Savings Account to enroll in this plan.

Note: If your spouse is enrolled in a traditional health care flexible spending account or non-high-deductible health plan, you will not be eligible to contribute to this plan or the MMC Health Savings Account.

My spouse contributes to a health savings account (HSA); can I participate in the Limited Purpose Health Care Flexible Spending Account?

Yes, if your spouse contributes to a health savings account (HSA) you can participate in the Limited Purpose Health Care Flexible Spending Account. However, you must also participate in the MMC Consumer Directed Health Plan and the MMC Health Savings Account to be eligible for this plan.

My spouse contributes to a traditional health care flexible spending account; can I participate in the Limited Purpose Health Care Flexible Spending Account?

No, because when your spouse has traditional health care flexible spending account coverage, your expenses can be reimbursed by that plan, thus disqualifying you from enrolling in the MMC Health Savings Account.

Enrollment

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

- 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.

You must enroll each PLAN YEAR in order to participate in the Limited Purpose Health Care Flexible Spending Account.

Enrollment procedures are described in the *Participating in Spending Accounts* section.

When am I not eligible to enroll in this plan?

You are not eligible to enroll in this plan if:

- you are not enrolled in the MMC Consumer Directed Health Plan and MMC Health Savings Account,
- you are covered by a traditional health care flexible spending account, including either the MMC Health Care Flexible Spending Account or another health care flexible spending account (e.g., through your spouse or another job), or
- you are covered by a non-high-deductible health plan (e.g., through your spouse or another job).

Contributions

How do I decide how much to contribute?

You select an amount to contribute for the PLAN YEAR. You can contribute between \$120 and \$7,200 per Plan year.

Since you will forfeit any amount you do not use and you cannot change the contribution election once you make it (unless you have a qualified family status change), you should carefully estimate your expenses before deciding on an amount to contribute.

You have to contribute to the Plan to be reimbursed for eligible expenses you incur during the Plan year or during the GRACE PERIOD. You cannot be reimbursed for services that are provided before your cover-age begins or after your coverage ends.

Keep in mind that some expenses are reimbursable only after you have met your MMC Consumer Directed Health Plan deductible (that is, the individual or family deductible, depending on your level of coverage) and estimate your contributions accordingly. Generally, eligible dental, vision and preventive care expenses are reimbursable without regard to whether you have met your MMC Consumer Directed Health Plan deductible. Other qualified medical expenses (e.g., coinsurance, copayments, over-the-counter prescription drugs) are reimbursable only after you have met your MMC Consumer Directed Health Plan deductible. See “Examples of reimbursable expenses” and “Excluded expenses” for more information.

Once you make your selection for the year, you cannot make any changes, unless you have a qualified family status change and then any changes must be due to, and consistent with, the qualified family status change.

If your projected expenses change during the year, you will not be able to change your contribution election to meet your new expense amount unless you have a qualified family status change. For example, if your health care provider tells you during the year that you are no longer a candidate for the LASIK eye surgery for which you had been contributing to the Limited Purpose Health Care Flexible Spending Account or is postponing a procedure to a subsequent year, you cannot reduce or stop your contributions.

Does the Company contribute to my Limited Purpose Health Care Flexible Spending Account?

No, the Company does not make contributions to your account.

What is the minimum amount I can contribute?

You can contribute a minimum amount of \$120 per Plan year to the Plan.

What is the maximum amount I can contribute?

You can contribute a maximum amount of \$7,200 per Plan year to the Plan.

My spouse's or domestic partner's employer also has a limited purpose flexible spending account that my spouse or domestic partner contributes to; is there a limit to how much I can contribute to my Limited Purpose Health Care Flexible Spending Account?

You and your spouse or domestic partner are each limited to the maximum contribution allowed by your respective employer. You can submit a claim only once and only to one limited purpose flexible spending account.

My spouse or domestic partner and I both work for the same company; how much can we put in the Plan?

You and your spouse or domestic partner can each contribute up to \$7,200 per Plan year to this plan.

You cannot receive reimbursement for the same claim from both employees' accounts.

How are contributions credited to my account?

Your contributions will be deducted on a before-tax basis from each paycheck you receive after you commence participation and credited to your account.

When will contributions start to come out of my paycheck?

When you first enroll as a newly eligible employee or as a result of a qualified family status change, your contributions will begin in the next available pay period after your enrollment is processed.

