

November 1, 2007

Long Term Care Insurance Plan MMC



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Long Term Care Insurance Plan

This plan helps you pay for the care you or a family member could require as a result of an illness, an accident, or age. This care may be needed for a lengthy period of time, either in your home or in a facility that provides long-term care.

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.

SPD and Plan Document

This section provides a summary of the Long Term Care Insurance 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.

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The Plan at a Glance

The Long Term Care Insurance Plan helps you pay for the care you or a family member could require as a result of an illness, an accident, or age. For more information, see “How the Plan Works” on page 9.

Plan Feature Plan Feature	Highlights
How the Plan Works	<ul style="list-style-type: none"> This plan helps you pay for the care you or a family member could require as a result of an illness, an accident, or age. This care may be needed for a lengthy period of time, either in your home or in a facility that provides long-term care.
Eligibility	<ul style="list-style-type: none"> You are eligible to participate in this program if you meet the eligibility requirements described below. See “Participating in the Plan” on page 3 for details.
Family Eligibility	<ul style="list-style-type: none"> Your spouse/approved domestic partner and certain family members, to the extent permissible by state insurance regulations, are also eligible to apply for coverage. See “Participating in the Plan” on page 3 for details.
Enrollment	<ul style="list-style-type: none"> New hires have 90 days to enroll for coverage without submitting EVIDENCE OF INSURABILITY. You must be ACTIVELY AT WORK on your effective date of coverage. Your family members always need to provide Evidence of Insurability. New hires enrolling in the Long Term Care Insurance Plan within the 90 day new hire window can enroll by completing an online application form. Employees applying outside of the 90 day new hire window, as well as family members, need to fill out a paper enrollment form which is available through MetLife.
Cost of Coverage	<ul style="list-style-type: none"> The cost of coverage for you and your family members is an amount based on the coverage level you choose and your age as of the date your coverage becomes effective. Each covered family member has his or her own cost based on the above factors.

Plan Feature Plan Feature	Highlights
Levels of Coverage	<ul style="list-style-type: none"> ▪ You can create a personalized plan by choosing from these levels or options of coverage. ▪ Daily Benefit Amount Options: <ul style="list-style-type: none"> – \$100 daily benefit option (minimum) – \$150 daily benefit option – \$200 daily benefit option – \$250 daily benefit option (maximum) – Total Lifetime Maximum Options: <ul style="list-style-type: none"> – 3 years (1,095 days) – 5 years (1,825 days) ▪ Nonforfeiture Coverage Option: The Nonforfeiture feature is only available, as an option, if you design a custom plan. ▪ With this feature, if you stop paying premiums after three years, you keep a reduced level of benefits. The amount will be based on the greater of the total premiums you have paid, or 30 times your daily benefit amount.
Contact Information	<p>For more information, contact:</p> <p>MetLife Phone: (800) 438-6388 Website: www.metlife.com/mybenefits MMC does not administer this Plan. MetLife's decisions are final and binding.</p>

Participating in the Plan

The following section provides information on how you start participating in the program.

If you are an employee of MMC or any subsidiary or affiliate of MMC and you meet the requirements set forth below, you become eligible on your eligibility date.

You can also cover your eligible family members and approved opposite gender or same gender domestic partners under this Plan to the extent permissible by state insurance regulations.

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).

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.

"You," "Your," and "Employee"

As used throughout this plan summary, "employee," "you" and "your" always mean:

- For Kroll participants: a U.S. FULL-TIME REGULAR EMPLOYEE OF KROLL, Inc and any of its subsidiaries
- For MMC participants: a U.S. salaried employee of MMC or any subsidiary or affiliate of MMC (other than Kroll, Inc. and any of its subsidiaries).

Eligible Employees

Eligible MMC Employees (other than Kroll)

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 (other than Kroll, Inc., and any of its subsidiaries).

MMC employees who are classified on payroll as hourly employees or who are compensated as independent contractors are not eligible to participate.

Eligibility Date

There is no waiting period if you are **ACTIVELY AT WORK**. Your eligibility date is the first day you are actively at work on or after your date of hire.

Eligible Kroll Employees

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. You are considered "full-time" if you are generally scheduled to work 35 hours or more per week.