If you enroll during the Annual Enrollment period, your contributions will begin with the first paycheck of the new Plan year.

Can I transfer contributions between my Dependent Care and Limited Purpose Health Care Flexible Spending Accounts?

No, the IRS requires that this Plan and Dependent Care Flexible Spending Account remain separate. You cannot transfer money between accounts or use money in one account to pay expenses related to the other.

What happens to contributions in my Limited Purpose Health Care Flexible Spending Account that I haven't used by the end of the grace period?

In accordance with IRS rules, you will forfeit any account balance not used to pay eligible expenses INCURRED between January 1 and December 31 of the Plan year or between January 1 and March 15 of the following Plan year (the grace period) if they are not submitted by May 31.

If your participation ends during the Plan year, you will not be reimbursed for expenses incurred after the date your participation ends (for example, after your employment ends, unless you continue participation through COBRA). You will, however, have until May 31 of the following Plan year to submit for reimbursement eligible expenses you incurred during the Plan year while you were participating.

Taxes

See the *Participating in Spending Accounts* section for more information about taxes.

How the Plan Works

You may contribute to the Plan through payroll deductions on a before-tax basis. When you have reimbursable health care expenses, you can receive your money back tax-free, up to the amount you elect to contribute for the year. You are reimbursed for eligible expenses that are not covered under another benefit plan.

The Limited Purpose Health Care Flexible Spending Account can only reimburse eligible dental, vision and preventive care expenses that are not reimbursable by another health plan. Qualified medical expenses are not reimbursable unless they are INCURRED after you meet the applicable MMC Consumer Directed Health Plan deductible for the PLAN YEAR (that is, the individual or family deductible, depending on your level of coverage).

You contribute to the Limited Purpose Health Care Flexible Spending Account over a 12-month Plan year, from January 1 to December 31 (or fewer months, if you start or stop participating during the Plan year). You may use your Limited Purpose Health Care Flexible Spending Account to pay for eligible expenses incurred during the Plan year.

If you have a balance remaining in your Limited Purpose Health Care Flexible Spending Account after December 31 of the Plan year, you have an additional 2½-month GRACE PERIOD (until March 15 of the following Plan year) to incur eligible dental, vision and preventive care expenses (provided you were still participating on December 31 of the Plan year and excluding expenses incurred after your employment ends). The Plan will not reimburse qualified medical expenses (e.g., copayments, coinsurance, over-the-counter prescription drugs) during the grace period, unless you have met the MMC Consumer Directed Health Plan deductible for the current Plan year.

You have until May 31 to submit for reimbursement eligible expenses you incur during the Plan year and during the grace period.

In accordance with IRS rules, you will forfeit any account balance not used to pay eligible expenses incurred by March 15 of the following Plan year (the end of grace period) if they are not submitted by May 31.

Example: You can use your 2008 Limited Purpose Health Care Flexible Spending Account to be reimbursed for eligible expenses incurred between January 1 and December 31, 2008 (the Plan year) or between January 1, 2009 and March 15, 2009 (the grace period). You must submit claims for those expenses no later than May 31, 2009.

Reimbursements

In general, the Plan will reimburse:

- eligible dental, vision or preventive care expenses not covered by another plan or eligible medical expenses INCURRED after you meet the applicable MMC Consumer Directed Health Plan deductible (that is, the individual or family deductible, depending on your level of coverage) and that generally would be qualified medical expenses under federal tax law, and
- eligible health care expenses incurred in the PLAN YEAR (including the GRACE PERIOD) for which you make contributions (During the grace period, you may be reimbursed only for eligible dental, vision or preventive care expenses or for qualified medical expenses incurred after you have met the current Plan year's MMC Consumer Directed Health Plan deductible.)

For examples of IRC Section 213 qualified medical expenses, see IRS Publication 502, which is available at www.irs.gov or by calling the IRS at 1-800-829-3676. Note that certain items listed in Publication 502 may not qualify for Limited Purpose Health Care Flexible Spending Account reimbursement, such as premiums for dental or vision insurance. In addition, Publication 502 does not specifically address all of the requirements of Limited Purpose Health Care Flexible Spending Accounts, including the requirement that some expenses are reimbursable only after you have met your MMC Consumer Directed Health Plan annual deductible (see "Examples of reimbursable expenses" and "Excluded expenses" for more information). You may also contact the Claims Administrator for information about reimbursable qualified medical expenses.

Who are the qualifying family members whose expenses may be reimbursed?

According to the IRS, a qualifying family member includes any person who qualifies for tax-free health plan benefits, including any of the following individuals:

- Your opposite-sex spouse
- A person for whom you can claim an exemption on your federal taxes

- A person who meets all of the following criteria:
 - Is your child (by birth or adoption), stepchild or foster child; your sibling or, step-sibling; or the descendant of your child, stepchild, foster child or sibling
 - Lives with you for more than half the year
 - Doesn't provide more than half his or her own support for the year
 - Is age 18 or younger for the entire calendar year; age 23 or younger and a full-time student for the entire calendar year; or permanently and totally disabled at any time during the calendar year (regardless of age)
 - Is either a US citizen, national, or resident; a resident of Canada or Mexico; or a child being adopted by a US citizen or national who shares that individual's home as a member of the household
- Another person (e.g., relative, domestic partner, same-sex spouse) who meets all of the following criteria:
 - Receives more than half of his or her support from you during the calendar year
 - Can't be claimed as anyone's "qualifying child" dependent
 - Is your relative or, if the person is not your relative, he or she must live with you for the entire calendar year as a member of your household (except for temporary reasons such as vacation, military service or education) and the relationship cannot be in violation of local law
 - Is either a US citizen, national, or resident; a resident of Canada or Mexico; or a child being adopted by a US citizen or national who shares that individual's home as a member of the household

You can be reimbursed for eligible expenses for you, your spouse or your qualifying family members.

Unless your approved domestic partner or his or her children qualify for tax-free health plan benefits (as describe above), the federal government does not permit you to use health care flexible spending accounts for eligible expenses incurred by your approved domestic partner or his or her children.

How do I get reimbursed from my account?

Complete a Limited Scope Health Care FSA Claim Form and return it as the form instructs. Attach the proper documentation to your form, including:

- an itemized bill or statement,
- an EXPLANATION OF BENEFITS detailing any reimbursement received from a benefit plan, or a

- a copayment receipt.

Note: Medical expenses (other than eligible preventive care expenses) incurred before your MMC Consumer Directed Health Plan deductible (that is, the individual or family deductible, depending on your level of coverage) is met cannot be reimbursed from the Limited Purpose Health Care Flexible Spending Account, even if the expense is not covered by the MMC Consumer Directed Health Plan. If you are requesting reimbursement for medical expenses incurred after you meet your MMC Consumer Directed Health Plan deductible, you will have to provide an Explanation of Benefits to confirm that your deductible has been met.

You should keep copies for your records.

Who issues the reimbursements?

Reimbursements are issued by the Claims Administrator. You can submit your eligible expenses for reimbursement at any time after you incur the expense.

Where can I get a Flexible Spending Account Limited Scope Health Care Reimbursement Form?

Forms can be found on the Claims Administrator's website and on MMC PeopleLink. In the "Forms" section of MMC PeopleLink, click "View and Print Forms." Then, select "Dental/Medical/Flexible Spending Accounts." Select the Aetna Limited Scope Health Care FSA Claim Form.

You may also request a claim form from the Claims Administrator by calling (888) 238-6226.

How is the reimbursement paid from my account?

The Claims Administrator will reimburse eligible expenses directly to you from your Limited Purpose Health Care Flexible Spending Account. The Claims Administrator will do one of the following:

- deposit your reimbursement amount directly into your checking or savings account on file with Payroll, or
- send your check to your home address if you do not have direct deposit of your paycheck

Your first reimbursement may be paid by check while the Claims Administrator authenticates your bank information for direct deposit.

Reimbursements are processed within five to seven days of the Claims Administrator's receipt of the completed claim form and required documentation.

How long does it take for claims to be processed?

Reimbursements are processed within five to seven days of the Claims Administrator's receipt of the completed claim form and required documentation.

Do I need a minimum amount of expenses before I can be reimbursed?

The minimum reimbursement is \$25. You should wait until your eligible expenses total at least \$25 before you submit them for reimbursement.

If your remaining eligible expenses incurred through March 15 of the following Plan year (that is, the end of the grace period) are less than \$25, you can submit them and be reimbursed for eligible expenses.

How much can I be reimbursed?