Kroll employees who are classified on payroll as contingent or part-time employees or who are compensated as independent contractors are not eligible to participate.

Eligibility Date

There is a 30 day waiting period after your date of hire. Your eligibility date is the 31st calendar day from your date of hire (the date your ACTIVE WORK STATUS began). For example, if you began your active work status on your date of hire on August 1, your eligibility date is August 31.

Eligible Spouses and Domestic Partners

To obtain spousal or domestic partner coverage, you will need to complete an Affidavit of Eligible Family Membership via MMC Benefits Online declaring that:

- Your legally married spouse is eligible to apply for coverage, to the extent permissible by state insurance regulations.
- Your approved same gender or opposite gender domestic partner, to the extent permissible by state insurance regulations is also eligible to apply for coverage.

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

Domestic partner coverage can be added via MMC Benefits Online.

Eligible Family Members

The following family members are eligible to apply for coverage, to the extent permissible by state insurance regulations:

- your parents
- your approved domestic partner, to the extent permissible by state insurance regulations
- your children over age 18 and their spouses, to the extent permissible by state insurance regulations
- your parents-in-law
- your approved domestic partner's parents or stepparents
- your approved domestic partner's grandparents
- your stepparents
- your grandparents
- your grandparents (in-law)

Enrollment

You have the option to enroll in Long-Term Care Insurance coverage.

New employees have 90 days to enroll without submitting EVIDENCE OF INSURABILITY. You must be ACTIVELY AT WORK on your effective date of coverage. You can apply outside of the 90 day new hire window, but you will be required to provide Evidence of Insurability. Your family members always need to provide Evidence of Insurability.

How do I enroll myself and my family members for coverage?

New hires enrolling in Long Term Care Insurance within the 90 day new hire window can enroll by completing an online application form. Employees applying outside of the 90 day new hire window, as well as family members, are required to fill out a paper enrollment form which is available through MetLife. Your family members always need to provide Evidence of Insurability.

Can I enroll myself and my family members after the 90 day new hire window?

If you missed the new hire enrollment period, you can apply for coverage any time during the year; Evidence of Insurability is required. Eligible family members may also apply at anytime throughout the year, to the extent permissible by state insurance regulations.

Evidence of Insurability is required.

Do my dependents and I have to re-enroll every year?

The Long Term Care Insurance coverage carries over from one year to the next, so you don't have to enroll each year.

Do I need an ID card?

Each insured will be sent an ID card with their Certificate of Insurance. You can contact MetLife if you need more ID cards or replacement cards.

Evidence of Insurability

Evidence of Insurability needs to be provided by:

- employees who do not enroll within 90 days of employment
- your eligible family members

Cost of Coverage

The cost of coverage for you and your family members is an amount based on the daily maximum you choose and your age as of December 1 on or preceding the date your coverage becomes effective. Each covered family member has his or her own cost based on the below factors.

Levels of Coverage

You can create a personalized plan by choosing from these levels or options of coverage.

Daily Benefit Amount options:

- \$100 daily benefit option (minimum)
- \$150 daily benefit option
- \$200 daily benefit option
- \$250 daily benefit option (maximum)

Total Lifetime Maximum options:

- 3 years (1,095 days)
- 5 years (1,825 days)

Nonforfeiture Coverage Option

- The Nonforfeiture feature is only available, as an option, if you design a custom plan. With this feature, if you stop paying premiums after three years, you keep a reduced level of benefits. The amount will be based on the greater of the total premiums you have paid, or 30 times your daily benefit amount.

Can I pay for coverage through payroll deductions?

You can pay for coverage through the following:

- you and your spouse or approved domestic partner can pay for your coverage through payroll deductions
- your eligible family members can be billed for their coverage quarterly, semi-annually, annually, or they can set up monthly deductions from their checking account.

When does my cost of coverage change?

Your premiums are based on the coverage level you choose and your age, as of the date your coverage becomes effective. Your premium may increase:

- if Long Term Care Insurance rates are adjusted on a class basis for all participants. These adjusted rates will be passed on to all participants
- if you buy additional coverage; your age as of the effective date of the increase will determine the price for the additional coverage

Will my cost for coverage increase as I get older?

Generally, your cost for coverage remains unchanged. However, if you elect the optional INFLATION protection feature, your cost for this increased coverage will be based on your age as of the effective date and reflects the additional cost associated with providing coverage to persons in your age category.

Are my premiums waived while I'm receiving benefits?

Yes, your premiums are waived for you while you are receiving benefits. Your premiums will start again the first day of the month on or following the date you are no longer certified as CHRONICALLY ILL.

You should contact MetLife regarding qualifying benefits.

Taxes

Do I pay with before-tax or after-tax dollars?

You make plan payments with after-tax dollars.

There is potential favorable federal income tax treatment of your Long Term Care Insurance premiums:

- a portion of your premium paid may be tax deductible. If your eligible premium, in conjunction with other medical expenses, exceeds 7.5% of your adjusted gross income and does not exceed dollar limits as specified by the IRS, it will be tax deductible if you itemize your taxes. There are caps on the amount that can be deducted, based on your age
- benefits you receive will generally not be considered taxable income, provided that they are within IRS limits or that amounts in excess of the IRS limits are used for medical care

When Coverage Starts

Coverage becomes effective the first of the month following acceptance into the Plan.

What happens if I'm not actively at work on the effective date?

If you are a MMC employee (other than Kroll) who enrolled without providing EVIDENCE OF INSURABILITY and you are not actively at work, or a Kroll employee and not in ACTIVE WORK STATUS, on the day your coverage is supposed to go into effect, your coverage will begin the first of the month following your return to work.

When can I change my coverage?

You can decrease your coverage any time during the year.

Evidence of Insurability is required to increase your coverage.

When Coverage Ends

What happens if I leave the Company?

If you leave the Company, you will have the option of continuing your coverage at your current premium rate. Upon termination, call MetLife to arrange for continuation of premium payments directly to MetLife.

What happens when I die?

If you die before age 65 and have benefits remaining, MetLife will return all of the premiums paid into the Plan, less any benefits you have received, to your estate.

If death occurs between ages 65 and 75, the amount your estate will receive will decline 10% each year, less any benefits received.

There will be no refund if you join the Plan after age 65 or if you die after age 75 because of the increased costs in providing coverage at and after age 65.

Note: The return of premium on death feature is not available to residents of Washington State. Residents of this state will have an enhanced respite care services benefit of 42 days per calendar year.

How the Plan Works

This plan helps pay for the care you or a covered family member require as a result of an illness, an accident, or age. This care may be needed for a lengthy period of time, either in your home or in a facility that provides long-term care.

In the event of a conflict among the terms in this Summary Plan Description and the Certificate of Coverage, the Certificate of Coverage will govern. You will receive a Certificate of Coverage from MetLife within 30 days after you are enrolled in the Plan.

What is long-term care?

Long-term care refers to the services and assistance you or a family member could need as a result of an illness, an accident, or age.

This care may be needed when someone becomes unable to care for himself or herself and requires help doing everyday activities like dressing, eating, bathing, continence, toileting and transferring. Just as it sounds, long-term care is about needing care for a lengthy period of time, either in your home or in a facility that provides long-term care services.

How do I or my covered family member qualify for benefits; is there a “waiting period”?

To qualify for benefits, you or your covered family member must be certified by a licensed health-care practitioner as being unable to perform at least two of the six Activities of Daily Living (bathing, continence, dressing, eating, toileting, transference) for a period (also known as the “waiting period”) of at least 90 days, or as requiring substantial protective supervision due to severe cognitive impairment.

When will I or my covered family members be qualified to receive long-term care?

You or your covered family member must be certified as CHRONICALLY ILL.

Can I choose where to receive my care?

Yes, you can choose where to receive care, in conjunction with your case manager.

Initial Care Planning Visit

Can I receive help in making my decisions on what kind of care to receive?

Yes. Independent CARE ADVISORS are available to meet with you and your family in your home or another location to explore care options and help you make decisions. Offered at no charge, this one-time service is initiated at your request after you qualify for benefits.

There is a limit of \$250 for this visit. Residents of Texas will have a limit of \$275 for this visit.

Care Management

What is the role of care management?