The total amount elected for the Plan year is available for reimbursement at the start of the year, regardless of your contributions at the time of reimbursement.

What if the amount of my expense is more than I currently have in my account?

You will be reimbursed up to the annual amount you have elected to contribute. You do not have to wait until your account is sufficient to cover your expense.

Can I be reimbursed before I pay my provider?

Yes, but you must submit documentation confirming that services were rendered including dates of service, services rendered and your cost for these services (such as an itemized statement from your provider or an Explanation of Benefits from the insurer) before you can be reimbursed for eligible expenses.

Keep in mind that qualified medical expenses (e.g., copayments, coinsurance, over-the-counter prescription drugs) are only reimbursable if incurred after you meet the MMC Consumer Directed Health Plan deductible applicable to you (that is, the individual or family deductible, depending on your level of coverage).

Can I be reimbursed for expenses incurred before I meet my MMC Consumer Directed Health Plan deductible?

You can be reimbursed for eligible dental, vision and preventive care expenses incurred before your MMC Consumer Directed Health Plan deductible is met. You cannot, however, be reimbursed for qualified medical expenses (e.g., coinsurance, copayments, over-the-counter prescription drugs) until your MMC Consumer Directed Health Plan is met.

Are there different deductibles for individual and family coverage?

Yes, your deductible is different depending on whether you elect individual or family coverage under the MMC Consumer Directed Health Plan. If you elect individual coverage, you will be considered to have met the deductible when you reach the MMC Consumer Directed Health Plan's individual deductible.

If you elect family coverage, you will be considered to have met the deductible once combined expenses for you and your covered family members have met the family deductible.

Do qualified medical expenses have to be incurred after I meet my deductible or submitted after I meet my deductible?

Qualified medical expenses must be incurred after you meet the MMC Consumer Directed Health Plan deductible. For example, let's say you meet your MMC Consumer Directed Health Plan deductible on October 1. You went to the doctor on September 15 and, on October 15 you submit a claim to your Limited Purpose Health Care Flexible Spending Account for your expenses related to that office visit. That claim would not be reimbursable from your Limited Purpose Health Care Flexible Spending Account since the expense for the office visit was incurred on September 15, before you met your deductible.

Note: Expenses are treated as having been "incurred" when the care or service is provided, not when you are billed or pay for it.

Can I be reimbursed for expenses incurred before participation in the Plan?

No, expenses incurred before your participation begins cannot be reimbursed.

How often can I request reimbursement?

You can submit your expenses for reimbursement as often as you would like after services have been provided to you, but the minimum reimbursement is \$25.

In accordance with IRS rules, you will forfeit any account balance not used to pay eligible expenses incurred before March 15 of the following Plan year, if they are not submitted by May 31.

What types of expenses are reimbursable if incurred during the grace period?

The Plan will reimburse eligible dental, vision and preventive care expenses incurred during the grace period. The Plan will not reimburse qualified medical expenses (e.g., copayments, coinsurance, over-the-counter prescription drugs) during the grace period, unless you have met the MMC Consumer Directed Health Plan deductible for the current Plan year.

Expenses incurred during the grace period but after your employment ends are not reimbursable.

What happens to contributions in my Limited Purpose Health Care Flexible Spending Account that I have not used by the end of the grace period?

In accordance with IRS rules, you will forfeit any account balance not used to pay eligible expenses incurred between January 1 and December 31 of the Plan year or between January 1 and March 15 of the following Plan year (the grace period) if they are not submitted by May 31.

If your participation ends during the year, you will not be reimbursed for expenses incurred after the date your participation ends (for example, after your employment ends, unless you continue participation through COBRA). You will, however, have until May 31 of the following Plan year to submit for reimbursement eligible expenses you incurred during the Plan year while you were participating.

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 refer to the *Administrative Information* section for a description of the appeal process.

How can I get a copy of IRS Publication 502?

Go to www.irs.gov and enter "502" in the "Search" box for more information about IRC Section 213 qualified medical expenses. Note that certain items listed in Publication 502 may not qualify for Limited Purpose Health Care Flexible Spending Account reimbursement, such as premiums for dental or vision insurance. In addition, Publication 502 does not specifically address all of the requirements of Limited Purpose Health Care Flexible Spending Accounts, including the requirement that some expenses are reimbursable only after you have met your MMC Consumer Directed Health Plan annual deductible (see "Example of reimbursable expenses" and "Excluded expenses" for more information).

You may also contact the Claims Administrator for information about reimbursable qualified medical expenses.

Examples of Eligible Expenses

Some expenses are reimbursable without regard to whether you have met your MMC Consumer Directed Health Plan deductible, while other expenses are reimbursable only after you have your MMC Consumer Directed Health Plan deductible (that is, the individual or family deductible, depending on your level of coverage). In addition, only eligible dental, vision and preventive care expenses are reimbursable if INCURRED during the GRACE PERIOD. The Plan will not reimburse qualified medical expenses (e.g., copayments, coinsurance, over-the-counter prescription drugs) during the grace period, unless you have met the MMC Consumer Directed Health Plan deductible for the current PLAN YEAR.

Eligible dental and vision expenses reimbursed without regard to whether you have met your MMC Consumer Directed Health Plan include:

- Eye exams, glasses (frames and lenses), contact lenses and solutions for contact lenses, lubricant eye drops, eye patches and reading glasses
- LASIK eye surgery
- Dental treatment, routine dental care (cleaning, X-rays, fillings, etc.), and over-the-counter products such as toothache relief, temporary filling, denture adhesive
- orthodontia (braces)
- Mouth guards

Examples of preventive care expenses reimbursed by the Plan

The following are examples of preventive care expenses may generally be reimbursed without regard to whether you have met your deductible:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals
- Routine prenatal and well-child care
- Flu shots (if not covered by the MMC Consumer Directed Health Plan or any other plan)
- Vaccinations
- Child and adult immunizations
- Tobacco-cessation programs
- Obesity weight-loss programs
- Screenings for conditions such as:
 - Cancer
 - Heart and vascular diseases
 - Infectious diseases
 - Mental health conditions
 - Substance abuse
 - Metabolic, nutritional, and endocrine conditions
 - Musculoskeletal disorders

- Obstetric and gynecological conditions
- Pediatric conditions
- Vision and hearing disorders
- Preventive over-the-counter expenses, such as:
 - Home diagnostic tests or kits for blood pressure, cholesterol screening, diabetes (e.g., glucose monitor), colorectal, HIV
 - Smoking-cessation relief, such as patches and gum
 - Pre-natal vitamins (with doctor's note of medical necessity)
 - Iron pills (with doctor's note of medical necessity)
 - Weight loss (with doctor's note of medical necessity)

Preventive care does not generally include any service or benefit intended to treat an existing illness, injury, or condition.

Examples of qualified medical expenses reimbursable after you meet your MMC Consumer Directed Health Plan deductible

Qualified medical expenses are reimbursable under the Plan if they are incurred after you have met your MMC Consumer Directed Health Plan deductible and while you are participating in the Plan. The Plan will not reimburse qualified medical expenses (e.g., copayments, coinsurance, over-the-counter prescription drugs) during the grace period, unless you have met the MMC Consumer Directed Health Plan deductible for the current Plan year. Examples of qualified medical expenses include:

- medical services provided by medical practitioners and that are not reimbursed by another medical plan
- charges for medically necessary services not reimbursed by medical plans, including but not limited to the following:
 - out-of-pocket expenses
 - copayments
 - coinsurance
 - charges exceeding reasonable and customary amounts
 - charges exceeding plan limits
 - prescription drug charges
 - other non-covered charges

- all medically necessary prescription drugs and certain other prescription drugs permitted by the IRS (e.g., contraceptives)
- certain over-the-counter non-prescription medicines, such as allergy and cold medications, aspirin and antacids, if they are intended to alleviate or treat personal injuries or sickness
- hearing aids
- cost differences between semi-private and private hospital rooms
- cost for special medical equipment installed in your home, or for home improvements for purposes of medical care, e.g., ramps, support bars, railings, etc.
- fees for special schools on the recommendation of a physician, including schools for the mentally impaired, physically disabled or individuals with severe learning disabilities
- transportation (amounts paid for travel primarily for, and essential to, medical care)
- personal use items if primarily used to prevent or alleviate a physical or mental defect or illness, e.g., wigs, Braille books, hearing aids
- nursing services in hospital, nursing home or your home
- smoking cessation programs
- weight loss programs (if you have a letter from your treating physician indicating medical necessity)
- alternative medicine
- Christian Science practitioners

For examples of IRC Section 213 qualified medical expenses, see IRS Publication 502, which is available at <http://www.irs.gov> or by calling the IRS at 1-800-829-3676. Note that certain items listed in Publication 502 may not qualify for Limited Purpose Health Care Flexible Spending Account reimbursement, such as premiums for dental or vision insurance. In addition, Publication 502 does not specifically address all of the requirements of Limited Purpose Health Care Flexible Spending Accounts, including the requirement that some expenses are reimbursable only after you have met your MMC Consumer Directed Health Plan annual deductible (as shown above). You may also contact the Claims Administrator for information about reimbursable qualified medical expenses.