You need to contact MetLife to develop a plan of care when you require long-term care services. MetLife will monitor your care to make sure you are receiving the best care, in their judgment, to meet your needs.

You can also contact MetLife for a recommendation and approval of alternative benefits.

Do I have to use care management?

Yes, you need to contact MetLife to develop a plan of care when you require long-term care. MetLife will monitor your case to make sure you are receiving the best care, in their judgment, to meet your needs.

When do I need to contact MetLife regarding care management?

You may contact MetLife at any time. You should contact MetLife as soon as you learn that you need long-term care services.

About Your Benefits

What services are covered by this Plan?

Once you are certified as eligible for Long Term Care Insurance, the Plan covers:

- adult day care—60% of the daily benefit selected
- Alzheimer's facility—100% of the daily benefit selected
- assisted living facility—100% of the daily benefit selected
- at-home hospice care—60% of the daily benefit selected
- home care—60% of the daily benefit selected
- in-patient hospice—100% of the daily benefit selected
- initial CARE ADVISORY visit—100% of the daily benefit selected

- nursing home services—100% of the daily benefit selected
- ongoing care advisory services—60% of the daily benefit selected
- respite care—100% of the daily benefit selected for 21 days per calendar year

There is a lifetime maximum benefit of:

- three years: 1,095 times your Daily Benefit Amount
- five years: 1,825 times your Daily Benefit Amount

For example, the lifetime maximum benefit for a \$200 daily benefit option for five years would be \$365,000 ($\$200 \times 1,825$).

Some services have specific limits or restrictions.

Some services are not covered (these are called exclusions).

Does the Plan cover organic and inorganic brain diseases?

The Plan covers disabilities resulting from organic brain diseases, including Alzheimer's disease and similar disorders. The Plan also covers dependencies resulting from brain diseases which are organically based, as long as the insured meets the benefit eligibility criteria. MetLife does not attempt to identify the cause of disability or mental disorder.

Are benefits provided outside the United States?

International coverage is available through the International Coverage Certificate Rider to U.S. salaried employees who are living or working outside the United States.

The daily benefit amount will be referred to as a "per diem benefit." The per diem benefit amount will be equal to 50% of the home care benefit and will be paid whether or not services are received once the insured has been deemed eligible for benefits and the "waiting period" as defined under "How the Plan Works" has been fulfilled. The per diem benefit will be paid in United States dollars.

For New York residents, the following applies: you will never receive less than \$25 per day. If you provide evidence of confinement in a licensed nursing home, the minimum amount paid will be \$50. The per diem benefit will be paid up to a maximum of six years while you are outside of the United States.

For non-New York residents: This benefit will be paid to a maximum of 10 years while the insured is outside of the United States.

Is there an automatic inflation protection feature?

No, there is no automatic inflation protection feature. Rather, an optional inflation protection feature is offered in connection with this coverage.

Does this Plan adjust for inflation?

To keep up with inflation, the Long Term Care Insurance Plan offers the opportunity to upgrade your daily benefit amount to protect against future increases in the cost of long-term care. This option is offered every three plan years.

When your daily benefit increases, your lifetime benefit will also increase. The amount of daily benefit increase will be approximately 5% compounded annually.

Your premium for the increase will be based on your age as of the effective date of the increase.

Am I always offered optional inflation protection?

The offering is guaranteed as long as the option has been selected once every two offerings. If you don't choose this option for two consecutive offerings, it will continue to be offered; however you must provide EVIDENCE OF INSURABILITY.

The offer is made regardless of age, claim status, claim history, or length of participation in the Plan.

Do I have a Nonforfeiture option?

The Nonforfeiture feature is only available, as an option, if you design a custom plan.

With this feature, if you stop paying premiums after three years, you keep a reduced level of benefits. The amount will be based on the greater of the total premiums you have paid, or 30 times your daily benefit amount.

Can I receive a discount on services?

There is no discount program. However, case managers often negotiate lower fees from physicians, facilities, equipment suppliers, etc. on behalf of a patient.

What is transition expense benefit?