Examples of Ineligible Expenses

You cannot be reimbursed for certain health care expenses, such as:

- medical expenses (except for certain preventive care expenses) that you incur before you meet the MMC Consumer Directed Health Plan deductible applicable to you (that is, the individual or family deductible, depending on your level of coverage)
- contributions to other employer-sponsored medical or dental plans, including plans sponsored by your spouse's employer (contributions to the Company's health plans are already made on a before-tax basis)
- premiums paid for any health care plan, including COBRA, Medicare, and plans sponsored by your spouse's employer
- costs you deduct as health care expenses on your federal income tax return
- expenses not eligible to be deducted under federal tax law
- expenses reimbursed by any other health plan
- health club membership dues
- cosmetic surgery, electrolysis, hair removal or transplants, liposuction, etc.
- vitamins and other dietary supplements, toiletries and cosmetics that are not medically necessary
- medications purchased merely to maintain your or your family's health
- prescription drugs that are not medically necessary and not permitted by the IRS (such as Rogaine)
- cosmetic dental work (including bleaching, bonding and veneers)
- undocumented travel to or from your physician's office or other medical facility
- weight loss programs (unless you have a letter from your treating physician indicating medical necessity)
- long-term care premiums and services

About Your Account

How can I find out my unused account balance?

To find out the balance in your account, log in to the Claims Administrator's website. If you are not currently registered, go to the Claims Administrator's website and follow the instructions for registration. Once you are registered, you will be able to login to the Claims Administrator's website and access your account information.

A statement showing your account activity will be issued twice per year in April and September and with each reimbursement check or direct deposit into your bank account.

What information can I find on my account statement?

You will find the following:

- the dates on which the reimbursements were made
- your balance as of the statement date
- your reimbursements
- your total contributions

Do I earn interest on my account?

No, your account does not earn interest.

Glossary

EXPLANATION OF BENEFITS

An Explanation of Benefits is a statement that the Claims Administrator sends to you after you, one of your covered family members or your health care provider files a claim for benefits. The Explanation of Benefits shows the charges that were submitted, the amount paid or not paid, and your balance, if any. For the MMC Consumer Directed Health Plan, the Explanation of Benefits also shows whether you have met your MMC Consumer Directed Health Plan annual deductible.

INCURRED

Expenses are treated as having been incurred when the care or service is provided, not when you are billed or pay for it.

PLAN YEAR

The Plan year is January 1 through December 31.

GRACE PERIOD

The grace period is the additional 2 ½-month period following the end of the Plan year. If you have a balance remaining in your Limited Purpose Health Care Flexible Spending Account after the end of the Plan year and you are still participating on December 31 of the Plan year, you may use that balance to be reimbursed for eligible dental, vision and preventive care expenses incurred during the grace period. For example, if you do not use the balance in your 2008 Plan year Limited Purpose Health Care Flexible Spending Account between January 1 and December 31, 2008, you may use the remaining balance to be reimbursed for eligible dental, vision and preventive care expenses incurred between January 1, 2009 and March 15, 2009 (the grace period).

You can be reimbursed only for eligible dental, vision and preventive care expenses incurred during the grace period. The Plan will not reimburse qualified medical expenses (e.g., copayments, coinsurance, over-the-counter prescription drugs) during the grace period, unless you have met the MMC Consumer Directed Health Plan deductible for the current Plan year.

Expenses incurred during the grace period but after your employment ends are not reimbursable.

CLAIMS FILING DEADLINE

The claims filing deadline is May 31 following the end of the Plan year. For example, for the 2008 Plan year, your eligible expenses must be incurred no later than March 15, 2009 (the end of the grace period) and must be submitted to the Claims Administrator by May 31, 2009 (the claims filing deadline).