The Plan's transition expense benefit provides a one-time payment up to five times the daily benefit amount to be used for long-term care purposes, such as a personal emergency response system, caregiver training, durable medical equipment, or offsetting costs of qualified services received during the "waiting period" in which you or a covered family member were being qualified for benefits as described under "How the Plan Works".

It is payable after completion of this waiting period. To access this benefit, proof of payment for a covered expense must be submitted to MetLife. It does not reduce the total lifetime benefit.

What Is Not Covered

Exclusions

Are there any Exclusions under this Plan?

The Long Term Care Insurance Plan does not provide benefits for any of the following:

- care specifically provided for detoxification of or rehabilitation for alcohol or drug abuse (chemical dependency), except drug abuse sustained at the hands of or while being treated by a Physician for an injury or sickness
- any service or supply received outside the United States or its territories (except for insureds who are eligible to receive benefits outside the United States)
- illness, treatment or medical condition arising out of any of the following:
 - war or act of war (whether declared or undeclared)
 - participation in a felony, riot or insurrection (unless the insured is acting in self-defense)
 - service in the armed forces or auxiliary units
 - attempted suicide (while sane or insane) or intentionally self-inflicted injury
 - aviation (this applies only to non-fare paying passengers)
- treatment provided in a government facility, unless otherwise required by law
- any care provided while in a hospital, except for confinement in a distinct part of a hospital that is licensed as a nursing home or hospice
- any service provided by your immediate family, unless the service is a covered service from an informal caregiver (such as a friend, neighbor, or family member)
- any service or supply to the extent that such expenses are reimbursable under Medicare, or would be reimbursable but for the application of a deductible or coinsurance or copayment amount. This exclusion will not apply in those instances where Medicare is determined to be secondary payer under applicable law
- service for which no charge is normally made in the absence of insurance

Alternate plan of service provision

What if the service I want is not covered?

This Plan has an “Alternate plan of service provision.” This provision means that a MetLife care manager can authorize benefits for qualified long-term care services not specifically covered under the Plan. Services must be qualified, must meet the needs of the covered person, and be a cost effective alternative.

Filing a Claim

How do I file a claim?

You or your covered family member file a claim by calling MetLife. The claim needs to be filed within 90 days of the date care is received.

You or your covered family member will speak with a care manager who is a registered nurse who will obtain the necessary information to make a decision regarding benefits eligibility. You or your covered family member will be notified of the decision within 10 business days of receipt of all the necessary information.

In some cases, the care manager may also contact a representative or others who may have relevant information about your or your covered family member's condition. In the event that necessary information is not available through these channels, MetLife may arrange an onsite visit at its own expense.

You need to contact MetLife to develop a plan of care.

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 *Plan Administration* 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 DEDUCTIONS (EMPLOYEE CONTRIBUTIONS)

Deductions taken from your pay after Social Security (FICA and Medicare) and federal unemployment insurance (FUTA) taxes and other applicable federal, state and local 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 DEDUCTIONS (EMPLOYEE CONTRIBUTIONS)

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

For certain plans, such as the 401(k) Savings & Retirement Plan and the Supplemental Savings & Retirement Plan, contributions are taken from your paycheck after Social Security and federal unemployment insurance taxes are withheld but before federal, and, if applicable, state or local income taxes are withheld.

CARE ADVISOR

A health care professional from a Care Management Organization.

Care advisors do not identify medical conditions (the insured's physician does this). Services performed by care advisors include:

- assessing long-term care needs;
- developing a long-term care service plan;
- requisitioning and coordinating long-term care services;
- implementing the long-term care service plan; and
- periodically monitoring and reassessing long-term care services.

CHRONICALLY ILL

Chronically Ill means that:

- you are unable to perform, without substantial assistance from another individual, at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- you require substantial supervision to protect you from threats to health and safety due to Severe Cognitive Impairment.

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.

EVIDENCE OF INSURABILITY

Evidence of Insurability is proof of good health and is generally required if you do not enroll for coverage when you first become eligible, if the coverage level you are requesting requires such evidence, or if you are increasing coverage. Establishing Evidence of Insurability may require a physical examination at the employee's expense. The Evidence of Insurability must be provided to and approved by the insurer before coverage can go into effect.

INFLATION

An economy-wide increase in costs and prices from one year to the next.